Assessing Community Readiness to Respond to Commercial Sexual Exploitation in Two Geographic Regions of Massachusetts: MetroWest and Central

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A strength-based, participatory assessment model called the Community Readiness Model was used to understand two geographic communities' [i] *readiness to respond to the effects of commercial sexual exploitation. Commercial sexual exploitation (CSE) is defined as the buying and selling of people, women and men, for the purposes of sexual gratification. From January through May 2013, eighty-eight one-on-one interviews were conducted using the Community Readiness Interview Tool across nine population sectors in two geographic regions of Massachusetts. Interviews were scored and analyzed to understand where on a continuum of readiness these regions are particular to responding to the problem of commercial sexual exploitation. Results indicate that 1) there is a significant lack of public awareness regarding how CSE affects the individual, family, and community; 2) leadership and funding are hindered because of this; and 3) there is widespread respondent denial that the community is affected by the problem or that those affected are deserving of services. Recommendations include identifying local leaders across the community to work to increase public awareness, creating partnerships with established service providers, and developing comprehensive trauma-informed programs*.

Commercial sexual exploitation and human trafficking are receiving increased state and federal scrutiny. Despite efforts to address these issues, local communities struggle with defining the problem, understanding the complexities of the problem, and engaging services that can effectively help the affected populations. Without sufficient awareness and the reallocation of essential resources from law enforcement to human service providers to healthcare and legal aide to emergency and longer-term housing, programs and efforts to address these issues will likely fail. This study assesses two geographic communities' readiness to respond – areas of Massachusetts commonly known as MetroWest and Central Massachusetts. The study is the first in a series of planned studies designed to inform aftercare service delivery models.

In 2000, the United States Congress passed the Trafficking Victims Protection Act (TVPA), that defines **human trafficking** as commercial acts or services of labor or sex induced by force, fraud and coercion, unless under 18 years of age. For minors, force, fraud and coercion become irrelevant according to federal statute. With the passage of this federal legislation, the US State Department created a specialized Human Trafficking Bureau to help with prosecutions and provide global leadership. Each year this Bureau produces an extensive report that categorizes countries into Tiers 1, 2, 3 based on efforts to combat trafficking. The United States was added to this tier system in 2010.

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[i] For the purposes of this study, 'community' was defined by 1) geographic region, and 2) interview sector, i.e. law enforcement, human services, businesses, medical/health, court and legal, government, clergy, education/training, and residents living in that region.

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Commercial Sexual Exploitation, or CSE, otherwise known as sex trafficking, is a broad term used to describe all facets of exchanging money, food, shelter, or other item(s) of value for sexual related activities. It may also be referred to as the buying and selling of people for the purposes of sexual gratification. CSE is enormously profitable for traffickers, self-serving for buyers, and deeply injurious to the exploited. In recent years, demand for commercialized sex has diversified and exploded due to a rapid expansion of technological, national, and global venues. CSE can include, and is not limited to, prostitution, stripping, pornographic films and images, live cam sites, escort and "call girl" services, [sex] trafficking, and sex tourism.[1]

This study defines commercial sexual exploitation in the context of venue and language, rather than legal proof of *force, fraud, and coercion*. Borrowing a common definition used by service providers and researchers, CSE here *includes and is not limited to stripping, pole dancing, lap dancing, massage parlors / saunas, brothels, escort agencies, prostitution, phone sex lines, internet sex chat rooms, pornography, trafficking, forced marriage, mail order brides, and sex tourism.* Throughout this paper, the words "women", "girls/children", and "people/persons" will be used interchangeably in order to express the reality of the affected populations.

Global, National and State Trends

It is difficult to reliably count the numbers of women, men, girls and boys who are experiencing CSE anywhere in the world. A sophisticated underground network of organized, criminal business moves people (as "transportable commodity" [2]) sometimes daily from one place to another. This coupled by the transient nature of the population make attempts to determine how many people are being affected very difficult. That said, much of the macro-level numerical analyses are educated estimates that unfortunately suggest a gross under-representation of the numbers.[3]

Globally, human trafficking and commercial sexual exploitation are profoundly complex public health problems, prospected to affect more than 29 million people each year, mostly women and children, and exceeding profits of $32 billion annually. Of that $32 billion, $15.5 billion is made in industrialized countries.[4,5] Men and boys are also at risk for sexual exploitation, although much less is known about their experiences and their pathways in and out of "the life."

In the United States, it is estimated that more than 300,000 people (mostly girls, at an average age of 12-15 years old) are forced into CSE annually.[4,6,7] Since 2002 when Washington state passed the first anti-human trafficking law, states across the country have passed various pieces of legislation combatting human trafficking. In 2011, Massachusetts passed its first such law making human trafficking -- the buying and selling of people -- a crime. The law - Bill H.3808, *An Act Relative to the Commercial Exploitation of People,* was recognized by the Polaris Project in Washington D.C. as one of the most comprehensive and promising laws in the country. As part of this legislation, Attorney General Martha Coakley led the organization of the Interagency Massachusetts Human Trafficking Task Force, which convenes a team of providers from the Commonwealth in the areas of public awareness, victim services, data collection and information sharing, education and training, and demand. Working intensely over more than a year, this Task Force released a critical report on August 19, 2013 titled, *Findings and Recommendations*. The report prioritizes the establishment of safe home services for children and adults who have been commercially exploited by labor or sex.[8]

Effects of Commercial Sexual Exploitation

Traffickers and "the trafficking business feed on conditions of vulnerability, such as youth, gender, poverty, ignorance, social exclusion and isolation, political instability, and ongoing demand." [3] Whether persons are trafficked internationally, recruited domestically, or enter "the life" by choice ("choices" made from positions of emotional, social, and economic vulnerability), evidence shows that exploited individuals experience the full continuum of symbolic, structural, emotional, and physical violence which begins at a very young age. Contributing to these conditions, often people involved in "the life" share histories of familial abuse and neglect that intensify their vulnerabilities to traffickers. In a study of 854 prostituted and exploited women across nine countries including the United States, 75% had experienced homelessness; 65%-95% had been sexually abused as children; and 39%-71% had been beaten "or hit until bruised as a child." [1,9,10] According to the National Center for Youth Law in Oakland, CA, traffickers and pimps understand how to find the most vulnerable among us, and so it is not uncommon for them to prey on children who are involved in child protective services and foster care throughout the country.

Analysis of multiple qualitative research studies, including longitudinal studies, interviews, mental and physical health intakes, and other integrated analyses, shows vast evidence that intrusive and repeated psychological and physical violence is a regular occurrence in commercial sexual exploitation resulting in epic levels of emotional and physical harm to the affected individuals.[1,11,12,13,14,15] Trafficking and sexual exploitation are highly correlated with the development of post-traumatic stress disorder (PTSD), anxiety, depression, suicidality, substance abuse, poor physical health, including chronic pain, STD/STIs, unwanted pregnancies, and dissociative behavior patterns.[1,12,14,15,16] Much of this poor mental and physical health is attributed to the emotional and physical violence the population experiences at the hands of buyers, pimps/traffickers, law enforcement, and society at large. This violence includes verbal harassment and physical assault, rape and sexual assault, coercion to make pornographic material, refusal to practice safer sex, intimate partner violence, threats, denial of access to services, and physical torture.[1,14,15,17] In one study "70%-95% of the women interviewed were physically assaulted in prostitution, 60%-75% were raped in prostitution, and 68% met the criteria for PTSD." [1] In another study of 204 girls and women across 12 countries, 77% of those interviewed fit the criteria for PTSD.[15] Yet another study shows that while "in the life", at minimum 63.6% of sexually exploited persons experienced sexual violence, 81.8% experienced physical violence, and 41.7% experienced an abusive john/buyer.[12]

Although "little research has been conducted on sex trafficking in the United States, the research that is available suggests that the experiences of women who are sexually exploited here parallel those in other countries." [12] Regardless of the means by which one enters CSE in the United States (international trafficking, domestic trafficking, "voluntary" entrance), or the type/venue of sexual exploitation (indoor versus outdoor prostitution, escort service, stripping, etc.), large and small-scale studies indicate abuse as well as mental and/or physical problems due to the nature of the sex industry.

"Choice" and the Lack of Choice
As a woman living in "the life" said, *"I feel like I imagine people who were in concentration camps feel when they get out…It's a real deep pain, an assault to my mind, my body, my dignity as a human being. I feel like what was taken away from me in prostitution is irretrievable."* [18]

Since most individuals are initiated into "the life" (pornography, stripping/dancing, prostitution) as children, federal statute recognizes that the issue of "choice" is irrelevant. Children and young people do not choose to be exploited; they are unequivocally forced. However, when these children become young adults living in "the life", the psychological and physical damage, as well as, the traumatic bonding to the perpetrators do not vanish. If anything, the feelings of being trapped and dehumanized become even more pervasive and multi-layered.

Many women interviewed across several studies explained that they wish to leave "the life", but the process of exiting seems unattainable -- rife with service gaps, relentless fear and trauma, and subsequent personal and economic immobilization. Furthermore, many do not see a viable option better suited to their economic survival, carrying with them a pervasive sense of shame and feelings of not belonging.[1,19,20,21]

While incredibly harmful to implicated individuals, trafficking in persons also incurs global economic and health risks that ultimately sustain poverty by hindering the social and economic development of the most vulnerable people in a society.[16] Human trafficking and the commercial exploitation of people are detrimental to the domestic and international community in that they also feed organized crime enormous profits, which exceed $87 million dollars a day.

With no awareness of the issue of CSE, minimal support available for adults,[13,16] and with organized crime profiting, there is little chance of a different future for the exploited. Long-term, sustainable solutions that address the physical, psychological, and social damage to survivors are vital. The services required to aid survivors are vast and complex, but efforts can be made to strengthen and broaden existing support networks and develop comprehensive trauma-informed programs for those who wish to exit prostitution and other forms of commercial sexual exploitation.

This study attempts to assess the magnitude of the work necessary to ready communities to respond to this issue. For example, are leaders across the community aware of the problem? Are these same leaders, or others ready to act and mobilize resources to support the affected populations?

METHODS

To assess readiness, we conducted a qualitative study that incorporated the Community Readiness Model (CRM). The term ''community readiness'' refers to the preparedness of a community to take action on an issue. The model is based on four premises: (1) readiness is issue-specific, meaning that a community can be at a high level of readiness to deal with one problem and a low level of readiness for another problem; (2) readiness can be accurately assessed; (3) readiness can be increased; and (4) determining a community's readiness is essential because interventions to move communities to the next stage of readiness differ for each. In addition, unless an intervention is consistent with the community's current readiness, it

is likely to fail. [22,23]

Respondents
From January through May 2013, the RIA House[ii] Advisory Team used the CRM, as adapted for commercial sexual exploitation, to conduct eighty-eight key informant interviews across nine population sectors in MetroWest (n=47) and Central (n=41), Massachusetts (see Appendix A and FIGURE 1). Each person interviewed was provided a privacy statement before the start of the interview (see Appendix B). Key informants were 73% female and 27% male, 64 and 24 respectively. Respondents represented 27 towns: Ashland, Athol, Framingham, Grafton, Holliston, Hopkinton, Hudson, Leominster, Leicester, Marlborough, Medfield, Milford, Natick, Needham, Newton, Northbridge, Sherborn, Shrewsbury, Southborough, Stow, Sutton, Waltham, Webster, Wellesley, Westborough and Worcester (second largest populated city in the state). The nine population sectors represented in the sample included law enforcement, court/diversion and legal services, businesses, human services, education, community residents, government, clergy/spiritual leaders, and health and medical.

The roles of the people interviewed across the two regions included detective, nurse, doctor, librarian, hotel manager, beautician, furniture store owner, consulting firm manager, police officer, lieutenant, state trooper, district court personnel, dance studio manager, personal trainer, state representative, board of health director, department of public health staff, post office staff, pastor, nun, rabbi, chaplain, human service executive director, rape crisis counselor, residential mental health clinician, survivor, public school staff, educator, guidance counselor, school principal, prison staff, victim witness advocate, assistant district attorney, attorney, legal aide staff, professor, college administrator, domestic violence advocate, licensed clinician, shelter director, child welfare social worker, massage therapist, photographer, bank manager, international small business owner, business association, social justice consortium, community development staff, city counselor, town government personnel, human rights commission, and other residents.

Model and Tool
The Community Readiness Model is a strength-based, participatory community assessment model developed in the late 1990s by a team of researchers at Colorado State University, Tri-Ethnic Center on Prevention Research. The model was chosen for this study because of its reliability and validity, its availability and ease of use, its cost effectiveness, and public health approach to change. Researchers from the Center found that communities can vary considerably in their ability to implement prevention programs, and unless a community is

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[ii] RIA House – Ready.Inspire.Act is a developing service organization assisting adult women who are coming out of a life of sexual slavery and commercial exploitation in central Massachusetts. Launched in October 2012, the vision of RIA House is to contribute to a world where women and children are loved and supported, not victimized and exploited. The mission is to provide much-needed coordinated services by way of a safe and sustaining home community that offers sisterhood, training and education, ultimately helping commercially sexually exploited women reintegrate into the community as leaders. RIA House has a passionate volunteer advisory team of women comprised of survivors, small business owners, a pastoral counselor, social workers, a psychologist and poet, an interior designer, a church organizer and domestic violence specialist, addiction recovery specialists, a rape crisis counselor, an educator, a physician, a musician and publicist, a survivor services director, a fundraiser, a realtor, and a public health organizer.

invested in and prepared for the particular intervention, even solid ideas that result in well-planned programs may not succeed.[22,23] The CRM was developed to assess and better understand a community's readiness to both prevent a public health problem while also measuring a community's readiness to mobilize around addressing that same problem. Although the CRM has not previously been used to understand the issue of commercial sexual exploitation, the model has been used in national and international settings to include understanding readiness related to childhood obesity,[24] community health center use,[25] and breast cancer health[26] to name a few.

The model is initiated through one-on-one interviews with key informants using an interview tool which includes six *dimensions* of questions related to Community Effort, Knowledge of that Effort, Leadership, Community Climate, Knowledge of the Issue, and Resources Available to address the issue (see Appendix A and TABLE 1). Each dimension is scored on a continuum of community readiness towards taking action on a particular issue. Readiness ranges from having no sense to perhaps a vague sense of what might be happening in the community and with no real understanding of what to do about it if it is happening, to having a high level of understanding of the issue and community ownership to addressing it (see TABLE 2).

TABLE 1[27]

Dimension	Description
Community Efforts	To what extent are there efforts and programs that address this issue?
Community Knowledge of the Efforts	To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?
Leadership	To what extent are appointed leaders and influential community members supportive of the issue?
Community Climate	What is the prevailing attitude of the community toward the issue? Is it one of helplessness or one of responsibility and empowerment?
Community Knowledge about the Issue	To what extent do community members know about the causes of the problem, consequences, and how it impacts the community?
Resources Related to the Issue	To what extent are local resources – people, time, money, space etc. – available to support efforts?

TABLE 2[27]

Stage of Readiness	Description
1. No Awareness	Issue is not generally recognized by the community or leaders as a problem (or it may not truly be a problem)
2. Denial/Resistance	At least some community members recognize that it is a concern, but there is little recognition that it might exist locally.
3. Vague Awareness	Most feel that there is a local concern, but there is no immediate motivation to do anything about it.
4. Preplanning	There is clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.
5. Preparation	Active leaders begin planning in earnest. Community offers modest support of efforts.
6. Initiation	Enough information is available to justify efforts.

	Activities are underway.
7. Stabilization	Activities are supported by administrators or community decision makers. Staff are trained and experienced.
8. Confirmation/Expansion	Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.
9. High Level of Community Ownership	Detailed and sophisticated knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues.

Data Collection and Analysis

Eleven members of the RIA House Advisory Team conducted the eighty-eight interviews for the study—between four and eight interviews by sector. Other members of the team who did not conduct interviews were either interviewed as part of the study (3), or opened a door in the community for another member of the team to conduct an interview (7). Prior to conducting the interviews, interviewers discussed the process as a team, and received via email, step-by-step guidelines on how to conduct interviews (see Appendix C). Particular attention was paid to taking copious and accurate notes that detailed what the person being interviewed stated or expressed.

Most interviews were conducted in-person, one-on-one, and took between 20 minutes and two hours to complete, with an average of 30-45 minutes each. Approximately 15% of the interviews were conducted over the telephone. Except for one that was typed directly onto a computer and printed, all interviews were captured in writing on a paper interview tool. All the interviews were conducted in English.

Respondents' names, personal information, and professional identification were kept confidential between the interviewer, research manager and person being interviewed. Each paper interview was coded at the top of the first page of the tool with geographic region (M)etro(W)est/(C)entral, consecutive number by order of being received by research intern, gender (M/F), first and last initials of interviewee, and first name of interviewer.

Once all interviews were completed, six individuals were trained by an experienced research consultant on how to score each. Trained individuals then worked in pairs to score each interview taking the average scores by *dimension*. These individuals were blind to the names and specific community roles of the respondents whose interview sheets were being scored. Average scores translated into stages from 1 to 9 on a continuum of readiness to respond to CSE as a public health issue (see TABLE 2). As explained in the Community Readiness Handbook "…scores correspond with the numbered stage, and are "rounded down" rather than up, so a score between a 1.0 and a 1.99 would be the first stage, a score of 2.0 to 2.99 would be the second and so forth." [27] After scoring each of the interviews across the nine population sectors, scores were converted to averages by sector. Average scores by sector and geographic region then translated into a stage of readiness for each.

RESULTS

Overall

The data analysis suggests that MetroWest Massachusetts is at Stage 2 (denial/resistance) and Central Massachusetts is at Stage 3 (vague awareness) on a continuum of readiness to respond to CSE (see FIGURE 4). The data across sectors remains consistent with readiness between 1 and 3 depending on the sector. When *dimensions* of readiness across sectors are analyzed, we see some differences depending upon the region. Here, readiness ranges between Stage 1 (no awareness) to Stage 5 (preparation) (see FIGURES 2, 3, 5-10). The analysis across the narrative responses also reflects a general and specific lack of awareness and understanding about the effects of CSE on the lives of exploited people, their families, and their communities, and with no to a vague sense of how to respond to it.

Community Efforts and Knowledge of Those Efforts

The first two *dimensions* of questions in the model assess to what extent are there local efforts, programs, and polices that address the issue of CSE, and to what extent do community members know about these local efforts and their effectiveness.

Respondents presented some variability in readiness as it relates to current efforts. The Law Enforcement, Business, Clergy, Education and Government sectors in Central and the Law Enforcement sector in MetroWest are at a preplanning stage, whereas the Court and Legal sector in Central, and the Human Services sector in MetroWest, are ready to begin planning efforts in this area. The Business sector in MetroWest and the Community sector in both regions remain the least aware of programs and efforts addressing CSE (see FIGURE 5).

Although some sectors were aware of efforts and programs addressing CSE in their community, when asked what they know about these efforts, all sectors knew very little. Most sectors in this area are between a readiness stage of no awareness, denial and resistance, and vague awareness with one notable exception, the Court/Legal sector in Central (see FIGURE 6).

Further, when each sector was asked where they would refer someone if they knew that the person was in need of CSE services, sectors responded that they would likely refer the person to someone else, frequently outside of his/her sector (see FIGURE 11). These referrals included to a local domestic violence shelter or addiction recovery program, clergy, law enforcement, trusted friend/family member or teacher, and local emergency room or other medical provider. More than a handful of respondents said “to nobody” and “don’t know” acknowledging that trust is seemingly impossible to overcome for people living in “the life.” Notable exceptions to this were Law Enforcement, Human Service and Medical/Health providers, and Clergy, who more consistently referred people to themselves rather than other sectors.

Leadership

The next *dimension* of questions assesses to what extent are appointed leaders and influential community members supportive of the issue.

Across sectors, leaders in the community were identified as having no to little awareness with some having vague awareness of the issue of CSE. Notable exceptions to this were in Central with the sectors of Clergy and Government, which are both at preplanning (see FIGURE 7).

More specifically, respondents thought that the current leadership in their community would support additional efforts to addressing CSE, (76% [67]). Although when asked to identify the current leadership addressing this issue, a majority of respondents stated "do not know", "not sure", "not aware of any", and "none".

Community Climate
This *dimension* assesses what the prevailing attitude of the community is toward the issue, one of responsibility and empowerment, or helplessness.

The attitude of several sectors in Central is one of preplanning. However, MetroWest across all nine sectors has readiness that connotes no, little or vague awareness of the issue of CSE (see FIGURE 8).

Across both regions, when people were asked if there are ever any circumstances when CSE should be tolerated, more than half (57% [50]) of the sample said "yes". In both Central and MetroWest, responses revealed that CSE is generally perceived as a "spectrum", with some experiences being tolerable/unavoidable (stripping, pornography, escort and massage services) and others being problematic and harmful (prostitution). Language biases regarding exploited persons and the "deserving victim" were suggested across all nine sectors. Responses included that this is "dirty", "unpleasant", "no one wants to touch it", that this "lowers the quality of life [in the neighborhood]", that one should "clean [this] up", and "it's bad for business".

Finally, each interview began with a question that asked how much of a concern is CSE in the community (1 being not at all and 10 being of great concern). More than half of respondents, 53% (47) of the sample stated that it was not much of a concern, with a score of 4 or lower. Each interview ended by asking respondents if they have had contact with someone living in "the life" in the past year. Of these same respondents that answered 4 or lower, 28% reported any contact in the past year. When looking at the inverse, 47% (41) of the sample identified CSE as a concern by a score of 5 or more; in these cases, a much higher percentage of the respondents, (66%), reported contact with someone living in "the life" in the past year.

Community Knowledge of the Issue
This *dimension* of questions assesses to what extent community members know about the causes of the problem, consequences, signs, symptoms, local statistics, effects on the family and friends, and how the issue of CSE impacts the community.

Sectors in both MetroWest and Central again share little to a vague sense about the issue of CSE and its effects on the individual, family or community. In one notable exception, the Court and Legal sector in Central is at preplanning (see FIGURE 9).

Before the start of almost every interview, the person being interviewed expressed a general disbelief that CSE happens in their community by saying "this doesn't happen here", "not in my backyard", or "I don't think that I am going to be very helpful to you, as I do not know anything about this." Many of these same people were likely to *admit* low awareness or knowledge of the issue. Using the "find" function, the raw data was analyzed to identify the precise number of times this concern was articulated. Excluding cross-listings like "Human Trafficking Awareness Day" and "higher education", a lack of "education" or "awareness" was cited 89 separate times

as a primary obstacle to identifying and addressing CSE. Some respondents also mentioned "naiveté", "no information", "no knowledge", "denial", "clueless" or "need training", all of which point to the theme of minimal awareness of the issue and its effects on the lives of real people.

Respondents also seemed to conceptualize exploited persons as non-domestic. Frequently, people mentioned "immigrants", or just brought up geographic locations like "Thailand" or "India", rather than recognizing CSE as both a domestic and international issue. A correlate to this was the "not in my backyard" phenomenon, now moving from the local to the global "backyard". People also seemed to associate those affected by CSE as being low-income and struggling with drug addiction and/or living costs. Although a few respondents alluded to knowing how people get involved in "the life", even fewer, as few as five revealed any sense of the young age when initiation begins.

There was also a complete absence of reported knowledge regarding the forms of violence and harm that individuals experience in "the life" of commercial sexual exploitation. Acknowledgement of the direct and indirect violence and social isolation prostituted people experience, at the hands of buyers and johns, pimps and traffickers, law enforcement, and the community at large was negligible in the sample across all interviews.

Resources Available to Address CSE

This *dimension* assesses to what extent local resources – people, time, money, space, etc. – are available to support efforts in this area.

When respondents across nine sectors were asked about available resources to address this issue, they reported no to little awareness of what those resources might look like and/or how to access them. One exception is the Clergy sector in Central that is at preplanning (see FIGURE 10).

Often, responses in this *dimension* were qualified by, "if we knew that this was happening in the community we would want to help in some way." In addition, when respondents were asked whether or not they were aware of any proposals or action plans addressing CSE, 95% (84) said that they were not aware of any proposals or such plans. Respondents who were aware of proposals or action plans repeatedly mentioned the "task force" in Worcester with one exception, a clergy member who provides programming for refugees and asylees.

Respondents identified the following four areas as the primary obstacles addressing CSE in their communities: 1) public awareness, 2) funding, money, resources, 3) denial, stigma, "secrecy", and 4) limited data, "invisibility" of the victim, and lack of reporting.

By examining 1) the stages of readiness across regions, 2) the stages of readiness across *dimensions,* and 3) the language used by respondents to conceptualize CSE and in particular the persons living in the sex industry, it becomes clearer how to respond to the complex problem of CSE and suggests what *kind* of "awareness" needs to be built moving forward.

DISCUSSION

The application of the CRM to assessing readiness to respond to the issue of CSE in MetroWest and Central Massachusetts is an important first step in these communities, and perhaps, any

community, when designing sustainable and effective programming that will support adult women coming out of "the life."

In these regions, we found a significant lack of public awareness about the issue of CSE, the experiences and the effects of CSE on the individual, the family, and the community across all nine sectors. This hinders local leadership and funding which further limits the development of specialized and longer-term programs and services for the affected populations. The following highlights the components and recommendations that should be seriously considered when designing an effective public awareness campaign around the issue of commercial sexual exploitation in MetroWest and Central Massachusetts.

Age of Initiation into "the life" at an average of 12-15

The data set was almost entirely devoid of respondent knowledge about the young age at which the vast majority of adults are lured into commercial sexual exploitation. In the United States, most people affected by CSE are American children who are introduced at an average age of between 12-15 years old and who come from all different types of families -- two-parent, single, divorced; White, Black, Asian, Hispanic; rural, urban, suburban neighborhoods; middle income, poor and rich. These children grow into adults who are then affected by CSE for a lifetime. Increasing awareness of the fact that exploitation can happen to anyone should help to inspire community interest and motivation to act.

Recommendation #1 – to increase awareness of the age of initiation

An awareness campaign must provide clear and succinct information that the vast majority of people involved in "the life" which includes pornography, stripping/dancing, prostitution, trafficking, escort services, were lured in as children by an adult predator.

CSE is happening in our backyard

Although CSE occurs in both MetroWest and Central regions, most respondents remained skeptical, unsure how to think about it in general, and thought that if this was happening in the community it mostly involved people from other countries. While international trafficking is a huge issue with massive individual, family, and community consequences, research suggests that domestic trafficking is more frequent in the United States and also harmful to both individuals and communities. Responses suggest that if the broader community was more aware of the pervasiveness and proximity of CSE, they would be more eager to help and the climate would change.

It is suggested from the data set that knowing someone who has experienced CSE dramatically affects one's responsiveness in addressing this issue. It also appears in the data that community events and government strategies can help raise levels of awareness; however, this awareness may not result in sustained community efforts. In the data set, respondents referenced "Human Trafficking Awareness Day", and a "task force" many times. This correlates to the work currently being done related to the "task force" in the City of Worcester – a task force that is organized to address street prostitution in the Main South neighborhood of the city. As well, the Central region scored slightly higher overall than MetroWest on a continuum of readiness to addressing CSE. The narrative responses suggest that this difference may be an indicator of this organized effort (again, consistently referred to as "the task force") in the City of Worcester.

The language in the data set reveals undertones of sexism, racism, classism, and ethnocentrism; each of which manifest attitudes that further isolate and ostracize exploited persons. While it also provides a template of *who* an exploited person is/or is not. These "other than me" and "not in my backyard" qualifications render CSE more deeply invisible. Further, respondents appear to believe that the people affected by CSE are mostly low income, from under-resourced, urban communities, and live in countries other than the United States. Each of these beliefs allows the community to ignore and dismiss the issue of CSE and the people that it affects. One can assume that psychologically it is hard for most people to comprehend the tragedy that being in "the life" would present for a loved one. It is easier to convince oneself that this is not a problem, so why should it be my concern? In truth, in the United States most people who live in "the life" are Americans who come from a variety of backgrounds and experiences.

Language biases regarding exploited persons were evident across all nine sectors; although, it is important to recognize that some of these biases are structurally inherent in the systems and environments where people work and live. Whether respondents used words like "survivor", "client", "prostitute", or "victim", this presents different perspectives and approaches to understanding who, if anyone, is in need of services, and what, if anything, that person suffers from. For instance, "victim" is a broad, albeit vague, term that suggests some form of harm and was used most often by law enforcement respondents. "Client" on the other hand is a more neutral term, even suggesting a non-issue, which was most used by the legal community in this study. The disparate descriptions show the multitude of perceptions that frame the discourse regarding CSE and the experiences of sexually exploited persons.

Solving this problem is made more complicated by the inherent nature of how services are provided across communities, particularly in that they do not typically address an individual's full spectrum of experiences. Instead, services address one or two presentations of behavior, experience, or other diagnosis, such as: addiction, HIV, domestic violence, criminal status, malnutrition, poverty etc. When respondents were asked where they would refer someone who has experience with CSE, their responses included DV shelters, addiction recovery programs, police, clergy, emergency room/medical provider, trusted friend etc.—none of which provide, or are linked to, comprehensive services in MetroWest and Central. Too often a survivor of CSE stumbles upon large service gaps within and between service agencies, frequently triggering (re)entry into "the life." [19,21] The referral processes cited by respondents spoke to perhaps limited awareness and understanding of the complexities of the problem, while they also reflect the inherent challenges in the way systems are currently structured to deliver services.

<u>Recommendation #2 – to involve local leaders and local stories</u>

Each community needs to feel that it is affected by CSE. There is significant rationale to design a community-wide approach to addressing this issue -- an approach that involves leaders across disciplines and experiences, and involves survivors at every level of work. Involving local leaders, survivors, and other concerned citizens in an awareness campaign is critical to increasing the community's depth of understanding of the issue, the lives it affects, and particularly, how each member of the community can contribute to a coordinated response addressing CSE. In addition, it is the responsibility of local leaders and service provides to address the inconsistencies as they relate to language and the conceptualization of the exploited. There is the need to reallocate resources through meaningful partnerships to better serve the myriad of service needs of the affected populations. It is the commitment of a few key

informants that will encourage and motivate the masses to get involved in responding to CSE in these regions.

"Choice" and the Role of Violence in CSE

Respondents overwhelmingly suggested that most people who are involved in "the life" are adults who chose to be there. Paralleling the history of community response to the issue of domestic violence, respondents appear to believe that CSE survivors can walk away from "the life" at any time, and certainly sooner if they had a place to stay, or a program to attend, or police protection, or a trusted friend to talk to, or a doctor to heal their injuries and infections. The paradox in this is that people, who are survivors of CSE experience complex trauma that parallels that of torture survivors and prisoners of war [28]; yet, they are made to feel responsible, humiliated and shamed.

Very few respondents mentioned the role that violence plays in the experiences of prostituted people. There was also little to almost no mention of the trafficker/pimp and/or buyer/john throughout the eighty-eight interviews. This perpetuates the myth that prostitution is a viable "choice," thus neglecting the economic, emotional, and physical violence inherent in its experience. This violence, marked by traumatic bonding (Stockholm Syndrome), complex PTSD, psychological harm, chronic health issues, lack of employability and social stigma all serve to generate reliance on pimps/traffickers, buyers, and the sex industry as a whole as a means for (literal and figurative) survival. Furthermore, when the buyer and trafficker are erased from the social discourse, the exploited person becomes the primary representation in our collective reality. While certainly an important part of this experience, this image of the exploited person alone is not helpful when tackling CSE as a local and global public health problem, well networked, expansive, and hidden in plain sight. The erasure of buyer and trafficker leave the exploited person as the only visible agent. In this invisibility, the social discourse continues to ensure the supply and demand of a human commodity, all at the expense of a predominately vulnerable population.

Recommendation #3 – to increase awareness of the role of traumatic bonding

An awareness campaign must elucidate some of the core components of CSE, which are psychological and physical traumatic bonding that both draw people into "the life" and then literally and forcibly keep them from being able to leave. Furthermore, there are real life fluctuations that overlap within the different experiences and contexts where CSE happens which should be amply discussed in any such campaign. Perpetrators exist across any experience of CSE. They are known as the seller/pimp/trafficker/madam and the sex buyer/john. They can be trusted friends and family members. Most importantly, we should not ignore, or protect them in this work.

In accordance with the CRM, there are many follow-up options to enhance MetroWest and Central Massachusetts' existing efforts and address the lack of public awareness about the issue of CSE towards improving the lives of people in the Commonwealth. Services for the affected population would include at a minimum compassionate long-term mental health, medical and dental care, education and job training, legal aide and court accompaniment, and short and longer-term housing. In addition, because of the deep level of social stigma and shame that survivors carry, community reintegration for this population must be intrinsic to any effort addressing CSE.

In the domestic violence movement, once the community understood that there was a perpetrator who had committed a crime, a crime of violence/passion against an intimate partner or spouse, with that came a shift in the discourse. This shift legitimated the experiences of thousands of people who were previously left immobile and isolated. CSE is not domestic violence, however, it can borrow from the decades of macro and micro-level work that ultimately unleashed leadership, funding and program development.

Limitations

Language and Defining the Issue

A limitation in our questionnaire was the use of a broad definition of CSE to include: …*stripping, pole dancing, lap dancing, massage parlors/saunas, brothels, escort agencies, prostitution, phone sex lines, internet sex chat rooms, pornography, trafficking, forced marriage, mail order brides, and sex tourism.* This broad definition, while exhaustive, could have been confusing for some of the respondents. For instance, it has been noted how certain forms of CSE are viewed as more acceptable/tolerable than others. If interviewees focused on one form more than the other, or perhaps did not register the entire list, they might have reported different perspectives.

Conducting Interviews

Although interviewers were trained on how to conduct an interview as a small group and received written guidelines, more training could have been helpful. Also, more than two thirds of respondents were female across all sectors, with one notable exception being Law Enforcement that was two thirds male. This could be the result that all respondents were a colleague, peer, friend or acquaintance of a member of the RIA House Advisory team: a team of all women. These limitations suggest that community awareness may be lower than originally calculated.

CONCLUSIONS

The recommendations from the CRM include, as a priority, 1) the identification of leaders within each sector of the community who are further along the continuum of readiness to addressing the issue of CSE. Other steps are 2) to develop comprehensive locally-based awareness campaigns (article distribution, publicizing descriptions of local incidents, engage existing relevant programs); 3) to promote community empowerment and mobilization against this issue (publicize at local community events, host relevant events, conduct billboard campaigns, informal local surveys and other interviews, publish articles/editorials with general information and local implications, visit and invest community leaders, conduct focus groups, continue to increase media exposure); and 4) to work on gathering information with which to plan locally informed and appropriate strategies for prevention and intervention (see TABLE 3).

In accordance with the recommendations in the CRM, it would appear that awareness building around the average age of initiation into “the life”, language and the conceptualization of the exploited, and the role of perpetrator in the exploitation are critical. Furthermore, the issue of “choice” should be seriously considered when addressing this issue. The very notion of “choice” should be interrogated in relationship to the individual, interpersonal, and community contexts, as well as to one’s viable economic and social survival. In practice and research, survivor-led and informed programming is critical to managing the range of biases that exist across the community related to understanding the experiences and needs of prostituted people. More importantly, developing partnerships across and between diverse experiences/backgrounds is key to comprehensively addressing the issue of CSE and sustaining community-wide support

over years to come. Finally, identifying local leaders across community sectors to partner, develop awareness and design comprehensive programming for and with survivors is critical.

Next Steps
RIA House is a developing service organization in Massachusetts that assists women who are coming out of the experiences of commercial sexual exploitation with healing and reintegration back into the community. The first step in our organizational development was to assess community readiness to support a program model, such as RIA House in service of the target population. From this critical work and through a more intimate understanding of community readiness to respond to CSE in MetroWest and Central, we will next identify the most respected, community leaders who can drive an education and awareness campaign across the regions.

Some considerations that should be integrated into this campaign include identifying what facts and stories will motivate a call to action to addressing CSE in MetroWest and Central; understanding who best to deliver this information and call to action; understanding with survivors what services are needed and desired; researching what services already exist and which ones are willing to help; providing services, such as one-on-one counseling and support groups to survivors; and finally, designing an effective home community where women can live and heal over 24 months.

Inevitably, public awareness, identification of community leaders, creation of dynamic service partnerships, and designing a comprehensive approach to healing and reintegration are predominant themes when considering how to respond to CSE in MetroWest and Central, Massachusetts.

TABLE 3[27]

Goals/General Strategies For Each Stage	Description
1. No Awareness **Goal: Raise awareness of the issue** · **Make one-on-one visits with community leaders/members.** · **Visit existing and established small groups to inform them of the issue.** · **Make one-on-one phone calls to friends and potential supporters.**	The community or the leaders do not generally recognize CSE as a problem. "It's just the way things are." Community climate may unknowingly encourage the behavior although the behavior may be expected of one group and not another (i.e., by gender, race, social class, age).
2. Denial / Resistance **Goal: Raise awareness that the problem or issue exists in this community** · **Continue one-on-one visits and encourage those you've talked with to assist.** · **Discuss descriptive local incidents related to the issue.** · **Approach and engage local educational/health outreach programs to assist in the effort with flyers, posters, or brochures.** · **Begin to point out media articles that**	There is little or no recognition that this might be a local problem but there is usually some recognition by at least some members of the community that the behavior itself is or can be a problem. If there is some idea that it is a local problem, there is a feeling that nothing needs to be done about it locally. "It's not our problem." "It's just those people who do that." "We can't do anything about it." Community climate tends to be passive or guarded.

describe local critical incidents. **· Prepare and submit articles for church bulletins, local newsletters, club newsletters, etc.** **· Present information to local related community groups. (Note that media efforts at the lower stages must be lower intensity as well. For example, place media items in places where they are very likely to be seen, e.g., church bulletins, smaller newsletter, flyers in laundromats or post offices)**	
3. Vague Awareness **Goal: Raise awareness that the community can do something** **· Get on the agendas and present information at local community events and to unrelated community groups.** **· Post flyers, posters, and billboards.** **· Begin to initiate your own events (pot lucks, potlatches, etc.) and use those opportunities to present information on the issue.** **· Conduct informal local surveys and interviews with community people by phone or door-to-door.** **· Publish newspaper editorials and articles with general information and local implications.**	There is a general feeling among some in the community that there is a local problem and that something ought to be done about it, but there is no immediate motivation to do anything. There may be stories or anecdotes about the problem, but ideas about why the problem occurs and who has the problem tend to be stereotyped and/or vague. No identifiable leadership exists or leadership lacks energy or motivation for dealing with this problem. Community climate does not serve to motivate leaders.
4. Preplanning **Goal: Raise awareness with concrete ideas to combat condition** **· Introduce information about the issue through presentations and media.** **· Visit and invest community leaders in the cause.** **· Review existing efforts in community (curriculum, programs, activities, etc.) to determine who the target populations are and consider the degree of success of the efforts.** **· Conduct local focus groups to discuss issues and develop strategies.** **· Increase media exposure through radio and television public service announcements.**	There is clear recognition on the part of at least some that there is a local problem and that something should be done about it. There are identifiable leaders, and there may even be a committee, but efforts are not focused or detailed. There is discussion but no real planning of actions to address the problem. Community climate is beginning to acknowledge the necessity of dealing with the problem.
5. Preparation **Goal: Gather existing information with which to plan strategies** **· Conduct community surveys.** **· Sponsor a community picnic to kick off the effort.**	Planning is going on and focuses on practical details. There is general information about local problems and about the pros and cons of prevention activities, actions or policies, but it may not be based on formally collected data. Leadership is active and energetic. Decisions are being made about what will be done and who will do it. Resources (people, money, time, space, etc.) are being

· **Conduct public forums to develop strategies from the grassroots level.** · **Utilize key leaders and influential people to speak to groups and participate in local radio and television shows.** · **Plan how to evaluate the success of your efforts.**	actively sought or have been committed. Community climate offers at least modest support of efforts.
6. Initiation **Goal: Provide community-specific information** · **Conduct in-service training on Community Readiness for professionals and paraprofessionals.** · **Plan publicity efforts associated with start-up of activity or efforts.** · **Attend meetings to provide updates on progress of the effort.** · **Conduct consumer interviews to identify service gaps, improve existing services and identify key places to post information.** · **Begin library or Internet search for additional resources and potential funding.** · **Begin some basic evaluation efforts.**	Enough information is available to justify efforts (activities, actions or policies). An activity or action has been started and is underway, but it is still viewed as a new effort. Staff is in training or has just finished training. There may be great enthusiasm among the leaders because limitations and problems have not yet been experienced. Community climate can vary, but there is usually no active resistance, (except, possibly, from a small group of extremists), and there is often a modest involvement of community members in the efforts.
7. Stabilization **Goal: Stabilize efforts and programs** · **Plan community events to maintain support for the issue.** · **Conduct training for community professionals.** · **Conduct training for community members.** · **Introduce your program evaluation through training and newspaper articles.** · **Conduct quarterly meetings to review progress, modify strategies.** · **Hold recognition events for local supporters or volunteers.** · **Prepare and submit newspaper articles detailing progress and future plans.** · **Begin networking among service providers and community systems.**	One or two programs or activities are running, supported by administrators or community decision-makers. Programs, activities or policies are viewed as stable. Staff are usually trained and experienced. There is little perceived need for change or expansion. Limitations may be known, but there is no in-depth evaluation of effectiveness nor is there a sense that any recognized limitations suggest an immediate need for change. There may or may not be some form of routine tracking of prevalence. Community climate generally supports what is occurring.
8. Confirmation / Expansion **Goal: Expand and enhance services** · **Formalize the networking with qualified service agreements.** · **Prepare a community risk assessment profile.** · **Publish a localized program services directory.** · **Maintain a comprehensive database available to the public.** · **Develop a local speaker's bureau.** · **Initiate policy change through support of local city officials.** · **Conduct media outreach on specific data**	There are standard efforts (activities and policies) in place and authorities or community decision-makers support expanding or improving efforts. Community members appear comfortable in utilizing efforts. Original efforts have been evaluated and modified and new efforts are being planned or tried in order to reach more people, those more at risk, or different demographic groups. Resources for new efforts are being sought or committed. Data are regularly obtained on extent of local problems and efforts are made to assess risk factors and causes of the problem. Due to increased knowledge and desire for improved programs, community climate may challenge specific efforts, but is fundamentally supportive.

trends related to the issue. **· Utilize evaluation data to modify efforts.**	
9. High Level of Community Ownership **Goal: Maintain momentum and continue growth** **· Maintain local business community support and solicit financial support from them.** **· Diversify funding resources.** **· Continue more advanced training of professionals and paraprofessionals.** **· Continue re-assessment of issue and progress made.** **· Utilize external evaluation and use feedback for program modification.** **· Track outcome data for use with future grant requests.** **· Continue progress reports for benefit of community leaders and local sponsorship. At this level the community has ownership of the efforts and will invest themselves in maintaining the efforts.**	Detailed and sophisticated knowledge of prevalence, risk factors and causes of the problem exists. Some efforts may be aimed at general populations while others are targeted at specific risk factors and/or high-risk groups. Highly trained staff are running programs or activities, leaders are supportive, and community involvement is high. Effective evaluation is used to test and modify programs, policies or activities. Although community climate is fundamentally supportive, ideally community members should continue to hold programs accountable. Remember:“Best practices” are only best for your community if they are congruent with your stage of readiness and are culturally appropriate for your community.

CONTRIBUTIONS

Members of the RIA House Advisory Team and Founder conducted all interviews. Consultants provided one-on-one advisement, training and other research guidance.

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Heather Wightman is the Founder of *RIA House – Ready.Inspire.Act*. Heather has more than 15 years of experience managing and designing multi-faceted federal, state and local human service programs in the area of violence prevention. Having received her MSW in macro social work practice, and MPH in social and behavioral sciences from Boston University, Heather is committed to social justice and the advancement of human rights. She is also trained and practiced as a MA Sexual Assault Counselor. Heather has served on the boards of the ACLU of MA, YWCA, and Matahari: Eye of the Day, and as a Peace Corps volunteer, in Guatemala, CA.

Heather Mooney is currently enrolled in a dual Masters program at Simmons College, focusing on Gender/Cultural Theory and Teaching. She is also a research intern with *RIA House*. After graduating from Clark University in May 2011 with a Bachelor of Arts in Women's and Gender Studies and Sociology, she began working as the teen services provider at Pathways for Change, Inc. This work included speaking in local area middle schools, high schools, colleges, as well as professional development settings about the complexities of domestic and sexual violence. Heather also provided counseling for teenage survivors of sexual violence, performed medical advocacy and staffed the rape crisis hotline. Heather hopes to pursue a career in education administration and curriculum development that focuses on conflict theory and social justice.

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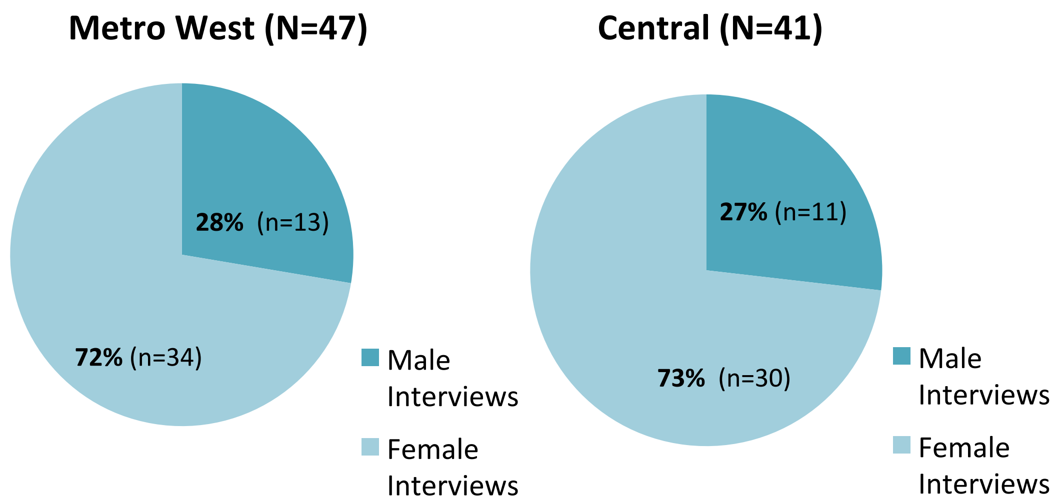
FIGURES

FIGURE 1



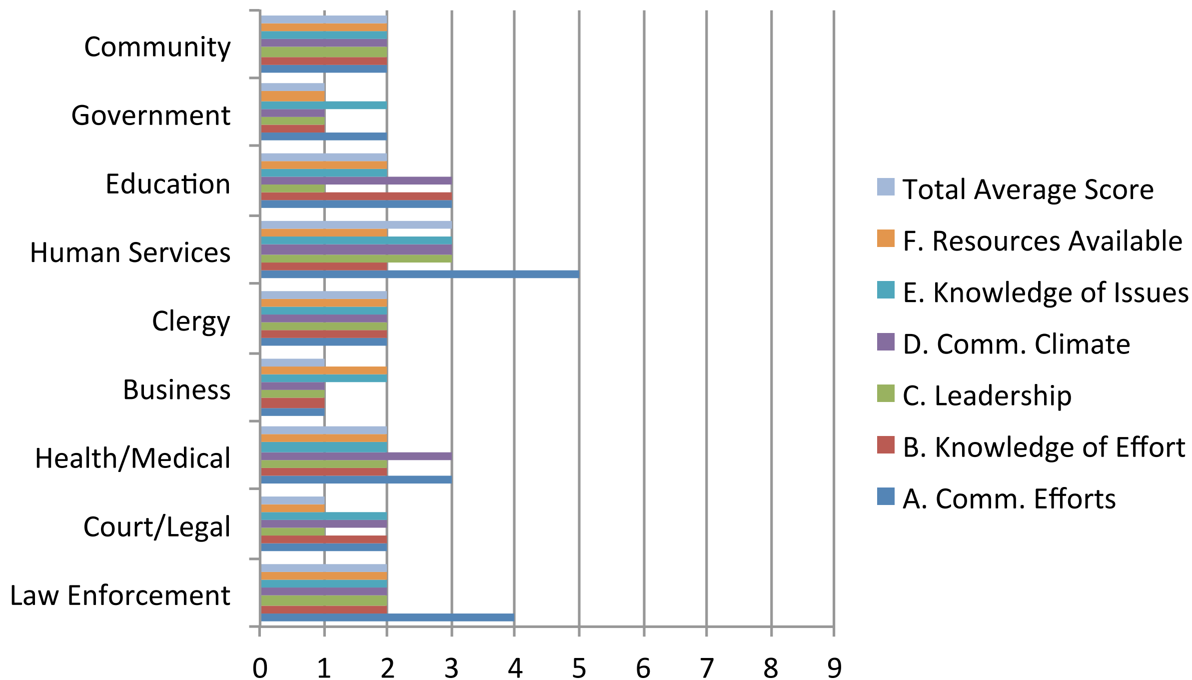


FIGURE 2
Metro West
Average Scores by Sector and Dimension
Community
Government
Education
Human Services
Clergy
Business
Health/Medical
Court/Legal
Law Enforcement
0
1
2
3
4
5
6
7
8
9
Total Average Score
F. Resources Available
E. Knowledge of Issues
D. Comm. Climate
C. Leadership
B. Knowledge of Effort
A. Comm. Efforts

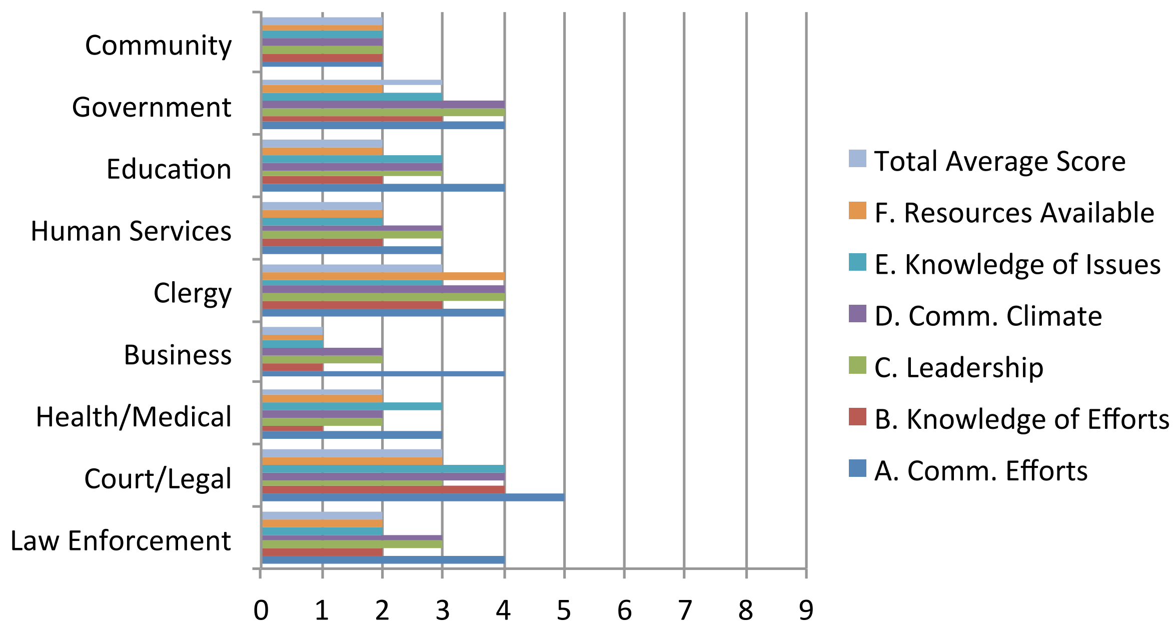


FIGURE 3
Central Mass
Average Scores by Sector and Dimension
Community
Government
Education
Human Services
Clergy
Business
Health/Medical
Court/Legal
Law Enforcement
0
1
2
3
4
5
6
7
8
9
Total Average Score
F. Resources Available
E. Knowledge of Issues
D. Comm. Climate
C. Leadership
B. Knowledge of Efforts
A. Comm. Efforts

FIGURE 4

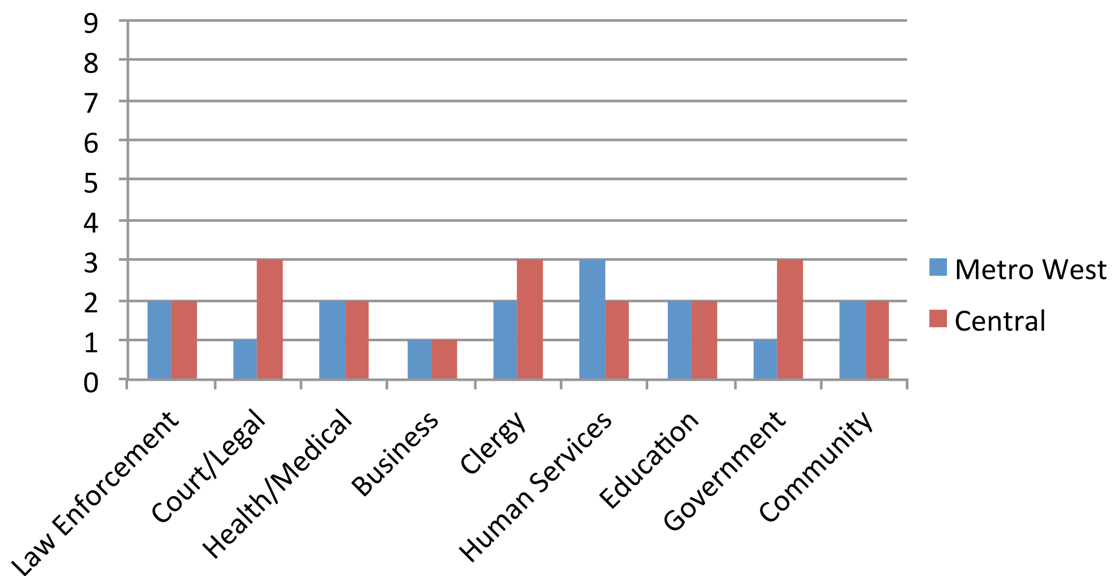
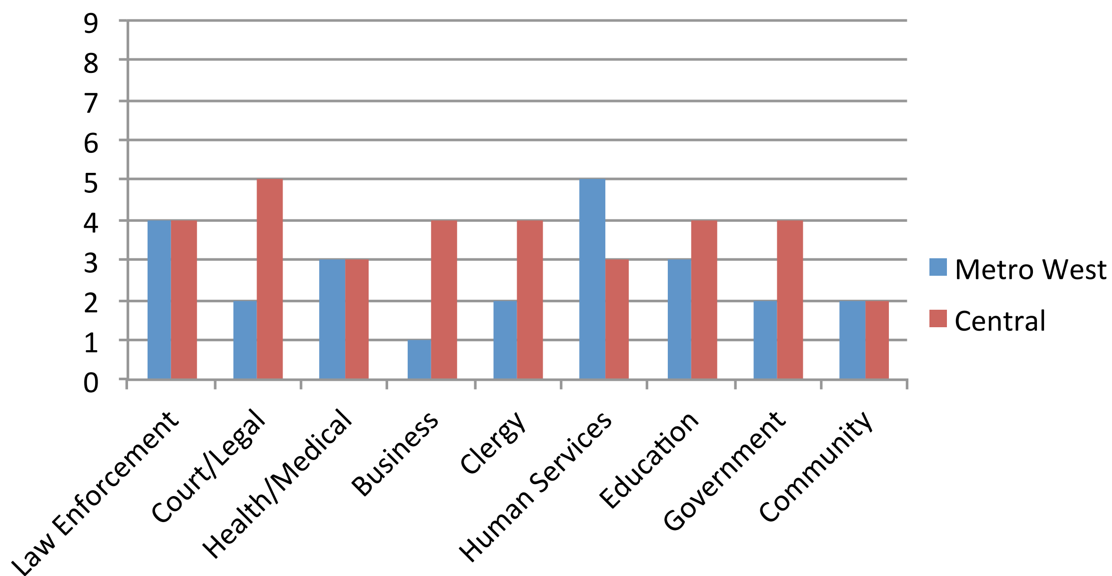


FIGURE 5

A: Community Efforts by Sector and Region



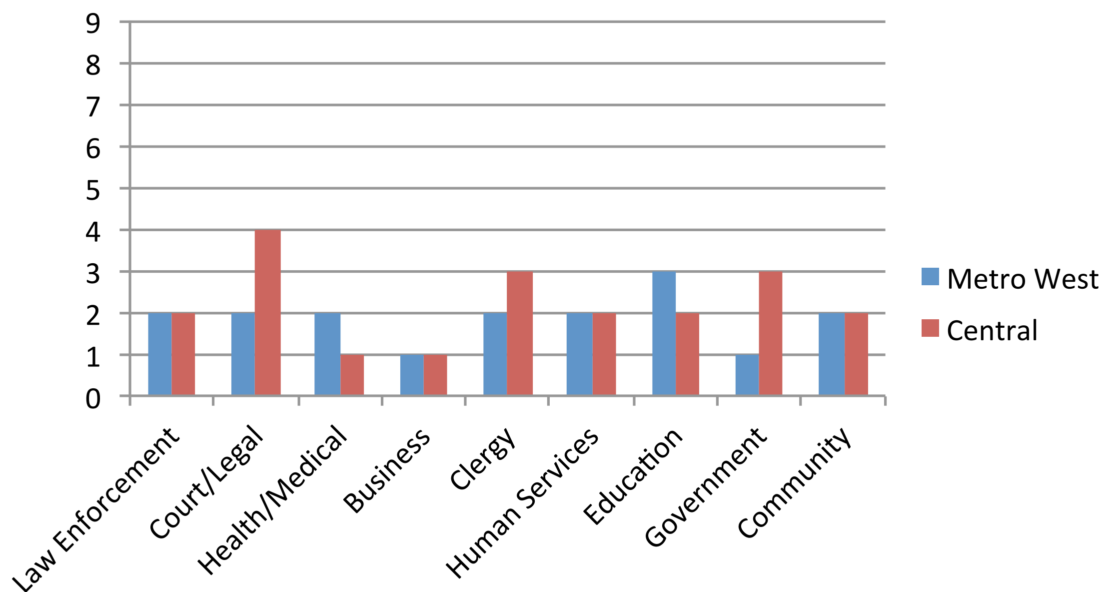


FIGURE 6
B: Knowledge of Efforts by Sector and Region
9
8
7
6
5
4
3
2
1
0
Law Enforcement
Court/Legal
Health/Medical
Business
Clergy
Human Services
Education
Government
Community
Metro West
Central

FIGURE 7

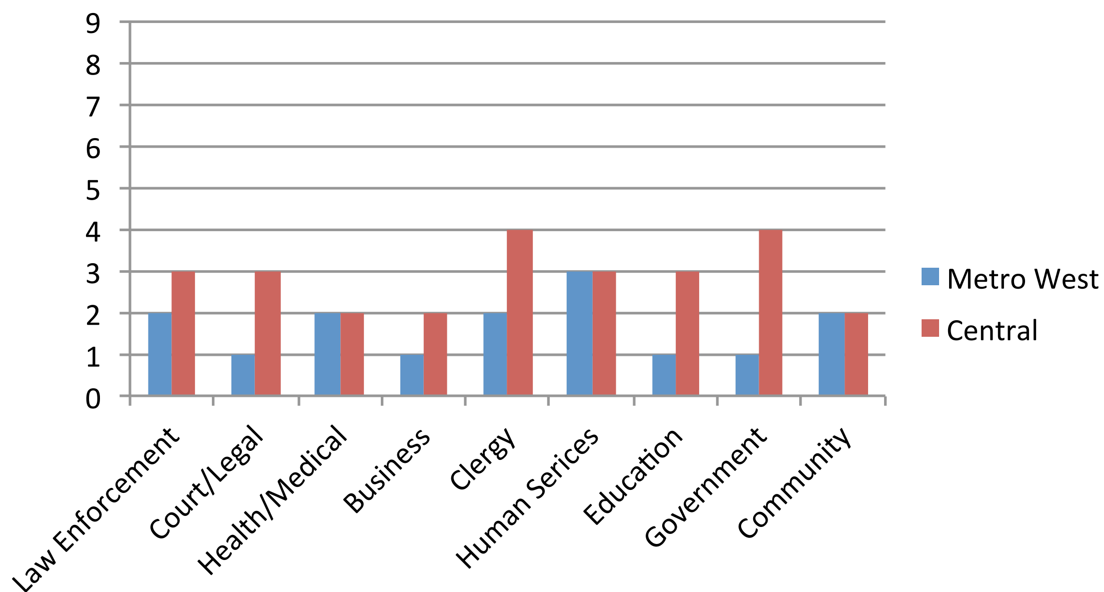


FIGURE 8

D: Community Climate by Sector and Region

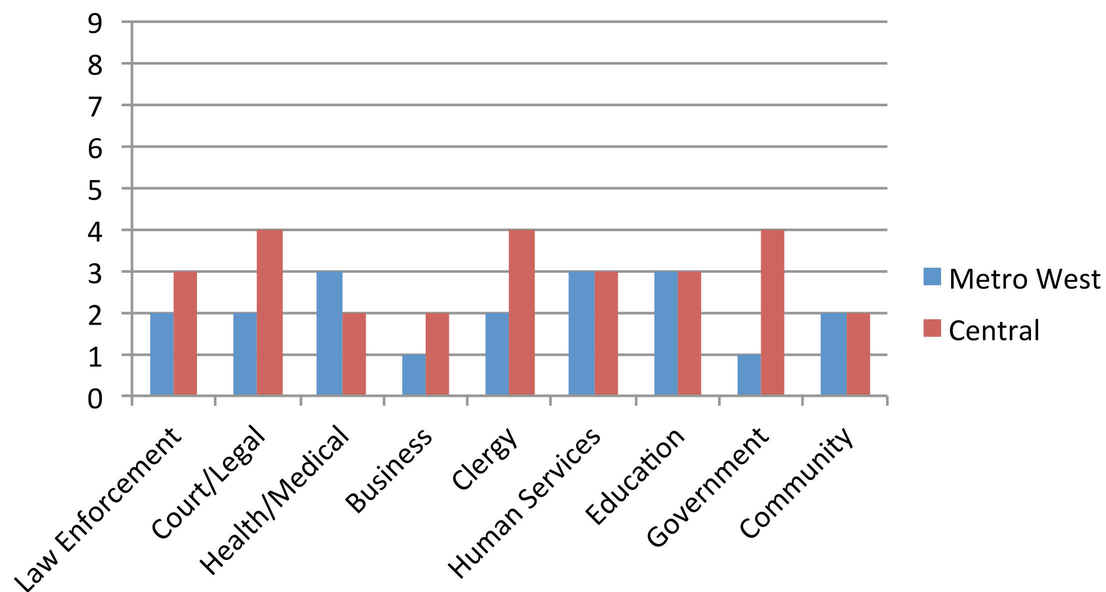


FIGURE 9

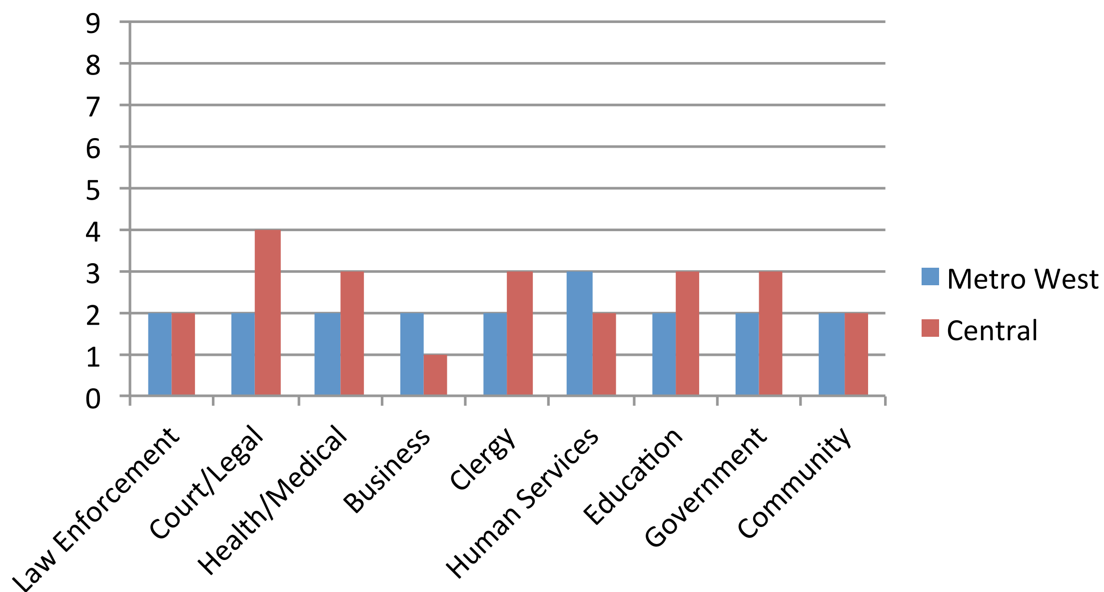
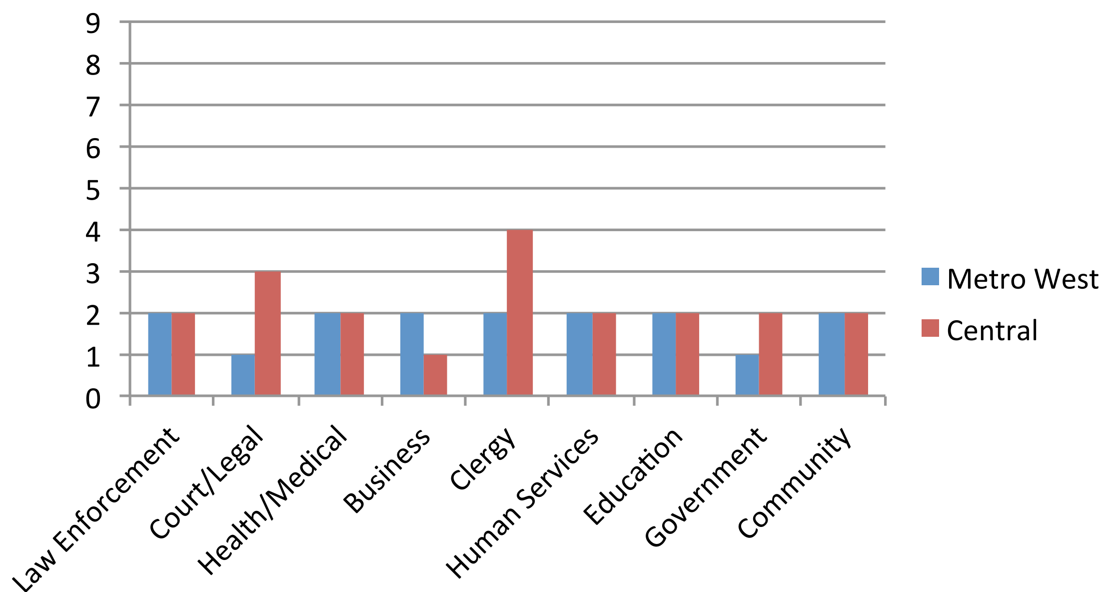
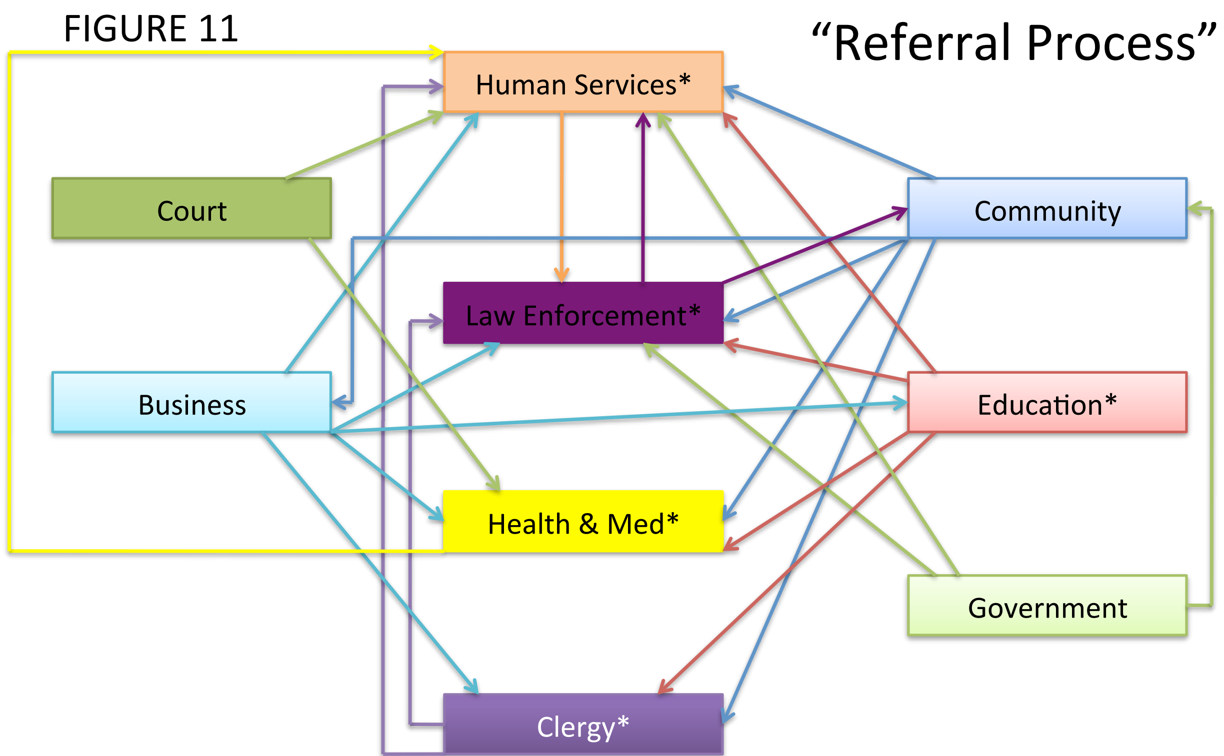


FIGURE 10





*=intra-sector referential

APPENDIX A (interview tool)

Sections A & B: Community Efforts & Knowledge of the Efforts:

A. *To what extent are there efforts, programs, and policies that address the issue of commercial sexual exploitation?*
B. *To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?*

Commercial Sexual Exploitation

(Commercial sexual exploitation is, but is not limited to … stripping, pole dancing, lap dancing, massage parlors / saunas, brothels, escort agencies, prostitution, phone sex lines, internet sex chat rooms, pornography, trafficking, forced marriage, mail order brides, and sex tourism.)

A1.	**Using a scale from 1-10, how much of a concern is commercial sexual exploitation in your community** *(with 1 being "not at all" and 10 being "a very great concern")*?	____________ *(write in rank)*
	Please explain:	
A2.	**Please describe the efforts that are available in your community to address commercial sexual exploitation.**	

A3.	**How long have these efforts been going on in your community?**

B4.	**Using a scale from 1-10, how aware are people in your community of these efforts** *(with 1 being "no awareness" and 10 being "very aware")*?	______________ *(write in rank)*
	Please explain:	

B5.	**What does the community know about these efforts or activities?**

Section C. Leadership:

To what extent are appointed leaders and influential community members supportive of the issue?

C6.	**Who are the "leaders" addressing commercial sexual exploitation in your community?**

C7.	*Are there other leaders in the community you suggest we interview?*

C8.	**Using a scale from 1-10, how much of a concern is commercial sexual exploitation to the leadership in your community** *(with 1 being "not at all" and 10 being "of great concern")*?	______________ *(write in rank)*

	Please explain:

C9.	**How are these leaders involved in efforts regarding commercial sexual exploitation? Please explain.** *(For example: Are they involved in a committee, task force, etc.? How often do they meet?)*
C10.	**Would the leadership support additional efforts?** ❑ **Yes** ❑ **No**

Please Explain:

Section D. Community Climate:

What is the prevailing attitude of the community toward the issue? Is it one of helplessness or one of responsibility and empowerment?

D11.	*Are there ever any circumstances in which members of your community might think that commercial sexual exploitation should be tolerated?*

D12.	**How does the community support the efforts to address commercial sexual exploitation?**

D13.	**What are the primary obstacles to efforts addressing this issue in your community?**
D14.	*Based on the answers that you have provided so far, what do you think is the overall feeling among community members regarding commercial sexual exploitation?*

Section E: Knowledge: *To what extent do community members know about the causes of the problem, consequences, and how it impacts your community?*

E15.	**How knowledgeable are community members about commercial sexual exploitation? Please explain.** *(Prompt: For example, dynamics, signs, symptoms, local statistics, effects on family and friends, etc.)*

E16. **What type of information is available in your community regarding commercial sexual exploitation?**

E17. **What local data are available on commercial sexual exploitation in your community?**

E18. **How do people obtain this information in your community?**

Section F. Resources Related to the Issue: *To what extent are local resources – people, time, money, space, etc. – available to support efforts?*

F19.	*To whom would an individual affected by commercial sexual exploitation turn to first for help in your community? Why?*
F20.	**What is the community's and/or local business' attitude about supporting efforts to address commercial sexual exploitation, with people volunteering time, making financial donations, and/or providing space?**

F21.	**Are you aware of any proposals or action plans that have been submitted for funding that address commercial sexual exploitation in your community?** ❑ **Yes** ❑ **No**
	If yes, **please explain.**
F22.	**Do you know if there is any evaluation of efforts that are in place to address commercial sexual exploitation?** ❑ **Yes** ❑ **No**

	If yes*, on a scale of 1 to 10, how sophisticated is the evaluation effort** *(with 1 being "not at all" and 10 being "very sophisticated?")?**	______________________ *(write in rank)*
F23.	**Are the evaluation results being used to make changes in programs, activities, or policies or to start new ones?**	

Section G. Additional Questions (not scored)

G24.	In the past year, how often have you had contact with a person who has lived, or is living, in the life of commercial sexual exploitation? Including direct communications by email, phone and in person, would you say you have had contact: ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Rarely (less than 4 times in the past year) ☐ No contact in the past year ☐ No contact in the past five years or more
G25.	If you've had contact with a person who has lived, or is living, in the life of commercial sexual exploitation in the past year, please describe your role. For example, were you in the role as a peer, doctor, caseworker or other professional liaison, neighbor, family member, friend, combination of roles etc.
G26.	Do you have any other thoughts or information that you would like to share with us?
G27.	Would you be interested in receiving training in commercial sexual exploitation? ☐ **Yes** ☐ **No**

THANK YOU!

For reprints and other information, email Heather Wightman, hwightman@riahouse.org.

APPENDIX B (privacy statement)

RIA House Community Readiness Assessment Description

RIA House aspires to be a home community in a quiet part of MetroWest/Central Massachusetts for adult women coming out of the life of *commercial sexual exploitation*.

For the purposes of this assessment, *commercial sexual exploitation* includes the following, but is not limited to…*stripping, pole dancing, lap dancing, massage parlors / saunas, brothels, escort agencies, prostitution, phone sex lines, internet sex chat rooms, pornography, trafficking, forced marriage, mail order brides, and sex tourism.*

The primary goal of this assessment is to evaluate the current environment and atmosphere in the MetroWest/Central Massachusetts areas for providing services and other supports to adults who have lived, are coming out of living, or are currently living in the life of commercial sexual exploitation. This assessment will also help RIA House, as a service organization, understand where and how, it will be situated within the current provider network of services.

RIA House Assessment Privacy Statement

RIA House is committed to respecting your privacy and recognizes the need to hold confidential any personally identifiable information that you share with us, such as your name, email address, or phone number.

If you choose to provide personal information while talking with one of the interviewers, it is our intent to let you know how we will use that information. If you tell us that you do not wish to have this information used as a basis for further contact with you, we will not do so.

Other information volunteered by you, such as your responses to surveys and/or comments and feedback, will be used to aggregate data and develop a detailed needs assessment for potential funders to use. At no time, will any personally identifiable information be disclosed. All interview sheets will be coded so that no personally identifiable information will be associated with your responses to questions. Only the researcher in charge of the study and the person conducting the interview will be able to link your information to your responses. At the conclusion of the study, all identifiable information will be destroyed.

Thank you for your participation in this assessment.

APPENDIX C (guidelines)

RIA House
Community Readiness Interviews

A Step-by-Step Process

Step 1 – setting up the interview

- Schedule a time/day, and place, if necessary, for the interview. Please borrow language from the document titled, *RIA House Privacy Statement* to describe why and how you will conduct the interview.
- Interviews can be conducted in-person or via telephone only. No mailed-in forms are allowable.
- Interviews will take between 60-90 minutes.

Step 2 – preparing for the interview

- In preparation for the interview, you should have with you two printed documents:
  1) *RIA House Privacy Statement*
  2) RIA House Interview Tool - document, *RIA House CRI Long Form*

Step 3 -- CODING THE INTERVIEW TOOL

- Before conducting the interview, write-in the name of the Sector that the person belongs to:
  1) Law Enforcement, including correctional facilities
  2) Court, Diversion Programs and Immigrant Law
  3) Health and Medical Community, including community-based and college/university health care centers
  4) Business, including hotels, nail salons, massage parlors and other
  5) Clergy and other religious/spiritual leaders
  6) Human Service Providers, such as rape crisis centers, dv shelters, behavioral health providers, drug treatment and recovery centers
  7) Education and Vocational Training
  8) Government, state and city
  9) Community, including the target population
- Then, in the *upper right hand corner of each page* of the interview tool, please write the initials of the person whom you are interviewing (first letter of the first and last name), AND your last name.
- **All interview forms will be destroyed (shredded) after the individual form is scored and all scores are aggregated.**

Step 4 – conducting the in-person interview

- Read to the person whom you are interviewing the Privacy Statement. Ask him/her if she understands it and agrees to what it says. Give the person a copy of the statement for her records. Assuming the person agrees to what the statement says, then begin the interview.

- Your job is to write down, to the best of your ability, exactly what the person says to you in answer to each of the interview questions. Please do not paraphrase or interpret answers. If you do not understand what the person has said, then ask clarifying questions, or repeat back to the person what you think s/he has said and have her explain further. If the person doesn't know what to say, then simply document that she did not know.
- The last page of additional questions (Section G) is very interesting for us moving forward, so although they are not scored, please do not skip them.
- Remember to enjoy yourself and the person whom you are interviewing.

Step 5 – conducting the telephone interview

- Read to the person whom you are interviewing the Privacy Statement. Ask him/her if she understands it and agrees to what it says. Offer to send via mail a copy of the statement to the person (ask for mailing address, if necessary). Assuming the person agrees to what the statement says, then begin the interview.
- Your job is to write down, to the best of your ability, exactly what the person says to you in answer to each of the interview questions. Please do not paraphrase or interpret answers. If you do not understand what the person has said, then ask clarifying questions, or repeat back to the person what you think s/he has said and have her explain further. If the person doesn't know what to say, then simply document that she did not know.
- The last page of additional questions (Section G) is very interesting for us moving forward, so although they are not scored, please do not skip them.
- Remember to enjoy yourself and the person whom you are interviewing.

Step 6 – completed interviews

- Please keep all completed interviews together in the same envelop/folder etc.
- Either mail or give envelop/folder to research manager who will keep all completed interviews together until we are ready to begin scoring them.

THANK YOU