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Commercially sexually exploited youths' health care experiences, barriers, and recommendations: A qualitative analysis

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Abstract

The current study sought to understand commercially sexually exploited (CSE) youths' health care experiences, barriers to care, and recommendations for improving health care services. We conducted focus groups (N=5) with 18 CSE youth from February 2015 through May 2016 at two group homes serving CSE youth in Southern California. We performed thematic content analysis to identify emergent themes about CSE youths' perspectives on health care. Youth described facilitators to care, including availability of services such as screening for sexually transmitted infections, knowledge about sexual health, and a strong motivation to stay healthy. Barriers included feeling judged, concerns about confidentiality, fear, perceived low quality of services, and self-reliance. Overall, youth emphasized self-reliance and "street smarts" for survival and de-emphasized "victimhood," which shaped their interactions with health care, and recommended that health providers develop increased understanding of CSE youth. Our findings suggest that

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providers and community agencies can play an essential role in raising awareness of the needs of CSE youth, and meet their health needs through creating a non-judgmental environment in health care settings that validates the experiences of these youth.

Keywords

commercial sexual exploitation of children; sex trafficking; qualitative

Introduction

The overlapping issues of *commercial sexual exploitation of children (CSEC)* and *child sex trafficking* are critical public health problems in the United States (U.S.). Roughly 4,500 to 21,000 youth within the U.S. are commercially sexually exploited each year (Swaner, Labriola, Rempel, Walker, & Spadafore, 2016). The United Nations Palermo Protocol defines human trafficking as "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation." The term exploitation includes both "prostitution of others or other forms of sexual exploitation." Further, under the Palermo protocol, a child (less than 18) meets the definition of being trafficked even without the use of the aforementioned means, including force, threat, abduction, deception, or the abuse of power (United Nations, 2000). In the U.S., the Institute of Medicine (IOM) defines CSEC as a range of acts where a minor is exploited for sexual purposes, this includes trafficking for sexual exploitation, exploiting through "prostitution," and involving in the exchange of sex acts for necessities, money, or something of value, among other crimes (Clayton, Krugman, & Simon, 2013). In 2013, the IOM highlighted significant deficits in knowledge among health professionals about commercially sexually exploited (CSE) youth and called for increased detection within the health community (Clayton et al., 2013).

CSE youth are at high risk for significant physical and mental health issues, including sexually transmitted infections (STIs), unwanted pregnancies, violence-related injuries, substance use disorders, depression, and post-traumatic stress disorder (PTSD) (WestCoast Children's Clinic, 2012; Greenbaum, 2014; Hossain, Zimmerman, Abas, Light, & Watts, 2010). Surveys conducted among trafficked youth and women receiving services in Europe found that 77% had probable PTSD and 55% had high level of depression symptoms (Hossain et al., 2010). One study found that 89% of female sex trafficking survivors experienced depression and 42% had attempted suicide while trafficked (Lederer & Wetzel, 2014). A study on CSE youth found that 70% reported substance use and 31% experienced sexual violence (Varma, Gillespie, McCracken, & Greenbaum, 2015). Many CSE youth have histories of prior adversities, including homelessness, victimization due to sexual orientation, and childhood abuse (Cochran, Stewart, Ginzler, & Cauce, 2002; Reid, Baglivio, Piquero, Greenwald, & Epps, 2017; Seng, 1989; Stoltz et al., 2007). A study of CSE youth in Burkina Faso found that 28% of the youth had suffered sexual abuse; 31% had an

unwanted pregnancy; and 20% suffered various significant life events including the death of a parent, undergoing female circumcision, or community rejection (Hounmenou, 2016).

The health care system is a vital point of interaction with trafficked individuals (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011). In Los Angeles, 50% of a sample of trafficked adult women saw a health provider while trafficked (Baldwin et al., 2011). Similarly to trafficked adults, CSE youth often present for health care; one multi-site study found that 64% had seen a physician within the past 3 months (Swaner et al., 2016). In New York City, CSE youth were most likely to present for care for a general check-up (42.6%), followed by STI testing (34.1%), and testing for HIV (20.9%) (Curtis, Terry, Dank, Dombrowski, & Khan, 2008).

Despite the extraordinarily high health needs among this population, best practices for health providers who serve CSE youth are underdeveloped. Surveys of physicians and medical students demonstrate that most providers lack training (Beck et al., 2015) and awareness of how to detect CSEC and, if encountered, how to respond (Titchen et al., 2015). Beyond the health care system, although CSE youth may interact with multiple systems of care, including law enforcement, child welfare, and other social service agencies, there is a lack of cohesion among service providers across disciplines on how to best care for CSE youth (Sapiro, Johnson, Postmus, & Simmel, 2016; Swaner et al., 2016). Furthermore, it is unclear what factors drive CSE youth to seek and engage in health services, the barriers to accessing care, or what type of services are most desired.

Qualitative research can illuminate experiences and voices of hard-to-reach populations and can potentially transform care (Israel, Eng, Schulz, Parker, 2005). Prior studies have interviewed stakeholders, health care professionals, and social service providers about CSE youth and their needs (Sapiro et al., 2016; Swaner et al., 2016). Qualitative studies among CSE youth have provided important perspectives on engagement with street outreach workers, and challenges faced by youth at risk for involvement in CSEC (Holger-Ambrose, Langmade, Edinburgh, & Saewyc, 2013; Kruger et al., 2013). The Office of Juvenile Justice and Delinquency Prevention sponsored a multi-site study of interviews with nearly 1,000 sex trafficked youth, which provided a varied depiction of the lives of CSE youth throughout the U.S., and demonstrated high rates of health care and social services need (Swaner et al., 2016). Yet, there remains a dearth of studies focused on the barriers to health services and recommendations for improving care from CSE youths' perspectives, especially from youth residing in group homes.

Given the gap in the literature about how to best provide health services to CSE youth, we conducted focus groups with CSE youth in Southern California, including Los Angeles County, an FBI designated high-intensity area for CSEC. Our purpose was to explore CSE youths' perspectives on their health needs, experiences with physical and mental health care, and recommendations for improving health services, to best improve care for this important population.

Methods

Participants

Five focus groups were conducted with a total of 18 CSE youth residing in group homes, from February 2015 through May 2016, at two programs serving CSE youth located in a large metropolitan region in Southern California. All participants were female as the two programs served exclusively females. Youth were eligible for participation if they were: 1) between the ages of 12–19; and 2) if they identified as ever being sexually exploited for someone else's gain. Team members screened youth for meeting the eligibility criteria immediately prior to the focus group. Youth were asked to provide assent to participate in the study. Only one potentially eligible youth declined to participate. Participants received $20 in the form of cash or a gift card for participating.

Procedures

Focus groups ranged between 2–5 participants and lasted an average of 60 minutes. Four trained facilitators from the research team led the groups (RM, LT, MC, and EB). Prior to each focus group, participants completed a brief demographic survey. Race and ethnicity were assessed in order to provide demographic characteristics of the focus group participants. Racial categories were modeled after the U.S. Office of Management and Budget (OMB). The facilitators used a semi-structured focus group guide that explored: 1) participants' experiences with health care (including physical health, mental health, and substance use services); 2) barriers to accessing health services; and 3) youth recommendations for improving access to services. To test the validity of our findings, the team conducted one-on-one semi-structured interviews with three CSE youth residing in the group homes. The University Institutional Review Board approved all study procedures.

Data Analysis

Focus groups were audio-recorded and transcribed, with the exception of one focus group, for which notes were taken by a team member due to the group home's restriction on audio recording. Three members of the team reviewed the transcripts to identify preliminary themes and sub-themes. Preliminary themes were also discussed with two focus group participants and their feedback was incorporated. Two coders then conducted rounds of independent coding and met to reconcile differences in the codes. Team members discussed the themes and sub-themes during team meetings and expanded, collapsed, and eliminated codes until consensus was attained. Coding was conducted using Dedoose software (Dedoose, 2016).

Results

Demographic surveys were administered to four of the five focus groups. Of the 13 survey participants, the mean age was 16 years old, 69% identified as Black, 39% as Hispanic, 23% as White, and 8% as other. Thirty eight percent had a history of homelessness (Table 1).

Three themes emerged that described youths' experiences accessing health services: 1) facilitators to care, with three sub-themes; 2) barriers to care; and 3) recommendations for

improving health services. Although the focus group discussions centered on health, a picture of youths' general experiences "in the life"—a term that youth often use to refer to commercial sexual exploitation —emerged. We categorized these general experiences within an additional theme called "lived experiences 'in the life.'"

Lived Experiences "In the Life"

This theme described participants' experiences and perspectives on CSEC. Many participants resisted the idea that they did not choose their paths and did not want to be viewed as victims by health care providers. There was consensus, however, that regardless of how one enters the life, being in the life was hard to endure, and hard to leave. One youth stated, *"You can leave. But your soul's gonna still be trapped."* Participants also described that the threat of violence was an everyday part of their lives. As one youth stated, "*I've been punched before. I don't know how to shut up sometimes."*

Facilitators to Care

Overall, participants reported utilizing a range of health services including reproductive, emergency, primary care, and mental health care. Youth described most frequently accessing reproductive services, especially Planned Parenthood. Within our analysis of this theme, three sub-themes emerged regarding facilitators to health service use: 1) perceived availability of services; 2) general knowledge of STIs; and 3) motivation to stay healthy. Sexual and reproductive health services seemed most strongly tied to these three themes.

Availability of services—Youth expressed that reproductive health services were more widely available compared to other types of health services, which facilitated their use. As one youth described, *"They have Planned Parenthoods everywhere."* Many of the youth described seeking care at Planned Parenthood for reproductive services, especially STI testing. A few described receiving testing on site at the group homes or via mobile health vans.

Although youth felt that mental health services were also available, the availability was generally limited to when youth were in detention centers or group homes. Youth conveyed that they commonly received mental health services in these settings, whether or not they wished to. Unlike the reproductive health services, only a small number of youth described actively seeking mental health services in the community setting; one participant stated that she obtained business cards from mental health providers she met in detention, in case she needed services in the future.

Youths' general knowledge of STIs—Most participants described the importance of getting *"checked"* (i.e. tested for STIs), which was a robust motivator for seeking health services. In particular, youth demonstrated a strong understanding of the risk of contracting STIs if one did not use condoms ("*not just AIDS, you can get herpes, hepatitis, and other things!")*. Some participants received testing for STIs every few months, and some reported visiting health clinics weekly for condoms. Participants expressed that they viewed other girls in the life who did not practice safe sex as "dumb."

Motivation to stay healthy—Seeking out services to protect one's health, particularly from STIs, was a pervasive theme. Youth explained needing to protect their reproductive health in order to continue working or to protect their sexual partners. As one youth stated, *"My vagina's the best thing on me… I have to get it checked out, because without your vagina you're worthless in the game."* Although much less ubiquitous, some youth also acknowledged a need to safeguard their emotional well-being. One participant highlighted her desire to prevent worse mental health outcomes, *"If I feel like I need help, I'm gonna to go talk to somebody because, if I don't, I'm just gonna to get more mentally ill…"* Youth expressed becoming more gradually comfortable with seeking out services when "in the life" because of their strong drive to stay healthy.

Barriers to Care

Although youth generally reported that health services were available to them, many youth did not readily access care. Several central barriers emerged to using services, including feeling judged, concerns about confidentiality, general fears, perceived low quality of care, and self-reliance.

Feeling judged—Although some youth noted positive interactions with providers, including times when providers asked them questions and explained how to care for their bodies, many described situations where they felt judged or stigmatized by a provider. For many youth, feeling judged eroded their trust in providers. Several youth expressed feeling bothered that providers would offer opinions, such as *"you should be in school…you shouldn't be doing this or that,"* without trying to understand the context of their lives. Youth explained that this dynamic led them to avoid health providers and limited the extent of their participation in required therapeutic activities.

Concerns about confidentiality—Concerns about confidentiality were voiced by youth throughout the groups, tying closely to their worries about being stigmatized or stereotyped. Youth worried about being identified by staff at reproductive clinics. Others worried about keeping information confidential from their probation officer or staff in the group home. For example, one youth described that her probation officer would be notified if she became pregnant and needed to seek an abortion, despite her desire to keep this information private. Some youth expressed feeling upset that they could not leave their particular group home to attend reproductive clinics (e.g. Planned Parenthood) for needed contraception, pregnancy concerns, or STI testing without staff present. Instead, youth felt they should be able to take care of their own personal needs without staff intervening in their "business." Youth also reported keeping mental health matters to themselves out of concern that staff would "write it up," and that their private information would be documented for others to see. These concerns deterred youth from attending necessary clinics or confiding in staff about their needs.

General fears—Fear was a powerful barrier to seeking services among participants, including fears about traffickers, certain diagnoses, and the police. Youth reported a specific fear of going to the emergency room or hospital over concern that they could be traced or arrested by police for having an outstanding warrant. Due to this fear of police, several youth

expressed avoiding needed medical and mental health care services. "*They're a lot of girls out here that get raped and robbed and stuff… But it's like you can't really do too much because you're scared that you're gonna get turned in.*"

Perceived low quality of services—Although many youth described receiving appropriate care, they also expressed concerns about receiving low-quality care. For example, several youth described painful cervical exams, which they attributed negatively to poor techniques of the provider. Overall, however, the concern about poor quality care was most commonly expressed with regards to receiving mental health services.

Though many youth acknowledged the prevalence of mental health problems—including depression and trauma—youth held negative views about mental health care and the quality of services available to them. For example, one participant believed that college students were providing therapy services at the group home instead of licensed professionals. Others expressed that the mental health care was not tailored to the individual needs of the youth. Youth described feeling irritated that therapists would frequently and routinely ask about self-harm or suicide without truly listening to their needs. One youth described her therapy experience, *"I feel like they're hearing me but they're not hearing me… ain't nobody's ears really open…what is the point of me telling you something?"* Perceived low-quality of care, particularly mental health care, formed a barrier to accessing needed services.

Self-reliance and street smarts—Youth also described strategies for survival "in the life" including strength, self-reliance skills, and "street smarts." The necessity for "working" frequently competed against youths' desire to seek health care. One youth rationalized not seeking medical care for a violence-inflicted injury, *"Just because I have a busted lip, doesn't mean I wasn't gonna go make my money. Carmex, ice, it's not the end of the world."* Her priority, as echoed by many of the youth, was to survive.

Recommendations for Improving Care (Table 2)

The youth offered pragmatic recommendations for improving access to and quality of health care for CSE youth. Recommendations included improving understanding among providers, increasing access to mentors, and enhancing education on CSEC. Youth all agreed that providers should take a non-judgmental approach to CSE youth. Related to this, many consistently voiced the importance of having mentors, including volunteers appointed through the dependency court, such as Court-Appointed Special Advocates (CASA), who support youth throughout their cases, and CSEC survivor mentors. Youth also suggested raising awareness about CSEC and available health care resources through billboards and posters, including education on healthy reproductive practices and STIs early within schools.

Discussion

Overall, youth in our study voiced significant health risks and needs, including violence exposure, worry about STIs, and mental health problems. Notably, we found that *availability* of health services was not the limiting factor to accessing health care for our participants. Rather, it was the multiple barriers that the youth experienced when engaging in services that affected use of care. Several of the barriers voiced by the youth in our study align with

barriers to care described among non-CSE ethnic and racial minority youth. For example, there is a large body of literature describing barriers to mental health care among racial and ethnic minority youth, which includes concerns about confidentiality (Lindsey & Marcell, 2012). Certain barriers seem to overlap with other youth involved in the juvenile justice system, such as fear of being caught by police in the hospitals and confidentiality concerns regarding staff and probation workers. However, specific barriers seem unique to the CSE population and directly related to the experiences of sexual exploitation, including an extremely strong reliance on self, related to a sense of "street smarts," and a necessity for continuing to "work." Many youth in our study voiced barriers related to particularly negative experiences that youth had with providers at health settings, such as a sense of feeling judged by providers for their lifestyles, or a fear of being caught by police in the hospitals. These barriers may be accentuated among this population due to an underlying distrust of authorities, potential to negatively view providers as aligned with law enforcement, and stigmatization that many CSE youth experience (Musto, 2013). Despite the notable barriers to care, our study also revealed positive factors that motivated youth to seek care, including youths' impressive knowledge of STIs, and the impetus to protect oneself and one's sexual partners. This study's findings that youth most readily sought out reproductive health services are consistent with prior research findings that testing for STIs and HIV are major reasons that CSE youth present for care (Curtis et al., 2008).

Given the dangers and risks related to sex trafficking, historically some providers and agencies have taken a more paternalistic approach with CSE youth (Sapiro et al., 2016; Swaner et al., 2016). Sapiro and colleagues describe a tension among those working with CSE youth between respecting the self-agency of CSE youth, and providing health and safety protections to their clients (Sapiro et al., 2016). Youth in our study described an acute sense of feeling criticized for their actions or lifestyles and being told what to do by providers, which often deterred them from seeking care. Our findings suggest that to improve youth engagement in care, providers should take a nonjudgmental approach to understanding the needs and lifestyles of the youth, and build sincere relationships with them.

Further, many CSE youth have learnt to rely on themselves out of necessity and may be proud of their "street smarts." We observed in our focus groups that self-reliance may have resulted from facing numerous barriers to care, such as homelessness, extreme poverty, and abuse, and may also serve as a barrier itself to seeking health care (Cochran et al., 2002; Stoltz et al., 2007). Focused on survival in a tough environment, many of the CSE youth felt care was not needed, given the adaptations and self-care skills they had developed. Providers who apply a strengths-based approach to CSE youth and understand that many youth do not identify as victims, may find greater success with trust-building, developing a therapeutic rapport, and engaging youth in services.

Youth voiced a number of complaints about mental health services, including feeling that services were generally low quality, that repeated questions about suicide or self-harm were bothersome, and that mental health services were often not warranted. This is notable given the extremely high mental health needs among CSE youth. Given the dearth of evidence-based therapies for CSE youth (Ijadi-Maghsoodi, Cook, Barnert, Gaboian, & Bath, 2016)

and that many mental health providers may not receive CSEC specific training (Beck et al., 2015; Coverdale, Beresin, Louie, Balon, & Roberts, 2016), these findings suggest that CSE youth may require unique approaches.

First, many youth consistently voiced the value of mentors and advocates, including peer mentors, adult survivor mentors, and court-appointed advocate/mentorship programs. Peer mentors can be effective among high-risk groups of adolescents, including combating suicide in schools (Wyman et al., 2010), and addressing reproductive health concerns among youth (Mahat, Scoloveno, De Leon, & Frenkel, 2008). Utilizing mentors and advocates, such as peers, survivors, or agencies that specialize in CSEC advocacy, in the group home or community settings, in addition to health professional-delivered mental health services, may represent a promising approach to enhancing treatment. Youth described particular concerns about mental health treatment, confidentiality, and feeling judged by providers. Peer and survivor mentors can help address these concerns by sharing their own experiences with both health and mental health and leaving "the life," along with normalizing and facilitating other youth to engage in mental health treatment. Although survivor-led mentorship programs are not yet a standard practice, several programs exist (Clawson & Goldblatt Grace, 2007). For example, Railway Children, an organization operating in India to eradicate street homelessness, trains formerly homeless youth peer outreach workers to help engage youth living on the street in services (Our Work in India, n.d). Additionally, in Canada, findings from a pilot peer health education program for sex workers showed increased self-esteem, confidence, and ability to mobilize resources in the community among the peer educator trainees (Benoit et al., 2017). Additional research measuring the effectiveness of survivor-led mentorship programs are needed.

Second, the girls' concerns about the quality of mental health services align with provider concerns about the best practices for treating CSE youth (Cohen, Mannarino, & Kinnish, 2017). CSE youth represent a population with a high prevalence of complex trauma, disrupted attachments and loss, substance use, risky behaviors, and poor social determinants of health—including homelessness, poverty, and decreased social supports. Research demonstrates that CSE youth experience high rates of childhood emotional, physical, and sexual abuse (Stoltz et al., 2007); one study found the majority of traumatic exposures occurred in the caregiving environment (Cole, Sprang, Lee, & Cohen, 2014). Given the complex trauma in this population—which can be tied to difficulty trusting providers and engaging in treatment, along with demonstrating risky behaviors—clinicians and experts have questioned if current therapy approaches appropriately meet the needs of CSE youth (Cohen et al., 2017). There is a general dearth of research studies on treatment for CSE youth. One exception is a randomized controlled trial of CSE youth in the Democratic Republic of Congo which found improved PTSD, anxiety, and depressive symptoms among girls receiving trauma-focused cognitive behavioral therapy (TF-CBT) (O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013). Building on this, Cohen and colleagues have advocated delivering TF-CBT to CSE youth and tailoring treatment to focus on safety, engagement strategies, and incorporating motivational interviewing techniques (Cohen et al., 2017).

Among the youth interviewed in our study, the level of training and expertise of the mental health providers who have worked with the youth is not known. However, several factors may impact the quality of mental health services, including transitions in care and disruptions in continuity when youth are transferred among different group home settings, or after running away or returning to traffickers. Indeed, CSE youth would likely benefit from ongoing therapeutic work with high-quality mental health clinicians who are experienced with complex trauma, loss, avoidance, and risky behaviors among youth. Engaging experienced and skilled mental health providers to work with CSE youth could make a significant difference in addressing mental health need in this population. Additionally, partnering with CSE youth and mentors to help train medical and mental health providers to apply a trauma-informed approach to understanding the youths' unique needs and concerns, such as those voiced by youth in the focus groups, may also be helpful.

Finally, our results suggest that accessing non-reproductive physical health care seemed infrequent and often only for crisis or emergency situations. We suggest bolstering efforts to enhance provider awareness and treatment of CSE youth among reproductive health clinics. Given CSE youths' familiarity and relative comfort with accessing reproductive care, reproductive clinics can incorporate mental health services and vital aspects of primary care (e.g. routine adolescent immunizations) by following an integrated care model. In addition, as suggested by the youth in our study, campaigns to increase awareness and education about CSEC and services available for CSE youth should occur beyond clinics, at the community level. CSE youth want providers to understand them and treat them with respect —building awareness about CSEC signifies an important step towards that goal.

Limitations

Our study data were limited to CSE youth accessing health services through their group homes, limiting the generalizability of our findings. Our sample was restricted to only females who were living in group home programs; experiences of males who have been commercially sexually exploited, as well as presently homeless youth, may be different. Future research to explore the experiences and needs of CSE youth, including males, in other settings is needed. Further, to be involved in the study the youth only needed to have experienced one episode of commercial sexual exploitation and we did not inquire on the number of incidents of commercial sexual exploitation that youth experienced. The discussions among the youth and the themes presented largely portray the experience of youth with repeated episodes. However, we recognize that youth who have only experienced one episode of sexual exploitation may have different experiences than youth with recurrent episodes. Also, possible lack of trust towards the focus group leaders and other focus group participants may have limited the discussion on highly sensitive topics such as substance use. However, the topics discussed were confirmed with several individual interviews, and feedback from several focus group participants on early findings. Despite these limitations, our findings contribute to the literature by voicing the perspectives of CSE youth regarding their health needs, strengths, and recommendations for improving care.

Conclusions

Commercial sexual exploitation of youth is an emerging problem in the U.S. Many providers, hospitals, and community agencies are still in the early stages of understanding how to best engage and care for this population. Understanding the experiences and perceptions of CSE youth regarding health services is critical to developing evidence-based treatment and prevention services for this highly vulnerable population. Innovative approaches, such as recognizing the willingness to access reproductive health care services, and using these services as a conduit to primary care and mental health services, may help overcome many of the health barriers that CSE youth experience. Promoting peer mentoring programs—a key solution recommended by CSE youth— offers a promising approach for building on assets of CSE youth while providing supports. Health professionals and service providers can lead the way in raising awareness of the needs of CSE youth, educating the community about using a non-judgmental approach when working with CSE youth, and partnering with CSE youth to develop policies and programs that improve the health and well-being of this important population.

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Table 1

Demographic Characteristics of Focus Group Participants (N = 13): Southern California, 2015-2016

Variables	Overall N	Percent
Age		
13–15 years old	3	23.1
16–17 years old	8	61.5
18 years old	2	15.4
Race:		
Black	9	69 .2
Other	1	7.7
White	3	23.1
Ethnicity:		
Hispanic	5	38.5
Last Grade Completed:		
Below 8 th grade	2	15 .4
8th Grade	1	7.7
9th Grade	2	15.4
10th Grade	3	23.1
11th Grade	2	15.4
12th Grade	3	23.1
Residence-Last 3 months		
Family's home	1	7.7
Foster/Group home	9	69.2
Own apartment	1	7.7
Some other place	2	15.4
Homeless-Ever *		
Yes	5	38.40
No	7	53.8

* = One participant did not answer question

Table 2

Commercially Sexually Exploited (CSE) Youths' Recommendations for Improving Health Services and Representative Quotes: Southern California, 2015–2016

Youth Recommendation	Supporting Quote
Promote Provider Understanding • Improve provider understanding of the experiences of CSE youth	• "In the clinics, they should have more people that understand." • "I'm pretty sure some girls want to get off the street, but they're like, 'Oh, they don't understand my story.'"
Provide Mentors for CSE Youth • Provide access to long-term mentorship, such as through advocates appointed through the court, and survivor mentors who can understand their experiences	• "I think every girl who is in the life needs somebody who has come out of the life." • "I'm going to college and I think other people need somebody to talk to, to help them put their head on, like, 'This is not you, this is not your life,' especially all the minors who are starting to exploit themselves…"
Improve Awareness and Communication • Provide visible billboards and posters in the community to raise awareness of CSEC and provide information on health care treatment and resources • Improve education about STIs and reproductive care early in schools	• "They should have billboards and commercials around the Tracks or Blades so they [CSE youth] could call that number." • "You're not going to stop teenagers from having sex." • "In high school, they should provide condoms and magazines about that [STIs] so kids would read about them and how to keep themselves healthy."