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Towards the Discreet Identification of Commercial Sexual Exploitation of Children (CSEC) Victims and Individualized Interventions: Science to Practice

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The purpose of the present study was to build on the extant Commercial Sexual Exploitation of Children (CSEC) screening options available for use in the juvenile justice system, where screenings must be brief, objective, and nonintrusive. Our goal was not to develop a system to identify CSEC victims, but instead to objectively discern *CSEC risk* in youth to be further examined through a referral process. Risk factors or indicators of risk for CSEC victimization have been proposed, and used to develop semistructured interviews intended to inform clinical judgments. We propose an objective, quantitative decision-making system for determining CSEC risk called the Sex-Trafficking Assessment Review (STAR © 2015 District of Columbia Courts). Participants included 901 youth (95.34% African American; 45.17% female; *Mean age* = 15.44, *SD* = 1.50) arrested in Washington, DC. A codebook was developed to aid scoring of STAR items, and kappa interrater reliability coefficients were developed to assure adequate agreement in STAR scores among screeners. An Item Response Theory (IRT) model was applied to STAR scores, and 3 CSEC risk statuses were identified: (a) High Risk, (b) Moderate Risk, and (c) Low Risk. Consistent with the CSEC literature, STAR statuses were associated with depression and other clinical symptoms as well as perceptions and attributions known to be common in sexual abuse victims. Also in keeping with theory, STAR statuses were associated with gender, but not age. Results are discussed in the context of service provision in a juvenile court system, including the implementation of the STAR.

Keywords: Commercial Sexual Exploitation of Children, delinquency, family court, juvenile justice, Sex-Trafficking Assessment Review

The prevalence of the Commercial Sexual Exploitation of Children (CSEC) in the United States (U.S.) is unknown, and where estimates are provided there is considerable disagreement (Salisbury, Dabney, & Russell, 2015). Hypotheses range from 300,000 (Willis & Levy, 2002) to 1,450 (Mitchell, Finkelhor, & Wolak, 2010), and the two poles are best explained by differences between data based on parsimonious arrest rates and crude estimates of risk. Despite the lack of clarity around the prevalence of CSEC victimization, there has been an increased interest among U.S. government agencies and academics to both examine CSEC more closely and develop protocols to address the issue.

On September 29th of 2014, President Obama signed Public Law 113–183 (HR 4980): Preventing Sex Trafficking and Strengthening Families Act. Section 101 includes specific compliance mandates, which have implications for juvenile justice personnel:

> [It is required that the] state agency has developed policies and procedures for identifying, documenting in agency records, and determining appropriate services with respect to, any child or youth over whom the state agency has responsibility for placement, care, or supervision who the state has reasonable cause to believe is, or is at risk of being, a victim of sex trafficking or a severe form of trafficking in persons.

Researchers have opined that youth involved with the juvenile justice system are more likely to be CSEC victims than peers who are not (Salisbury et al., 2015), largely because many CSEC victims' juvenile records include runaway charges and, or, charges intended to mask prostitution (Finkelhor & Ormrod, 2004). Therefore, a liberal read of Section 101 implies that youth who come in contact with the juvenile justice system are encouraged to be screened for CSEC victimization. In fact, some jurisdictions have already developed legislation mandating the development and implementation of CSEC screening in juvenile court respondents. For example, District of Columbia Law 18–239 (District of Columbia Official Code § 22–1834) reads as follows:

> As part of the behavioral health screening required by paragraph (1) of this subsection, the Agency shall identify children who are victims of, or who may be at risk for becoming victims of, sex trafficking of children under section 104 of the Prohibition Against Human Trafficking Amendment Act of 2010, effective October 23, 2010.

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Beyond the research literature and associated government statutes, the present study includes a focus on an applied forensic setting with an administrative crisis: Superior Court of the District of Columbia (DCSC). Therefore, a brief description of the context is provided to set the stage for the current investigation. DCSC personnel have reported an increase in the personal observation of CSEC among court involved youth. For instance, DCSC probation officers have reported instances of CSEC victimization during probable cause hearings and trials, and DCSC psychologists have reported CSEC victimization in court ordered evaluations. Further still, DCSC family court judges have voiced concerns in administrative meetings regarding the amount of CSEC victimization reported to them during hearings. These anecdotal data alongside DC statutes prompted the DCSC presiding family court judge, the Honorable Hiram E. Puig-Lugo, to formally request the development of a CSEC screening procedure to both identify victims and connect them with services. Efforts to achieve this goal were initiated with a review of the extant CSEC screening options, and issues associated with prompting CSEC disclosure in forensic settings.

The Shortcomings of Prompting CSEC Disclosure

The purpose of CSEC screenings is to yield disclosure, which is paramount to recovery in both CSEC victims and victims of other types of sexual abuse (Bradley & Follingstad, 2001; Sperry & Gilbert, 2005). However, prompting CSEC disclosure is not suggested outside of a therapeutic setting because of the intensity of associated, emotional material. Instead, less intrusive lines of questioning are recommended (Leitch & Snow, 2010; Salisbury et al., 2015). Protocols focused on overtly prompting CSEC disclosure are particularly problematic in forensic settings, where a youth could be asked to disclose information about victimization multiple times. Following arrest, a youth typically undergoes interviews with a variety of personnel, including police, probation officers, and both health and mental health professionals.

It should also be noted that the strong majority of CSEC and other sexual abuse victims refrain from disclosure of their victimization for a host of reasons: (a) fear of negative judgments, (b) fear of being blamed, (c) feelings of helplessness, (d) self-blame, and (e) self-doubt (Alaggia, 2005; London, Bruck, Ceci, & Shuman, 2005; Summit, 1983). Moreover, and anecdotally, DCSC psychologists and probation officers reported to the authors that observations had been made of youth who did not have knowledge of their own CSEC victimization. Youth without knowledge of their victimization were observed to perceive their traffickers as boyfriends or friends.

Given the shortcomings and risks of retraumatization associated with prompting CSEC disclosure in juvenile court respondents, best practices in the identification of CSEC victims should include clinical interviewing by personnel who will also act as therapist. In cities where more than 3,000 juvenile arrests occur per year (e.g., Washington, DC), clinical interviewing of each detained youth by a potential therapist is not administratively possible. In fact, it would not be possible to provide that service exclusively for youth who present with mental health issues. Data show that approximately 50% of males and 60% of females involved in the juvenile justice system likely meet diagnostic criteria for at least one mental health disorder (Abram, Teplin, McClelland, & Dulcan, 2003; Andretta et al., 2014). Therefore, it is advantageous for large agencies such as juvenile justice systems to develop a CSEC triage process to identify youth who are most likely to be victims without prompting disclosure. An effective CSEC triage process should include a screening procedure that is informed by indicators of CSEC risk identified in the literature.

Indicators of CSEC Risk

Researchers have shown that child sexual abuse is associated with a constellation of symptoms including posttraumatic stress (Priebe et al., 2013), depression (Maniglio, 2010), suicide (Maniglio, 2011; Ystgaard, Hestetun, Loeb, & Mehlum, 2004), self-destructive behavior (Nada-Raja & Skegg, 2011), dissociation (Kisiel & Lyons, 2001), substance abuse (Plant, Miller, & Plant, 2004), social difficulties (Abdulrehman & De Luca, 2001), poor self-esteem (Stern, Lynch, Oates, O'Toole, & Cooney, 1995), and offending/delinquency (McGrath, Nilsen, & Kerley, 2011). Although much is known about the symptom sequellae associated with sexual abuse, scholars have not been able to differentiate victims of sexual trauma from victims of other types of trauma based on psychological symptoms (London et al., 2005). Therefore, mental health screenings are not likely to be effective in identifying CSEC victims based on symptom profiles alone.

Though not specific to CSEC victimization, some researchers have pointed to common attributions and perceptions among child sexual abuse victims. For example, Mannarino, Cohen, and Berman (1994) reported that victims of child sexual abuse commonly feel different from same age peers, feel as though they are to blame for negative events, and perceive a low level of interpersonal trust. With regard to demographics, gender is associated with CSEC, where girls are more likely than boys to experience victimization (Grace, Starck, Potenza, Kenney, & Sheetz, 2012). Although age is not associated with CSEC, first sexual and drug experiences are both associated with the onset of victimization (Reid & Piquero, 2014).

Scholars have also identified and described common social and environmental attributes of CSEC victims (Salisbury & Dabney, 2013), which have been used to opine CSEC risk. Salisbury and Dabney (2013) reviewed the literature, and provided a list of CSEC risk factors that included but was not limited to the following: (a) having an older boyfriend, (b) tattoos or brands, (c) possession of materials (i.e., clothes or devices) that youth are not likely to afford, and (d) being accompanied by an older male that is not a family member. In a subsequent investigation, Grace et al. (2012) developed case studies of identified CSEC victims in schools, and reported on CSEC risk factors: (a) new cell phone, (b) increased visits to the health office, (c) often fatigued, (d) frequently tardy, (e) wearing suggestive clothing and accessories, (f) use of suggestive language, (g) frequent altercations, (h) decline in academics, (i) more than one girl dating the same male, (j) fighting over expensive gifts, and (k) self-esteem issues. Other researchers have used sets of CSEC risk factors to generate interview forms focused on identifying victims.

Extant CSEC Interview Forms

Shared Hope International developed the INTERVENE to assess social and environmental indicators of CSEC victimization, and this assessment has been successful in the identification of victims in the states of Washington and Maryland (Leitch & Snow,

2010). The INTERVENE includes questions that yield information on, but are not limited to, the following: (a) where the youth has been staying, (b) frequency and durations of runaways, (c) history of court contact, and (d) observable evidence of abuse (i.e., bruises, etc.). It is a multitiered assessment with two stages of interviewing. The first interview includes 34 open-ended and intentionally noninvasive questions (e.g., Have you ever left home without parent/guardian knowledge?). The decision to refer for the second, more invasive interview is based on clinical judgment, and this interview includes an additional 48 open-ended questions (e.g., Has your boyfriend ever asked you to do things sexually with other guys?). To date, there are no peer-reviewed studies published on the efficacy of the INTERVENE.

More recently, Salisbury et al. (2015) applied CSEC risk factors to the identification of actual victims involved in the juvenile justice system. Salisbury et al. developed the InterCSECt interview, which is multitiered and includes three potential interviews. Tier 1 of the InterCSECt is developed at intake shortly following arrest. The purpose of Tier 1 is to determine risk through the use of nonintrusive questioning focused on specific CSEC risk factors: (a) prior foster care placement, (b) current residence, (c) history of runaways, (d) Child Protective Services involvement, (e) suspicious brands/tattoos, and (f) concerning possessions (e.g., hotel keys). At the conclusion of the first interview, the interviewer is required to make a clinical judgment regarding the youth's level of CSEC risk: (a) self-disclosed victim, (b) nondisclosed/suspected, or (c) nondisclosed/not suspected. Youth who are labeled nondisclosed/suspected are provided with Tier 2 and potentially Tier 3 interviewing, which is accounted for by the implementation of the two aforementioned INTERVENE interviews. Salisbury et al. identified 47 youth as being nondisclosed/suspected in a sample of 535 using the InterCSECt, six of which were confirmed CSEC victims.

In summary, indicators of risk for CSEC victimization have been proposed and used to develop qualitative, semistructured interviews intended to inform clinical judgments (Leitch & Snow, 2010; Salisbury et al., 2015). In populous cities like the District of Columbia, more than 3,000 youth per year need to be screened for CSEC risk following arrest. Where the volume of youth arrests is high, a brief, objective, and nonintrusive CSEC screening alternative is needed. Therefore, the goal of the present study was not to identify CSEC victims, but instead to generate a triage tool intended for the objective discernment of *CSEC risk* in youth to be further examined through a referral process.

The Present Study and Data Analysis

We propose a quantitative decision making system for determining a youth's amount of CSEC risk by applying a rubric to score CSEC interview questions: (a) risk = 0, (b) Low Risk = 1, or (c) High Risk = 3. In other words, we hypothesize that a set of ordinal observed variables measure levels of CSEC risk (i.e., the latent trait), and that CSEC risk causes the observed scores. Because the observed variables are categorical and the latent variable is continuous, IRT is the appropriate methodology for analysis (Collins & Lanza, 2010). IRT is a model-based theory used to show the probabilistic relations between responses to items and a latent trait (Bartholomew, Knott, & Moustaki, 2011).

IRT rests on two underlying assumptions: (a) unidimensionality and (b) local independence (Bartolucci, Bacci, & Gnaldi, 2016). Unidimensionality is tested by examining eigenvalues and item-to-total correlations using exploratory factor analysis (EFA; Gomez, 2008). Eigenvalue coefficients are quantifications of the ratio between shared and unique variance (Ho, 2006), and unidemensionality is established when the eigenvalue ratio between factor 1 and factor 2 is large (Gomez, 2008). Local independence means the associations among item scores are explained by the latent variable, and this psychometric property is established by residual correlations below .20 (Reeves et al., 2007).

There are many IRT models to choose from in the literature. The graded response model (GRM; Samejima, 1969) was selected to examine CSEC risk scores because this method of IRT is commonly used when data are polytomous and the latent variable is continuous. GRMs include two primary item parameters. λ_j refers to the discriminating parameter of item j (i.e., item number), and β_{jy} refers to the difficulty level for response category y of item i (Bartolucci et al., 2016). GRM allows both item parameters to be unconstrained, which results in the following parameterization: $\lambda_j(\theta_i - \beta_{jy})$, where θ_i refers to the latent trait level of individual i. Using a GRM, the probability of scoring y on item j is calculated using the following formula, where $p^*_{jy}(\theta_i)$ denotes that a generic participant endorses category y or higher (Bartolucci et al., 2016, p.128):

$$p_{jy}(\theta_i) = p^*_{jy}(\theta_i) - p^*_{j,y+1}(\theta_i)$$

It is also important to note that GRM yields response dichotomies: $k - 1$ or m_i, where k refers to the number of response options (Gomez, 2008). In the present study, there are three score options and two response dichotomies that show the probability of endorsing a certain option when compared to the remaining options (e.g., compare the first response category with the second and third). Each dichotomy can be illustrated using an operator characteristic curve (OCC).

Both threshold parameter (β) and item discrimination parameters (α) are used to examine item scores in IRT (Bartolucci et al., 2016). β denotes the level of latent trait required for a 50% probability of responding positively to the item. α is an indicator of how well an item is able to discriminate between individuals with different levels of trait, which is illustrated using an item characteristic curve (ICC). A steep ICC curve suggests a high level of discrimination given a certain level of trait. Item characteristics can also be examined using item category characteristic curves (CCC), which show the probability of response for each item category across levels of trait. It is also possible to plot an ICC for the whole instrument, and this analysis is called a test characteristic curve (TCC). Additionally, the effectiveness of the observed variables in the measurement of the latent trait can be analyzed using a test information function (TIF).

Operationalization of STAR Scores

In the city where the study occurred, it was made clear by DCSC stakeholders that the court could expect to identify local organizations with a specific expertise in CSEC to further evaluate and potentially provide intervention services for approximately 20% of youth arrested each year. Therefore, to meet administrative demands specifically, we aimed to identify a cut-score for identifying the 20% of youth at most risk of CSEC victimization. IRT test characteristic curves can be used to estimate scores on a scale based on levels of the latent trait. Therefore, we propose to operationalize estimated scores based on levels of CSEC risk that

are one (84th percentile) and two (98th percentile) standard deviations above the mean to denote Moderate and High Risk.

If the estimated cut-scores developed using the test characteristic curve are valid, adolescents with STAR scores below the cut-scores should be less likely to be experiencing CSEC victimization than peers with scores above the cut-scores. Using the cut-score to split participants into three groups based on CSEC risk allows for the examination of convergent and discriminant validity. Convergent validity is established when an association is shown between two constructs that theoretically should be associated. In contrast, discriminant validity is established when no association should be observed between two constructs, and in fact data confirm the hypothesized lack of association.

If risk statuses based on cut-scores are valid, they should be associated with gender but not age (Grace et al., 2012; Reid & Piquero, 2014); substantively more females than males should be observed in the Moderate and High Risk groups. Third, based on victims of sexual abuse research, adolescents in the Moderate and High Risk group should present with higher levels of depression and other clinical symptoms than peers in the Low Risk group (e.g., Maniglio, 2010). It was further hypothesized that when compared with Low Risk peers, adolescents in the Moderate and High Risk groups would report higher scores for attributions and perceptions specific to victims of sexual abuse (Mannarino & Cohen, 1996): Moderate and High Risk adolescents were hypothesized to report higher levels of children's stigmatization and self-blame for negative events, and lower levels of perceived credibility and interpersonal trust when compared with peers with Low Risk.

Method

Participants

Participants included 901 youth arrested in Washington, DC. Ages ranged from 10 to 19 with an average of 15.44 ($SD = 1.50$), and the sample included almost even numbers of males ($n = 494$, 54.83%) and females ($n = 407$, 45.17%). It is noted that considerable efforts were made to garner a gender-balanced dataset. Specifically, data collection for females extended six months beyond data collection for males due to higher rates of male than female arrests. The sample included 859 African Americans (95.34%) with disproportionately smaller percentages represented by Latino ($n = 39$, 4.33%) and European Americans ($n = 3$, .33%). The city where the study took place is approximately 50% African American. A previous study on a large sample of juvenile court respondents ($N = 1040$) involved with the same court also showed disproportionate numbers of males (75%) and African Americans (95%), and an average age of 15.83 ($SD = 15.83$; Andretta et al., 2014).

Procedure

The decision to develop the present study was initially made to inform the courts and before making the decision to disseminate data beyond the court system. A mandate to screen all youth for CSEC victimization was written into the statutes of the city where the study took place before the presence of an administratively feasible screening procedure with accompanying tool. Therefore, the Washington D.C. Commercial Sexual Exploitation of Children Subcommittee Task Force (Task Force) was initiated and developed by the Honorable Hiram E. Puig-Lugo, the presiding family court judge, to address issues of identifying and treating CSEC victims with DC Superior Court contact. The Task Force includes representatives from the Office of the Attorney General, the Public Defender Service, the Department of Behavioral Health, the Child and Family Services Agency, the Department of Youth Rehabilitative Services, District of Columbia Public Schools, as well as the Presiding Family Court Judge of the Superior Court of the District of Columbia. The CSEC Task Force also includes representatives from local organizations interested in participation.

The Task Force sanctioned the development of the Sex-Trafficking Assessment Review (STAR © 2015 District of Columbia Courts) in 2014, and sanctioned the internal dissemination of findings for the purposes of meeting compliance with DC statutes. In 2015, external agencies (e.g., the Department of Homeland Security) visited the court and expressed interest in the scale; the Task Force sanctioned the external dissemination of the findings following the interest for use outside of DC Superior Court.

Participants were told that data collection was being developed, and they were given the opportunity to assent to participate in the study. However, formal consent by parents and guardians was not sought because the screening was both court-mandated and mandated under DC statutes. Screenings took place after interviews by police and probation officers. To control for reading differences, items on all scales administered were read to participants, a method shown to yield reliable scores in the same population (Andretta et al., 2014). Participants were screened at one of two intake facilities by one of six screeners. All youth arrested in the host city are provided a mental health screening, and the development of a CSEC risk scale was incorporated into the mental health interview. The interviews took approximately 25 min to complete (i.e., including all scales).

Measures

CSEC risk. The STAR was developed at the first author's institution. The STAR includes eight questions to be administered to the youth, and three questions for the screener to answer following the screening (see Table 3**,** e.g., items). Items were developed, in part, by identifying risk factors reported by Salisbury and Dabney (2013), Salisbury et al. (2015), Grace et al. (2012), and Leitch and Snow (2010). For each STAR item, the screeners endorsed an objective level of risk: (a) *Low Risk* (1), (b) *Moderate Risk* (2), and (c) *High Risk* (3). For example, item 1 includes, "Where were you staying last night (or the night prior to your arrest)?" Item 1 is scored using the following rubric: (a) at home = 0, (b) at a friend's house = 1, and (c) at a boy/girlfriend's house = 2. If a response does not clearly fall into one of the three aforementioned categories, the interviewer refers to a codebook. The codebook indicates scores that are applied to irregular and uncommon responses (see Procedure).

Attributions and perceptions. The Children's Attributions and Perceptions Scale (CAPS; Mannarino et al., 1994) is an 18-item inventory for use in children and adolescents. Each CAPS item is a description of a feeling, and adolescents endorse the frequency with which they have experienced each feeling during the past six months on a Likert-Scale ranging from *never* (1) to *always* (5). The CAPS is intended to assess Feeling Different From Peers (4-items, $\alpha = .78$; e.g., Do you feel different than other girls/boys your age?), Personal Attributions for Negative Events

(4-items, α = .62; e.g., Do you feel that you make bad things happen to other people?), Perceived Credibility (5-items, α = .76; e.g., Do you think people believe you when you tell them something?), and Interpersonal Trust (5-items, α = .80; Do you ever feel that it is hard to trust other people?).

Clinical symptoms and depression. The Conners Comprehensive Behavior Rating Scales Self-Report (CBRS-SR; Conners, 2008) is a 177 item, self-report measure intended to assess mental health in youth ages 8 to 18. In the present study, CBRS-SR scores for Major Depressive Episode (MDE; 15 items, α = .88) and the Clinical Index (CI; 24 items, α = .90) were used. MDE is intended to assess depression as outlined in the DSM. The Clinical Index is a broad scale intended to identify individuals who are most likely to meet diagnostic criteria for a mental illness (i.e., raw score of 12 = 90% chance for a clinical classification). CI items assess disruptive behaviors, learning and language disorders, mood disorders, anxiety disorders, and Attention Deficit/Hyperactivity Disorder.

Conners (2008) reported internal consistency estimates for MDE (α = .88) and CI (α = .76) scores in a large sample of youth (N = 2,057), which included clinical (n = 700), normative (n = 1,000), and general population (n = 1,357) groups. The results of Conners construct development study further showed that MDE (.79) scores correctly classified youth in the clinical sample. In a study that included African American adolescents involved in the juvenile justice system (N = 1,040), Andretta et al. (2014) showed that MDE (α = .87, ω^h = .88) scores were both internally consistent and factor saturated. Examples of CBRS-SR items are not provided because it is a proprietary instrument owned by Multi-Health Systems Incorporated.

Results

Preliminary Analyses

A codebook[1] was developed to aid decision making about DC-STAR scores during interviewing. Amendments were made to the codebook each of the nine times interrater reliability was examined among screeners between June of 2014 and June of 2015. Before live interviewing for the purpose of actual screening and data collection, mock scenarios were used to develop initial kappa scores, and .80 was used as a benchmark for acceptable calibration. If kappa scores were observed below .80, disagreements were discussed, amendments were made to the codebook, and another opportunity to score a mock interview was provided. After interviews with youth commenced, interrater reliability was examined an additional eight times to control for the development of differences in scoring at 1 month, 2 months (i.e., twice), 8 months (i.e., twice), 9 months, 10 months, and 1 year. In June of 2015, the final wave of interrater reliabilities were developed where one screener screened two youth with each of the other five screeners. Kappa scores developed from 11 of the 12 youth interviews were equal to or above .82 with just one equal to .75.

Descriptive Statistics

Correlations and descriptive statistics for the outcome variables are shown in Table 1. There are a substantial number of missing data for depression. The reason for the missing data is administrative in nature. The MDE scale of the CBRS-SR was mistakenly left out of the data collection at onset. When it was realized that the youth were not completing the depression portion of the inventory, it was included immediately. Both CI and depression scores were positively associated with all four attributions and perceptions as assessed using the CAPS. Missing data were left out of the analyses, which meant that only part of the sample was included in analyses using MDE scores. Table 1 shows substantive correlations between CI and MDE scores (i.e., clinical symptoms and depression), and substantive correlations among scores on the four CAPS subscales. Outcome scores were not skewed or kurtotic with the exception that personal attributions for negative events scores were leptokurtic with scores clustered around the mean.

Table 1
Descriptive Statistics and Intercorrelations Among Outcome Variable Scores

Variable	1	2	3	4	5	6
1. Clinical index	—					
2. Depression	*.81*	—				
3. Feeling different	*.34*	*.38*	—			
4. Personal attributions	*.48*	*.50*	*.41*	—		
5. Perceived credibility	*.31*	*.31*	*.33*	*.41*	—	
6. Interpersonal trust	*.40*	*.42*	*.42*	*.41*	*.40*	—
M	.56	.69	2.74	1.69	2.40	2.36
SD	.49	.64	1.13	.71	.73	1.04
Skewness	1.15	.97	.24	1.10	.65	.22
Kurtosis	4.11	3.18	2.12	4.01	3.52	2.20
Missing	.00	126.00	.00	1.00	1.00	1.00

Note. $p \leq .001$ where $r \geq .31$. Power analyses were developed using the *pwr* package in *R* statistics (Champely, 2012). Power was set to .80 (Ellis, 2010), and statistical significance was set to .008 using Bonferroni's adjustment. Results indicated that .12 was the cutoff for a minimally interpretable effect size, and effect sizes above this cutoff have been *italicized*.

IRT Graded Response Model for STAR Scores

Table 2 substantiates the unidimensionality and local independence of STAR scores, as evidenced by a high ratio of the eigenvalues of factor 1 and factor 2, a substantial mean item-to-total correlation, and small residual correlations (i.e., ≤ .10). IRT parameter estimates from the graded response model (GRM) for STAR scores are shown in Table 3. Item discrimination parameters (α) for items 9 and 10 were low, which means that these items are not providing a lot of information. β estimates can be interpreted as thresholds, where the values denote the points at which the response curves intersect on the trait scale. The trait scale is denoted by the symbol θ, which refers to CSEC risk levels, with a mean of zero and a standard deviation of one. For example, the estimated parameters of item 1 show that an individual with θ = 2.19 has a 50% probability of answering 0 (Low Risk) versus greater than or equal to 1 (Moderate or High Risk), and a person with θ = 3.33 has a 50% probability of answering 0 (Low Risk) or 1 (Moderate Risk) versus 2 (High Risk).

[1] Please contact the corresponding author to receive a copy of the codebook.

Table 2
Unidimensionality and Local Independence of STAR Scores

Exploratory factor analysis	
Eigenvalue of factor 1	2.26
Eigenvalue of factor 2	.61
Ratio of factor 1:factor 2	3.79
Mean item to total correlation	.45
Largest correlation for residuals	.10

The aforementioned coefficients (i.e., β_1 and β_2) are plotted in Figure 1 using category characteristic curves. β_1 and β_2 values are all well above the mean, suggesting that STAR scores are not useful when discriminating between individuals with Low Risk ($-2.00 \geq \theta \leq 0.00$) and individuals with Low Risk CSEC risk ($0.00 \geq \theta \leq 0.50$). Instead, STAR scores appear more effective at discriminating between individuals with no to Low Risk ($-2.00 \geq \theta \leq 0.50$) and individuals with moderate to high CSEC risk ($1.00 \leq \theta \leq 4.00$). This hypothesis is substantiated by the rapid increase in the steepness of the test characteristic curve shown in Figure 2, which occurs almost exactly at the point at which theta is equal to .5. Moreover, the test information function, also shown in Figure 2, shows that the STAR scores yield the most information when theta is between the mean and two standard deviations above the mean.

Operationalizing STAR Scores

As previously mentioned, the operatorationalizaion of STAR scores is guided, in part, by administrative demands. Specifically, the goal of the present study was to identify youth at the most risk of CSEC victimization with a limit of only being able to provide intervention for approximately 20% of youth arrested in Washington, DC. The test characteristic curve shown in Figure 2 indicates a rapid increase in information with an onset at theta (θ) equal to .5, which decreases where theta is equal to one. If theta equal to 1 is designated as the threshold level of trait, approximately 16% of the youth would be identified as "at-risk" for CSEC victimization with the cut score of seven (i.e., rounded from 6.62; see Figure 2). A second cut-score of 10 would identify youth with CSEC risk that is equal to or greater than two standard deviations above the mean. Therefore, three groups were identified using the two cut-scores: (a) Low Risk ($0.00 \geq \theta \leq 0.99$, $n = 742$, 82.35%), (b) Moderate Risk ($1.00 \geq \theta \leq 1.99$, $n = 91$, 10.10%), and (c) High Risk ($2.00 \geq \theta$, $n = 68$, 7.55%).

Validity of Latent Trait Cut-Scores

As hypothesized, Table 4 shows that STAR risk statuses were associated with gender with a substantial effect size. Specifically, there were far higher percentages of females represented in the High Risk group than males, and far higher percentages of males represented in the Low Risk group than females. Percentages of males and females in the Moderate Risk group were similar. Analysis of variance (ANOVA) indicated that STAR risk groups were associated with age, $F(2, 900) = 4.12$, $p < .02$, $\eta^2_{\text{partial}} = .009$, where power analysis showed that a partial eta-squared of .0051 was the cutoff for a minimally interpretable effect size. However, the practical differences across the three risk groups were meaningless with all three mean ages in the same developmental year (i.e., 15): (a) Low Risk mean age = 15.37 ($SD = 1.53$), (b) Moderate Risk mean age = 15.77 ($SD = 1.32$), and (c) High Risk mean age = 15.72 ($SD = 1.42$). Therefore, it was concluded that STAR scores were not meaningfully associated with age despite statistical inference pointing to an association.

The third and fourth hypotheses were also supported. Results of a MANOVA showed substantive differences in CI and MDE scores across STAR classes, $F(2, 744) = 16.24$, $p < .001$, Wilk's $\lambda = .92$, $\eta^2_{\text{partial}} = .04$ (95% CI .02 to .07): Power analysis showed that a partial eta-squared of .004 was the cutoff for a minimally interpretable effect size. Table 5 shows the results of planned comparisons of CI and MDE scores between STAR statuses. Youth with High Risk reported substantially higher CI and MDE scores when compared with peers with low and Moderate Risk. Furthermore, CI and MDE scores were substantially larger among youth in the Moderate Risk group when compared to the Low Risk group.

Table 3
IRT Parameter Estimates From the GRM for STAR Scores (N = 901)

Risk factors	α	β_1	β_2
1. Where were you staying last night (or the night before detention if detained)?	1.16 (.16)	2.19 (.21)	3.33 (.36)
2. Are you living with anyone? If so, who are you living with and what is your relationship to them?	.93 (.23)	4.09 (.83)	4.92 (1.05)
3. Have you ever been placed in foster care or a group home?	1.05 (.13)	1.69 (.16)	2.69 (.27)
4. Have you ever run away or left home/foster care?	11.23 (.00)	.78 (.03)	1.11 (.04)
5. How long do you usually stay away?	11.63 (3.66)	.68 (.03)	.79 (.03)
6. Are you dating anyone? If so, how old are they?	.78 (.11)	1.82 (.22)	3.62 (.46)
7. What are some things you bought for yourself over the past month? Who paid for it?	.58 (.10)	2.04 (.33)	3.97 (.65)
8. What names have you used other than your own?	.56 (.09)	.87 (.17)	6.19 (.99)
9. Do you have any tattoos? If so, do they have special meaning?	.23 (.08)	2.50 (.89)	8.79 (3.09)
10. Evidence of abuse (e.g., ligature marks, burns, bruises)?	.24 (.11)	7.16 (3.21)	16.12 (7.37)
11. Are there any other "red-flag" charges on record?	.91 (.12)	1.71 (.18)	3.31 (.38)
12. Charge of solicitation/prostitution?	1.63 (.58)	4.03 (.95)	4.17 (1.01)

Note. α is an indicator of how well an item is able to discriminate between individuals with different levels of trait. β_1 = the level of latent trait required for a 50% probability of answering 0 (low risk) versus greater than or equal to 1 (moderate and high risk). β_2 = the level of latent trait required for a 50% probability of answering 0 (low risk) or 1 (moderate risk) versus 2 (high risk).

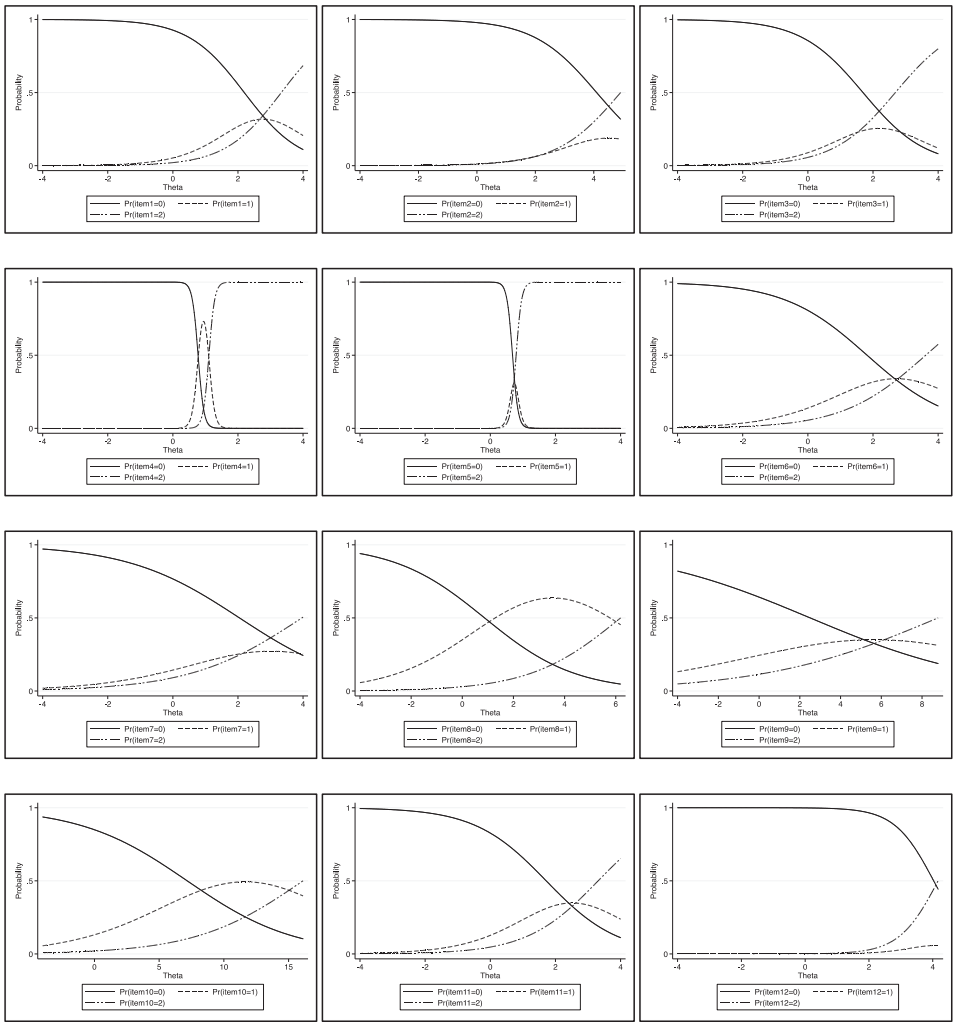

Figure 1. Category characteristic curves for all 12 STAR item scores. θ = level of CSEC risk with a mean of 0 and a standard deviation of 1.

MANOVA also showed meaningful differences in CAPS scores across STAR statuses, $F(2, 899) = 15.11$, $p < .001$, Wilk's $\lambda = .88$, $\eta^2_{\text{partial}} = .03$ (95% CI .01 to .06): Power analysis showed that a partial eta-squared of .003 was the cutoff for a minimally interpretable effect size for this observation. As shown in Table 6, scores across all four CAPS subscale scores were substantively higher in adolescents with High Risk when compared with Low Risk. Youth with Moderate Risk reported higher levels of feeling different from peers and lower levels of interpersonal trust than Low Risk youth, but scores for personal attributions of negative events and perceived credibility were both similar between the low and Moderate Risk groups. Last, High Risk youth reported higher levels of feeling different from peers and personal attributions of negative events than Moderate Risk peers; scores for perceived credibility and interpersonal trust were similar between youth in the Moderate and High Risk classes. Readers are invited to contact the corresponding author to gain the scale, codebook, and consultation regarding the implementation of the STAR.

Discussion

The availability of a brief, objective, and nonintrusive screener for the purpose of generating likelihood of CSEC victimization is sorely needed in cities where thousands of youth are arrested per year. In the present study, a scoring system was developed and applied to questions that were previously used to collect qualitative data for the purpose of subjective, clinical decision-making in populations at risk for CSEC. Results included the introduction of the STAR survey, and an item response theory model (IRT) of STAR scores yielded three CSEC risk statuses in a large sample of youth with court contact: (a) Low Risk, (b) Moderate Risk, and (c) High Risk.

Numerous differences across and between STAR risk groups pointed to the validity of the aforementioned statuses. First, previous research has shown that CSEC victimization is disproportionately female (Grace et al., 2012), and representation in the High Risk status was observed to be disproportionately female. Second, STAR statuses were not shown to have a meaningful

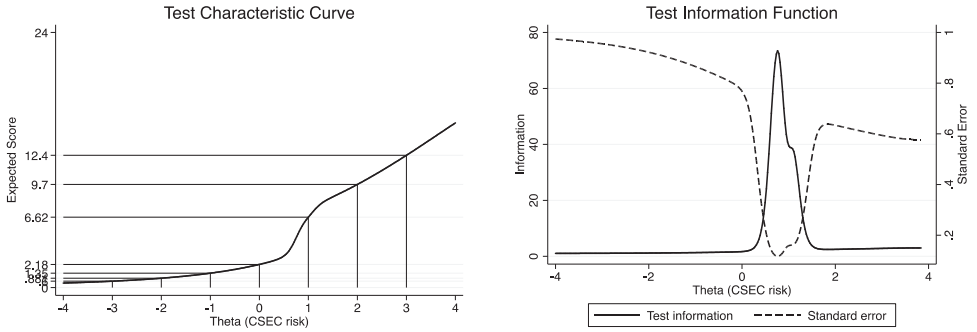

Figure 2. TCC provides expected scores (*Y*-axis) given levels of CSEC risk (*X*-axis). For example, an individual with CSEC risk that is equivalent to 1 *SD* above the mean is expected to yield a STAR score equal to 6.62. The TIF shows how much information the STAR yields given specific levels of CSEC risk. The test information line shows that the most information is yielded at 1 *SD* above mean. In practical terms, STAR scores are most efficient at discriminating between individuals with CSEC risk that is equivalent to 1 *SD* above mean from peers with less risk.

association with age, a finding that is consistent with previous research (Reid & Piquero, 2014). Sexual exploitation has also been shown to be positively associated with depression and other clinical symptoms (Maniglio, 2010), as well as the development of problematic attributions and perceptions (Mannarino et al., 1994; Mannarino & Cohen, 1996). In keeping with prior research, adolescents with High Risk reported substantively higher levels of depression and clinical symptoms than their peers with Low Risk. High Risk youth also reported to feel more different from peers, and to apply higher levels of personal attributions to negative events when compared to their peers with Low Risk. Furthermore, adolescents in the High Risk group perceived a lower level of credibility, and harbored a lower level of interpersonal trust than Low Risk youth. These data suggest that STAR scores successfully identified youth who are the most likely to be victims of CSEC.

STAR Scores and Latent Statuses

Scrutiny of STAR category characteristic curves revealed some interesting trends. For one, where youth slept the night before arrest appeared to differentiate between STAR statuses (i.e., item 1). In contrast, where the youth reported to live did not differentiate latent statuses (i.e., item 2). The frequency and duration of runaways were strong indicators of risk classifications, and this finding is consistent with the literature. Specifically, homeless youth and youth on the run have been shown to be at an increased risk for CSEC victimization via recruitment (Dank et al., 2014). Interestingly, the person youth are dating (e.g., older boyfriend/girlfriend or the same age) provided a moderate amount of information. Not in keeping with the extant CSEC research, the presence of suggestive nicknames and tattoos did not discriminate across levels of risk classifications (Grace et al., 2012; Salisbury et al., 2015). Per the report of confirmed victims to the authors, traffickers often give CSEC victims professional names to work under, and sometimes brand individuals to ward off recruitment from competing affiliations.

The three STAR indicators that were completed by screeners independently produced results that warrant attention. Not surprisingly, the presence of a previous charge of prostitution was not effective at all. Prior research has shown that police are most likely to assign youth masking charges rather than an actual charge of prostitution. Furthermore, in Washington DC (i.e., setting of the present study) the Metropolitan Police Department recently stopped charging youth with prostitution because they are under the age of legal consent and therefore victims. That might provide one hypothesis for why the presence of masking charges (e.g., loitering) differentiated between risk classifications in the present study (i.e., item 11). Last, evidence of abuse provided little infor-

Table 4
Prevalence of STAR Risk in Males (n = 494) and Females (n = 407) With Juvenile Court Contact

Latent class	Male *n* (%)	Female *n* (%)	$\chi^2(2)$	*p*	Cramér's *V*
Low Risk	444 (90)	298 (73)			
Moderate risk	37 (07)	54 (13)			
High risk	13 (03)	55 (11)	49.91	<.001	.2354

Table 5
Cohen's d for Planned Comparisons Between STAR Risk Classes

Class	1	2	3
Clinical index			
1. Low risk	—		
2. Moderate risk	*−.30*	—	
3. High risk	*−.94*	*−.58*	—
Depression			
1. Low risk	—		
2. Moderate risk	*−.36*	—	
3. High risk	*−1.02*	*−.63*	—

Note. $p \leq .001$ where Cohen's $d \geq .30$. Power analyses were developed using the *pwr* package in *R* statistics (Champely, 2012). Power was set at .80 (Ellis, 2010), and statistical significance was set at .008 using Bonferroni's adjustment. Results showed that minimally interpretable effect sizes for the planned comparisons were .30 between Low and Moderate Risk, .27 between Low and High Risk, and .33 between Moderate and Heavy Risk groups. Effect sizes that are equal to or above the minimally interpretable cutoff are *italicized*.

Table 6
Cohen's d for Planned Comparisons Between STAR Risk Classes

Class	1	2	3
Feeling different			
1. Low risk	—		
2. Moderate risk	*−.49*	—	
3. High risk	*−1.09*	*−.63*	—
Personal attributions			
1. Low risk	—		
2. Moderate risk	.21	—	
3. High risk	*−.88*	*−.60*	—
Perceived credibility			
1. Low risk	—		
2. Moderate risk	.17	—	
3. High risk	*−.53*	−.30	—
Interpersonal trust			
1. Low risk	—		
2. Moderate risk	*−.52*	—	
3. High risk	*−.85*	−.34	—

Note. $p \leq .001$ where Cohen's $d \geq .25$. Power analyses were developed using the *pwr* package in *R* statistics (Champely, 2012). Power was set at .80 (Ellis, 2010), and statistical significance was set at .004 using Bonferroni's adjustment. Results showed that minimally interpretable effect sizes for the planned comparisons were .32 between Low and Moderate Risk, .29 between Low and High Risk, and .35 between Moderate and Heavy Risk groups. Effect sizes that are equal to or above the minimally interpretable cutoff are *italicized*. Feeling Different = Feeling Different From Peers; Personal Attributions = Personal Attributions for Negative Events.

mation. That is, there did not appear to be much difference in probability of endorsing signs of abuse for youth across levels of risk classifications.

Operationalizing STAR Scores

Data in the present study suggested that adolescents with Moderate Risk were in less need of immediate mental health referrals than their peers with High Risk statuses. It should be noted, however, that data were cross-sectional. It is possible that Moderate Risk is an antecedent to High Risk, and a future study should include a longitudinal examination of STAR scores. For example, Moderate Risk might be indicative of early CSEC contact. Until the implications of Moderate Risk are ascertained, the best course of action is to provide these youths with a less intrusive and less costly intervention provided to adolescents with High Risk. Moderate Risk youths could be provided with a CSEC information session at the host agency. Another low-cost, low-impact intervention would be to contact the probation officers who supervise adolescents with Moderate Risk, and notify them of both the risk statuses and associated concerns. At the very least, these questions warrant further inquiry.

DCSC Family Court Policy

The Superior Court of the District of Columbia Court Social Services Division developed a multitiered approach to addressing CSEC in some way for all youth that are court-involved, which was largely based on suggestions provided by the Center for Court Innovation during a June of 2015 training (Human Trafficking and the State Courts Collaborative, 2015). First, triage is developed using STAR scores, which are gathered shortly after arrest or upon the request or referral of a judge or other judicial party: (a) Low Risk (STAR score <7), (b) Moderate Risk ($7 \geq$ STAR score <10), or (c) High Risk (STAR score ≥ 10). Though limited in number, some youth are referred by agencies other than DCSC like the Metropolitan Police Department. Youth with Low Risk follow the traditional processes and programming associated with their court cases. Efforts have been made to incorporate more general psycho-educational components into court supervision programming that bolster the awareness of risk associated with CSEC, substance abuse and unhealthy relationships for all juvenile court respondents.

Youth with High Risk statuses are referred to the CSEC multidisciplinary team (CSEC MDT) that meets once a month. The CSEC MDT is hosted at the DC Children's Advocacy Center and consists of representatives from the Metropolitan Police Department, the Child and Family Services Agency, the Department of Behavioral Health, the Office of the Attorney General, the Department of the Youth Rehabilitation Services (i.e., juvenile corrections department), DCSC probation officers and psychologists, and a pediatrician from the Children's National Medical Center who specializes in the treatment of children exposed to physical and sexual abuse. The CSEC MDT meetings include thorough case reviews, which are used to inform individualized, multidisciplinary intervention plans.

Typically, the agency that has the best working alliance with the youth referred to the CSEC MDT serves as the primary point of contact to facilitate recommendations made by the committee. Following the model of the city's existing multidisciplinary team for victims of child sexual abuse, the CSEC MDT aims to ensure the immediate safety of all youth referred, which may warrant the engagement of the Child and Family Services Agency or the DC Child Advocacy Center. In some cases, youth no longer appear to be in imminent danger of CSEC, but require physical health examinations and treatment, assistance with more stable housing or linkage to supportive mental health services. All youth with High Risk statuses are immediately referred to a local mental health provider that specializes in supportive services for CSEC survivors.

The CSEC MDT committee also considers the role of law enforcement and other legal proceedings relevant to combating CSEC. Youth referred to the CSEC MDT may be witnesses in future prosecution of alleged traffickers and therefore may require additional legal and family support to ensure safety and awareness of rights. Lastly, the CSEC MDT may provide referrals for additional family services to reduce the risk of CSEC for other minors that may be living in the home with an identified CSEC victim, and make available additional supportive assistance and education.

Limitations and Future Directions

There were numerous limitations associated with the present study. A sample of youth with juvenile court contact in a single city was used, and 95% of participants were African American adolescents. These demographics limit the generalizability of the results to other youth populations. Future studies of STAR scores should include both school and child and family service settings. It was also noted that data in the present study were almost entirely self-report, and therefore the results might be skewed by mono-informant bias (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003).

Furthermore, the data were cross-sectional, which prevented the authors from examining the effect of STAR classes on outcomes, and vice versa. It would also be important to know the stability of STAR classes over time, and to examine the lasting effects of covariates on CSEC risk.

The final and largest limitation of the present study was the lack of data ascertaining how many youth in the sample were actual CSEC victims. A future study should include an examination of true positives and false negatives across a variety of potential STAR cut scores. The confirmation of CSEC victims would also make possible a more nuanced examination between the genders. As an example, some item scores might prove more effective in the identification of female than male CSEC victims. Clinical interviewing with victims from both genders might also inform amendments to STAR items. Finally, some STAR items did not yield an adequate amount of information. These items, and the codebook information used to score these items, should be revisited in a future study.

Last, it should be noted that the STAR was developed in the context of a large agency which screens thousands of youth per year. Therefore, the STAR might not be a good fit for smaller agencies where longer and more thorough interviews of each youth are possible. Given the unique set of administrative demands at DC Courts, the authors decided to not prompt disclosure during initial screenings because this method was hypothesized to be both ineffective and potentially harmful. In fact, there appears to be a consensus in the research literature that prompting CSEC disclosure should not occur during initial screening. Nonetheless, the efficacy and consequences of prompting CSEC disclosure has not been thoroughly examined through empirical study, and this procedure provides an opportunity for a potentially fruitful line of inquiry.

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