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Stakeholder perspectives on the implementation of shared decision making to empower youth who have experienced commercial sexual exploitation

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Abstract

Objective: Shared decision making (SDM) has been proposed as a method to improve treatment adherence, placement stability, and other youth-centric outcomes for children who have been victims of commercial sexual exploitation (CSEC). This project seeks to characterize service providers' perspectives on the adoption and implementation of SDM into treatment and placement planning decisions.

Method: Sixteen key stakeholders who provide services for youth who have experienced CSEC in a Southern city, as well as adults who survived exploitation as children, were individually interviewed. These interviews focused on stakeholders' perspective on the appropriateness and contextual considerations regarding implementing this model to engage youth in decision-making conversations. Interview transcripts were qualitatively analyzed using group-based inductive content analysis.

Result: While all participants acknowledged the philosophical importance of including youth in decision-making, perspectives varied on how this philosophy could be operationalized. Trauma-bonds to offenders, distrust in service systems, and policy and time constraints were discussed as potential barriers to implementation. Perceived benefits to applying this model included encouraging youth empowerment, helping youth develop decision-making skills, and strengthening relationships between youth and providers. Implementation considerations mirrored those seen in other medical and behavioral health settings, including extensive training, fidelity

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monitoring, enforcement through policy and legislation, and ultimately resetting the culture of services to be maximally youth inclusive.

Conclusion: Participants supported the use of SDM to standardize the inclusion of youth in treatment and placement planning decisions. However, there exist challenges in defining exactly how to adopt this approach, and how to implement broad-scale cultural change within the service-providing community.

Keywords

Human trafficking; Trauma; Treatment adherence; Shared decision making; Patient education; Youth voice

1. Introduction & background

Commercial sexual exploitation of children (CSEC), or child sex trafficking, consists of the sexual abuse or exploitation of a child in which any sex act is performed by a minor for an adult in exchange for something of value (monetary or non-monetary) (Salisbury et al., 2015). This pervasive form of child abuse prevents the healthy development of youth by increasing a child's risk for numerous negative health and mental health outcomes, including self-harm, substance use, severe mental health issues (PTSD, depression, etc.), sexually transmitted infections (STIs), teenage pregnancy, and experiences of violence including sexual, physical, and psychological abuse (Felner & DuBois, 2016; Greenbaum, 2014). CSEC is often characterized by a relationship of power and control between an exploiter and a child. Traffickers, or exploiters, are skilled at identifying vulnerability and unmet needs in youth, and then meeting these needs through coercive control tactics that result in a survivor's perceived loss of autonomy and a trauma-bond to their offender (Doychak & Raghavan, 2018). This trauma-bond and need-fulfillment can keep children in a cycle of abuse and prevents them from disclosing about or recognizing their own exploitation, and from engaging in counseling or other services (Salisbury et al., 2015). Meanwhile, the service systems (child welfare and juvenile justice) that youth who have experienced CSEC interact with often act paternalistically and prescriptively towards youth, failing to give them a voice and thus keeping them in this vicious cycle of abuse (Rafferty, 2013). Self-determination and opportunities for participation are central components of trauma-informed systems of care that are often ignored in the face of more urgent-seeming safety and health related needs. This research seeks to examine stakeholder perspectives around implementing a model of participation that would restore a child's sense of autonomy and control while prioritizing both physical and psychological safety.

1.1. Trauma-informed systems of care: In theory

The importance of creating trauma-informed systems of care for survivors of CSEC is widely acknowledged. Anti-trafficking research and policy recommends a system-wide trauma-informed approach to care, focusing on supporting the rights of trauma survivors by utilizing a collaborative, relational approach to services in order to maximize an individual's agency and control (Sapiro et al., 2016). The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) outlines what it means to be trauma-informed, and

includes “Empowerment, Voice and Choice” as a key component. This principle recognizes the power differential that often exists between victim/survivors and the service systems and advocates they interact with, when shared decision-making, choice, and goalsetting are not prioritized to support healing.

Research conducted with child welfare (Damiani-Taraba et al., 2017; Damiani-Taraba et al., 2018; Leeson, 2007) and juvenile justice (Henning, 2010) involved youth, as well as more recent research interviewing 21 adolescent females with histories of CSEC (Barnert et al., 2020) confirms that youth themselves are eager for meaningful participation, and directly connect involvement in decision-making to treatment buy-in and engagement. Damiani-Taraba et al. (2018) interviewed child welfare-involved youth and found that participation in decision-making increases resiliency, self-esteem, and cognitive abilities, and is directly correlated with engagement and positive outcomes. In the juvenile justice context, Henning (2010) found that meaningful participation in decision-making increases the likelihood that a child will “buy into” the process of reform, helps the child improve their decision-making skills, and encourages positive self-determination.

Despite the literature to suggest positive outcomes derived from utilizing a trauma-informed approach that prioritizes empowerment and collaboration (Barnert et al., 2020; Damiani-Taraba et al., 2017; Damiani-Taraba et al., 2018; Henning, 2010; & Leeson, 2007), this same research suggests that in reality there is a lack of guidance, training, and resources around how these rights should be implemented (Damiani-Taraba et al., 2018; Leeson, 2007).

1.2. Trauma-informed systems of Care: In practice

Researchers in both the child welfare and juvenile justice systems found that conflicting viewpoints exist between recognizing the importance of youth voice and empowerment and the belief that children (especially those who have experienced trauma) are vulnerable and in need of adult protection (Damiani-Taraba et al., 2018, Henning, 2010; Leeson, 2007). Damiani-Taraba et al. (2018) found that while many child welfare agencies have policies that require youth participation, in practice, the involvement of children often amounts to tokenism due to a lack of training and tools to support effective youth engagement, as well as values and beliefs that conflict with these policies. The outcome, rather than youth being active participants in their own care planning, is often this phenomenon of “corporate parenting” – where several adults, some of whom have never met the child, are making decisions about the child’s care (Leeson, 2007). In the juvenile justice system, Henning (2010) found that juvenile attorneys often “intentionally ignore the child’s voice because they assume children categorically lack the capacity and good judgement to make important legal decisions in a delinquency case” (130). This research suggests that latent paternalism in youth-serving systems creates a disconnect between the acceptance of the need to be “trauma-informed” and the actualization of this concept.

Qualitative research by Sapiro et al. (2016) highlights this same disagreement between care providers working with victims and survivors of CSEC. Authors admit that there exists a complex balance of agency and vulnerability, with many youth-serving systems and individuals emphasizing protection of children, and thus, unintentionally minimizing their agency. As such, current multidisciplinary teams (MDT) and service systems (i.e. juvenile

justice and child welfare), which tend to the needs of youth who are identified as high-risk for CSEC or who are confirmed victims, often fail to adequately incorporate youth voice due to a paternalistic drive to protect youth who are viewed as vulnerable and incapable of making smart decisions (Komulainen, 2007). This paternalism, while well-intended, leaves youth feeling unheard and distrustful of service providers, keeping them in a cycle of abuse with an exploiter who often creates the illusion of autonomy and control (Sahl & Knoepke, 2018). When providers fail to adequately incorporate youth voice, they are unable to build trusting relationships with youth, and risk a loss of buy-in on the part of youth victims, leading to predictable treatment or placement challenges.

1.3. Shared decision making

Shared Decision Making (SDM) aims to address such challenges in the context of medical decisions, specifically by including the explicit value, goals, and preferences of those who will be affected by the decisions being made (patients) (Barry & Edgman-Levitan, 2012). SDM attempts to facilitate patient-centric decisions through a “meeting of experts” (Tuckett et al., 1985). In ideal SDM practice, clinicians and patients engage in a multilateral exchange of information inclusive of at least four distinct elements: (1) explicitly identifying that there is a choice to be made, ((2) outlining the options available, as well as the benefits and risks of each one, (3) discussing the patient’s goals and values which weigh on this decision, (4) discussing the decision to be made (including whether to defer the decision or, in some cases, whether to decide not to act) (Stiggelbout et al., 2015). The goal of this process is to decide on a course of action that is reflective of the preferences of an informed patient. A Cochrane Review of trials of SDM interventions concluded that this method consistently improves both patient knowledge about treatment options and their experience of being included in decision making, and reduces downstream regret about what was chosen (Stacey et al., 2017). SDM is traditionally used in medical practice to integrate patient voice into care and treatment processes, with known and emerging applications to treatment decisions in cancer (Charles et al., 2004), heart failure (Allen et al., 2012), obesity treatment (Osunlana et al., 2015), injury and suicide prevention (Betz et al., 2018), and medication selection (Nannenga et al., 2009) in chronic disease management, among a host of other areas (Elwyn et al., 2012; Barry & Edgman-Levitan, 2012). In fact, the Centers for Medicare and Medicaid Services now requires shared decision making (in the form of documented use of patient decision aids) for reimbursement for a growing list of medical tests and treatments (Spatz et al., 2017; Merchant et al., 2018; Matlock, Fukunaga et al., 2020). While current research identifies SDM as best practice in medical settings, and a recent proposal outlines the theoretic utility of applying SDM to treatment planning decisions involving youth who have been exploited through CSEC, (Sahl & Knoepke, 2018), less is known about the feasibility of applying SDM to reconcile the opposing viewpoints of protection versus participation.

The purpose of this qualitative study is to explore key stakeholder perspectives on implementing SDM in the traditional MDT and service system models of intervention with youth who have been sex trafficked or those youth who have been identified as being high-risk for being sex trafficked, with particular attention to (1) general perspectives on

including youth in treatment or other planning decisions, and (2) perceived barriers to including SDM tools in common service models used with youth.

2. Methods

2.1. Research team

The research team consisted of a core data gathering and analytic team (SS, MP, CH), with external methodologic advisement from the senior author (CK). Members of the team included those with master's and doctoral-level training in social work and public health, with additional expertise in qualitative research methods, services for youth who have experienced CSEC, health services research, and SDM. The project was approved by the University of Southern California Institutional Review Board.

2.2. Stakeholder interviews

A convenience sample of stakeholders that either influence decision-making processes for youth who have experienced CSEC or work directly with youth were recruited. Individuals were identified through their involvement with a multidisciplinary team (MDT) that coordinates service plans for youth who have experienced CSEC in a Southern city. Snowball sampling was used to identify additional stakeholders who were not active on the local MDT, but who are involved in making decisions with and for youth who have experienced CSEC. In total, 16 stakeholders were interviewed representing diverse backgrounds and roles including: legal services ($n = 3$), social workers/case managers/counselors ($n = 8$), medical personnel ($n = 2$), survivor advocates ($n = 2$), and other ($n = 1$). A breakdown of demographics can be found in Table 1. Additionally, two adult survivors who were trafficked as children were interviewed as part of this study. These survivors were approached due to their involvement as advocates and survivor-leaders in the local anti-trafficking community. Those interviews were conducted by the first author, (SS) a licensed social worker with extensive experience providing services to youth with histories of victimization, who was available to respond to, and reduce the risk of re-traumatization and provide immediate support in the event that a respondent be triggered by the line of questioning. Youth were not included in this study sample as the primary goal was to investigate contextual needs and beliefs of providers regarding the implementation of SDM, and thereby focused on the attitudes and opinions of professionals who would be charged with implementing these tools and processes. Future research should focus on how best to operationalize the inclusion of youth voice in these decisions and should include youth themselves as participants and research collaborators.

Researchers utilized a semi-structured interview guide to conduct interviews that lasted approximately one hour. The interview was broken up into two sections: (1) perspectives on the inclusion of youth voice in the current system that serves youth who have experienced CSEC; and (2) perspectives on the implementation of SDM to engage these youth. In the second section, participants were asked to review an informational SDM didactic handout with possible application to CSEC service provision. The top half of the handout described SDM (what it is, how it works, etc.) and the second half offered a step-by-step application to determining a safe placement with a youth who has been exploited through CSEC

(Sahl, 2019). A modified "Think Aloud" (Fonteyn et al., 1993) procedure was utilized in the discussion around the didactic handout to assess for stakeholder perspectives on implementation. Interviews were transcribed to facilitate qualitative analysis. Transcribed interviews were de-identified to ensure stakeholder confidentiality, allowing for more open and honest conversation around stakeholder values and beliefs.

2.3. Data analysis

Analysis was conducted using a multistage, iterative process of axial coding and team-based thematic adjudication to ensure credibility and trustworthiness (Creswell & Creswell, 2018). After each interview was transcribed, it was analyzed using an inductive open-coding process (Saldaña, 2015) conducted sequentially by a primary and secondary coder, both of whom were members of the analytic team to ensure definitional agreement. At regular intervals, the entire analytic team would meet to discuss themes and analytic memos, resulting in iterative refinement of the codebook. "Member checking" (Creswell & Creswell, 2018), whereby previous participants were asked to review and respond to themes and analytic memos resulting from these discussions, was additionally used to ensure credibility and trustworthiness of identified themes and interpretation. In every possible instance, the authors have followed COREQ reporting guidelines (Tong et al., 2007) in the organization of this manuscript.

3. Results

The interviews revealed several themes critical to the feasibility, design and implementation of SDM interventions with youth who are high-risk or have experienced CSEC. Responses were grouped into five thematic constructs including: 3.1. Perspectives on the Inclusion of Youth Voice in the Current System, 3.2. Importance of Youth Voice Inclusion, 3.3. Barriers to the Inclusion of Youth Voice, 3.4. Perspectives on Applying the SDM Model to Youth who have Experienced CSEC, and 3.5 Perceived Barriers to Applying the SDM Model.

3.1. Perspectives on the inclusion of youth voice in the current system

When discussing their perspectives on the inclusion of youth voice in the current youth serving systems, several participants discussed inclusion in the context of the MDT that meets to discuss service plans for youth who have been victimized through CSEC, while others discussed inclusion within service systems such as child welfare and juvenile justice that youth may interact with. Perspectives on the inclusion of youth voice in the current youth serving systems were coded into three categories, with quotes displayed in Table 2:

1. **Benefits of Interdisciplinary Collaboration.** Many participants felt that the MDT model was effective in increasing interdisciplinary collaboration and coordination of care for youth who have experienced CSEC, specifically by providing a venue in which diverse fields worked together to design plans for individual youth in care.
2. **Absence of Youth Voice in the Current MDT Model.** While participants identified the MDT process as enhancing interagency collaboration, many acknowledged that the perspective of the youth themselves is largely left out

of the process. When asked if youth voice was included in the MDT process, one participant noted that while it wasn't currently, it should be.

3. **Absence of Youth Voice outside the Current MDT Model.** When asked if youth currently participate in service planning and decision-making outside of the MDT context, participants expressed demonstrable ambivalence. Individuals who worked in the child welfare and juvenile justice systems recounted situations in which they personally made an effort to include youth voice, such as treatment planning in a diversion program, advocating for the expressed interests of youth in court, or goal setting in foster care, but often simultaneously second-guessed the wisdom of doing so. Several participants also felt that while inclusion may occur, youth voice is not included as frequently as it could be and inclusion may depend on the individual provider, owing to the lack of a systematic process for consistently and effectively including youth voice.

3.2. Importance of youth voice inclusion

While opinions differed on the extent to which the voices and choices of youth are currently included in service planning, all 16 participants saw the value and importance of doing so. Youth voice was discussed as an essential component to relationship and trust building, a way to give youth control back that has been taken by traffickers, and a way to help youth develop critical skills needed to become self-sufficient adults. Participants' perspectives on the Importance of Youth Voice Inclusion and the perceived Barriers to Youth Voice Inclusion are summarized in Table 2 with supporting quotations. Perspectives on the Importance of Youth Voice Inclusion were coded into four major subthemes including:

1. **Improve rapport building with youth.** Participants found that including youth in decision-making conversations improved their rapport and relationship with the youth.
2. **Helping youth regain autonomy/control over their lives.** Participants recognized that loss of control is central to the trauma of CSEC, and youth must be given some voice and control over their own outcomes in order to heal from that trauma.
3. **Essential to youth empowerment and growth.** Participants described youth voice and inclusion as essential components of youth empowerment and growth.
4. **Risk Re-traumatization.** Multiple participants discussed the failure to include youth voice as retraumatizing for youth and a barrier to engagement, relationship-building, and healing.

3.3. Barriers to the inclusion of youth voice

When asked if youth were currently included in decision-making conversations and service planning, participants described what they saw as potential barriers or challenges to including youth voice. Perceived Barriers to the Inclusion of Youth Voice were coded into the following four categories, summarized in Table 2:

1. **Trauma-bonds to their victimizers.** Trauma-bonds, or a desire to protect the trafficker was noted as a factor that could prevent effective or safe decision-making.
2. **Distrust of service providers.** Participants noted that youth may not trust service providers enough to actively engage in decision-making conversations.
3. **A Lack of a Standard Process for Including Youth**. Without a standardized process for including youth in decision-making, participants found that inclusion (and meaningfulness of inclusion) was dependent on the individual interacting with the youth having an intuitive ability and desire to ensure meaningful engagement.
4. **Well-meaning Paternalism.** Multiple participants described a paternalistic assumption held by service providers that youth are vulnerable and incapable of making smart decisions for themselves, so adults must make decisions for youth in order to keep them safe. Participants found that this well-meaning paternalism often meant that youth were left out of decision-making conversations entirely.

3.4. Perspectives on applying the SDM model to youth who have experienced CSEC

All sixteen participants reacted positively to the informational SDM handout, with eight participants stating their full support for use of the model, and eight stating their support with caveats. Speaking about the use of SDM more generally, two respondents felt SDM would be incredibly beneficial to giving autonomy to exploited youth, but feared the model would not be followed to fidelity. Interestingly, one medical provider felt SDM was already being implemented to the fullest extent in her workplace, while the other medical professional felt there were very few decisions youth could make given the medical guidelines she had to follow:

> "I think as medical providers, we worry that if things that are generally recommended are viewed as options, then youth might not want to take those options, and put themselves at further risk"
>
> (Participant 15, Medical).

Three participants were in support of the model in general, but feared that trauma experienced by the child, trauma-bonds to offenders, mental health diagnosis, substance use/abuse, and developmentally limited communication abilities could make effective SDM challenging. Finally, one participant could readily see the model fitting in to the dependency system in the juvenile court but was not sure if it could be applied to delinquency proceedings.

Perceived risks and benefits of applying the presented model are summarized in Table 3 with supporting quotations. Perceived benefits to utilizing SDM to develop service plans were coded into four major categories including:

1. **Empowerment & Self-worth.** Several participants felt that applying the model would help build self-esteem in youth, which would in-turn lead to better

outcomes. Participants felt that meaningful inclusion would make youth feel like their voices mattered, and like they mattered.

2. **Learn Decision-Making Skills.** Several participants noted that utilizing SDM would help youth learn how to make smart decisions and develop confidence in their decision-making ability.

3. **Rapport & Relationship Building.** Multiple participants felt that utilizing SDM would help build trust and rapport between youth and service providers.

4. **Restoring Power & Control.** A commonly cited benefit to applying the model was that it would give youth a feeling of control over their lives, which was thought to be an essential component of healing and growth. Restoration of control was described by participants in two ways:

    a. **Restoring control taken by the trafficker:** Loss of control was described as an aspect of trauma and CSEC, and SDM was viewed as a method for restoring this control.

    b. **Restoring control taken by service systems:** Loss of control was described as a factor that contributed to vulnerability to CSEC when caregivers and/or systems were the ones failing to provide choices. SDM was viewed as a method for preventing intentional or unintentional coercive control tactics on the part of service providers.

3.5. Perceived barriers to applying the SDM model

Perceived barriers or challenges to implementing SDM were coded into the following four categories (Table 3):

1. **Trauma-bonds to Exploiters (The influence of the relationship between victims and their perpetrators).** Multiple participants identified feelings of love and loyalty towards the trafficker as a potential barrier to effectively (or safely) engaging youth in decision-making. Participants expressed a tension between feeling like there is a need to give youth back a sense of control over their lives, but a concern that youth may not be capable of managing that control when they have positive feelings toward those who victimized them.

2. **Time & Policy Constraints.** The issue of time and policy constraints in the child welfare and juvenile justice system were also discussed as potential barriers to implementing SDM. Participants were concerned that the model would increase time spent with a child when case workers were already struggling to complete the necessary paperwork and steps.

3. **Lack of Available Options.** In addition to time constraints, some participants described a shortage of options for youth to choose from. These participants were concerned that inclusion would not be as meaningful if youth were not actually able to make a choice, or given options to choose from. After reviewing the proposed model, one medical provider discussed feeling like there may not be substantive decisions youth could make, but did see how youth could be

presented with smaller choices, such as choosing between different color hospital gowns.

4. **Buy-in & Fidelity Monitoring.** Some participants felt that the model was great in theory, but feared it would not be implemented to fidelity. Participants feared the ability to secure buy-in from service providers due to underlying paternalistic values.

4. Discussion

Overall, study participants saw the value and importance of incorporating youth voice into decision-making conversations and recognized that this currently is not being done sufficiently or consistently with youth who have experienced CSEC. Participants welcomed an evidence-based model for youth engagement, but expressed concerns about the ability to effectively implement SDM in various youth-serving contexts including the need to change social norms around how youth are viewed and interacted with, and the complex nature of trafficker-victim trauma bonds that could prevent safe decision-making.

In many ways, the conversation around implementing SDM in decision-making with youth who have experienced CSEC mirrors conversations and considerations surrounding SDM implementation in medical settings (Ĺegaŕe & Witteman, 2013). While medical providers generally agreed with the premise of including youth/patient voice in care discussions, many conversely believed that they already do so and that any instances in which they do not are actually well-intended paternalism (Knoepke & Mandrola, 2019; Sullivan, 2016) – the goal of which is to protect clients from making decisions contrary to the goals that the clinician believes they *should* have (Matlock et al., 2011). In the medical setting as well as CSEC serving juvenile justice and child welfare settings, provider behavior is guided by normative beliefs about the roles and abilities of providers and patients/youth. In the medical world, SDM implementation is often thwarted by normative beliefs that patients are passive recipients of provider decisions and treatment, or that the practice of SDM is tantamount to simply “being a good doctor” - no different from the norms and opinions alluded to by study participants (Joseph-Williams et al., 2014). Ultimately, research on SDM implementation in the medical field examines how to make SDM the “norm” in healthcare by addressing patient and provider-perceived barriers, as well as facilitators and/or incentives to increase and standardize the use of effective practices (Ĺegaŕe et al., 2008; Joseph-Williams et al., 2017; Knoepke et al., 2019). These contextual understandings can be applied to SDM implementation among professionals working with youth who have experienced CSEC, especially with respect to how SDM tools could support professionals needs (e.g. as educational materials, by allowing youth to provide information outside of meetings in addition to in-person conversations), how they could minimize burdens for these professionals (e.g. by not adding time to already-busy meetings, streamlining other administrate documentation), and what qualities would make them acceptable to youth themselves (including how they are delivered, question format, the types of decisions addressed, and others) (Matlock, Fukunaga et al., 2020).

4.1. Practice & policy implications

Beyond the philosophical nuances of agreeing with the notion that it is important to structurally include youth voices in decisions, there was the related matter of pragmatic issues around disseminating and implementing SDM tools to support these conversations into broad practice. While asking participants about their perspectives around the challenges and benefits to applying shared decision-making, the conversation in many interviews naturally moved towards implementation considerations. These considerations also mirrored those seen in other medical and behavioral health settings, including the need for extensive and ongoing training of providers, documentation of use, fidelity monitoring, and – as noted above – resetting the culture of services to be maximally youth inclusive (Brownson et al., 2013; Powell et al., 2015). To further ensure consistent use, multiple participants suggested SDM be mandated beyond local agency policies and incorporated into local, state, and federal legislation.

> "Ideally it would be great to somehow incorporate this in a legislative way to say this is a process that can be used in all juvenile settings to inform decision-making. I don't know how we would do that - it's a long long-term goal."
>
> (Participant 2, Legal)

Participants noted that documentation and ability to "benchmark" SDM conversations would be critical to supporting uptake and continued support among judges and other decision-making stake-holders. Such an ability would allow these leaders to concurrently audit whether and how conversations are occurring and follow up with youth, support professionals, and others to ensure that decisions made are informed by youth preferences to the greatest extent possible. Fidelity monitoring was discussed as an attempt to ensure that youth are actually involved in decisions, rather than simply "checking the box" that a tool had been used. These considerations also mirror efforts in other medical and behavioral health settings to not just ensure that the steps of SDM are followed, but that providers are meeting the true "spirit" of the model (Powell et al., 2015). This distinction could differentiate between the provider overestimating their success in including the youth in decision-making versus the youth actually feeling included. One participant suggested ongoing consultation and supervision to ensure fidelity:

> "I think that some people might buy in but then in practice default to what they're used to doing. So, you know, it's hard to change people's habits. I mean, a lot of times when we learn a new therapy model, part of getting certified is having long-term supervision and consultation and follow-up on it, so it's not like you just go to the workshop and then do the thing. I think that's what would make it more effective is working with somebody who's an expert, like as you're applying it… It would be constant check-in and supervision of how it's being applied."
>
> (Participant 8, Social Services)

4.2. Future research

While this study touched upon the perspectives of a broad array of service providers who work with youth who have experienced CSEC, future research should assess for values, attitudes, and perspectives of providers in targeted sectors: i.e. juvenile justice and child

welfare. Such targeted research would allow for SDM tools and practices to be developed to fit the unique needs and existing processes of these systems. The same is certainly true of youth being served by these systems, as their input would be critical to the design and use of SDM-supportive tools, training, and other methods. As such, future efforts should specifically define the decision support needs of youth.

Additional research is needed to clinically test the application of SDM along with specialized decision aids (Stacey et al., 2017) with youth who have experienced CSEC in juvenile justice and child welfare settings. As is typical in evaluation of decision aids meant to be used in other areas of healthcare, data should be collected on provider training on SDM, including changes in attitudes, knowledge, and behaviors pre- and post-training, implementation of the decision aid (including any adaptations made following use with youth in varied settings), and continued use of the tools and associated processes for an extended period following rollout (McCreight et al., 2019; Chambers & Norton, 2016). Research is also recommended to assess for effectiveness of SDM in improving process-level outcomes when working with youth who have experienced CSEC (perceived level of involvement in treatment planning among clients, satisfaction among clients and professionals, etc.). Existing measures can be utilized to assess for youth feelings of self-efficacy, satisfaction with decisions that are made, and relationship building with providers. Data should also be collected on downstream outcomes, including youth follow-through with co-determined decisions, placement stability, adherence to medical/psychosocial treatment, and others.

5. Limitations

Our findings should be understood within the context of several limitations. First, all themes and representations are reflective of our sample of youth service professionals in a Southern city and may not reflect the values and beliefs of professionals in other settings. Other groups of professionals might feel differently, based on demographics, professional background/training, geography, local political structures, etc. and future implementation efforts and research should be conducted with that in mind. Methodologically, and in keeping with the interpretive nature of our analysis, we were also potentially limited by our own preconceptions, both which we may be aware of and which we are not. With the knowledge that pure objectivity may not be possible (or preferable, as it risks undermining researchers' contextual grounding (Ahern, 1999)), our analytic process was designed to undermine the potential effects of interpretive bias, including double coding, the use of analytic memos, and bracketing discussions occurring at team meetings. Next, while our findings related to philosophical support for SDM, professional norms which inhibit uptake of SDM-facilitating tools, and reticence to implement in specific settings echo those observed in medical settings (Bhavnani & Fisher, 2010; Knoepke et al., 2019; Matlock, Mcilvennan et al., 2020; Wu et al., 2014), they may differ among other groups of youth service professionals.

Further, given the generally positive sentiment toward youth inclusion, participants responses to questions about their views on the topic may be subject to social acceptability bias, thereby overestimating the actual support for limiting paternalistic practices with youth

being served. Future research into the development of SDM-supportive strategies to use with youth or into beliefs and attitudes of youth-serving professionals may attempt to undermine the possibility of social acquiescence by either conducting anonymous surveys of participants, asking questions addressing agency in a list with other unrelated items (so as to mask the intent of the question), or to ask specifically if youth agency presents a trade-off with other professional or personal values. It may be possible that a subset of professionals would endorse paternalistic perspectives if they were able to articulate those views as being concordant with other socially acceptable beliefs or attitudes (such as promoting safety).

Finally, while the voices of survivors of CSEC should be central to any discussion regarding program or policy development, only two adults who had been trafficked as children were available to be interviewed as part of this study. Furthermore, researchers recognize that the views of these two survivor advocates are not necessarily representative of youth currently being served. Future research should focus on the needs of youth at the time decisions are being made and should include safety and transparency protocols to support their continued healing while contributing to the design and implementation of improved treatment methods.

6. Conclusion

Existing research demonstrates the importance and efficacy of utilizing Shared Decision Making in medical settings in increasing patient buy-in and participation in treatment planning, as well as patient adherence to treatment plans. The purpose of this study was to evaluate stakeholder perspective on the necessity and contextual considerations regarding implementing this model to engage youth who have experienced CSEC in decision-making conversations. Overall, study participants acknowledged the importance and value of including youth voice in decision-making in order to empower youth and build relationships with service providers. However, stakeholders reported that they currently lack the training, tools, and a standardized process for ensuring that youth participation is consistent and effective. When presented with the SDM model, participants discussed perceived benefits and potential challenges to applying the model and considerations for implementation. While additional research is needed to test the application of SDM along with specialized decision aids, this study provides support for the premise of such work, highlighting that providers believe that the potential exists for SDM to become a best-practice model for engaging youth who have experienced CSEC in decision-making conversations and restoring the human dignity of voice and choice.

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Table 1

Participant demographics.

Participant Demographics N = 16	
Male	1
Female	15
Participant Race	
Black/African American	4
White/Caucasian	11
Asian-American	1
Background	
Legal (individuals with law degrees and working in some legal capacity with youth who have experienced CSEC)	3
Social Services (social workers, case managers, counselors/therapists, etc.)	8
Survivor of CSEC	2
Medical (doctors, nurses, program directors, etc.)	2
Other	1
Years in their current role that interacts with trafficked or high-risk youth	
1–2 years	5
3–5 years	5
6–9 years	3
10–15 years	1
16–20 years	2

Table 2

The current MDT model & perceived importance & barriers to youth voice.

Perspectives on the Inclusion of Youth Voice in the Current MDT Model
Benefits of Interdisciplinary Collaboration
"…I like that MDT creates a more collaborative case management approach, so we can do wraparound services for a client and fill gaps as a team instead of as an organization…. I really like that resource-sharing, collaborative process as well." (Participant 16, Other)
"But what the MDT process has done is brought diverse groups together and is at least focusing on the problems and the needs and the possible solutions. So it may not solve any problems yet, but it's at least focusing on them, identifying them, and bringing people together to at least talk about them in order to get the solutions." (Participant 1, Legal)
Absence of Youth Voice in the Current MDT Model
"Well, I think it's important, because all of us are sitting around talking [at the MDT meeting] *and we don't really know. It's hard to get youth to open up about this topic. Like I said, most of the ones I talk to are not even identifying that there's a problem, so they just kind of want to be left alone. They don't really want to give their voice on it, or they'll give voice… but never really talk about themselves… So I think it is important and necessary and great. I think it's talked about a lot more than it's done." (Participant 6, Social Services)*
Absence of Youth Voice outside the Current MDT Model
"As a whole, I don't see a lot of children really being the center of what they want at all. It seems like it would be up to the social worker or the case worker… to make decisions for them, so the child at the mercy of someone else's control. And that could be a really great social worker, but they're not involving them in the process - they're just being handled." (Participants, Social Services)
"So, ideally… you're supposed to get the children's voice and the children's input. I don't think it really happens as much as people would like for it to happen or think that it happens. I think that most of the time treatment plans are being made by the provider without a lot of input from the clients themselves, which is good and bad." (Participant 6, Social Services)
Perspectives on the Importance of Youth Voice Inclusion
Improve Rapport Building with Youth
"I think it's important because it helps build rapport, if they think you're listening. Most teenagers don't like people to make decisions for them." (Participant 7, Social Services)
"I think it is very important to have the youth's input because we have no idea what that person has gone through. And to understand where they are and where they've been is a very big part of the healing process… So I think we have to establish the rapport and we first have to identify and recognize that they are victims." (Participant 10, Social Services)
Helping Youth Regain Autonomy & Control over their Lives
"It's important because they're used to being under control - so now let them have their control back - and let them lead their own lives. I don't want anybody to tell me how to live mine, so." (Participant 13, Survivor)
"I think it's something that we're going to need to do because right now, what we have is children who are put into placements that they don't agree with, and therefore, they run away from those placements. Then it puts them at further risk. We have children who are bonded to their traffickers and feel that that's where they get their autonomy - that they don't have autonomy outside of that. So anything we can do to get their buy-in would be helpful for them to start making decisions that we view as safer and healthier decisions for them to make." (Participant 15, Medical)
Essential to Youth Empowerment & Growth
"I think the more we can help them have their own voice heard, the better. And that will empower them moving into adulthood because if they're not feeling it now, it's going to be really hard when they're out on their own as an adult in society that expects to be able to have a voice - they're not going to feel empowered to have that voice as an adult. It's important to build it now." (Participant 2, Legal)
"So giving children choices really does make them feel heard - they have a voice - and they end up making decisions for themselves…it helps them grow and develop. It's an opportunity to build life skills that they're probably not getting at home…" (Participant 5, Social Services)
Risking Re-traumatization
"I think that we should incorporate their voice more. We should recognize the trauma that they're going through. Sure, they have gone through a trauma, but is the trafficking - that's the one that they're not going to identify as the trauma. The trauma they're going to identify is their time in jail or their time being forced to go to some group home, or a hospital - even when they don't think they need

to be hospitalized - or, you know, being arrested or having to tell their story and not doing that over and over again. So I think the biggest thing is recognizing the harm that we can do unintentionally." (Participant 3, Legal)

Perceived Barriers to the Inclusion of Youth Voice

Trauma-bonds

"We ask for their input, but sometimes you can tell they're guarded… so sometimes we don't get full participation because they realize "I don't want to get that perpetrator in trouble" - who they may be running back to." (Participant 10, Social Services)

Distrust in Service Providers

"You know, they don't trust the adults. Because they've never really had someone care about them. So I know that the adults are trying their best to include the children's voices… but it's a traumatic experience, and you know… they don't want to trust anyone at this point." (Participant 12, Survivor Advocate)

Lack of a Standard Process for Engaging Youth

"I think we all intend for youth to be engaged, but either (1) they're currently missing so there's no way to engage them in the process, or (2) we don't have the right structure to bring them in and ask them as a group. So, whoever is their case manager really guides that or whether or not they're engaged." (Participant 16, Other)

"It depends on the case manager, and it depends on the day and generally, no". (Participant 16, Other)

Well-meaning Paternalism

"I think that's one of the difficult things is that most people in the caring professions do have a little bit of a tendency to feel like we know what's best and to want to sort of say, 'well, what's best for you is to stay in a safe environment where there's no cell phones, and no traffickers, and no contact' and that everything else is a compromise that we'd probably need to start learning how to do. But then we worry that it'll be a foster home that the child continues to run away from." (Participant 15, Medical)

"Don't just sit in a room with a bunch of professionals and speculate why this kid is running away. I feel like they really need to listen to these children, who are victims. And I don't feel they listen to them enough. I feel like they feel they're children, they don't know what's best for themselves, and we make all these decisions." (Participant 7, Social Services)

Table 3

Perceived benefits and challenges to SDM implementation.

Perceived Benefits to Applying the SDM Model to Youth who have experienced CSEC
Encourage Empowerment & Self-worth
Well I like this because you're giving that client, that youth, a choice. And you're letting them have a voice. And maybe they don't make the final decision, because sometimes we don't make always great decisions when we're young but at least they feel like they participated in their own life. I think that's important for self-esteem and learning value for themselves. (Participant 16, Survivor of CSEC)*
I think helping give them self-esteem. I think that trafficked youth have often lost their own personal sense of identity and to do anything that helps them regain that, decreases their risk for future trafficking. You're giving them autonomy, which is what, again, most youth are looking for. (Participant 15, Medical Provider)
Develop Youth Decision-Making Skills
Well, I think it's ideal that the kids are making their own decisions or having input on their decisions. I mean, a lot of times they're making decisions that are self-destructive. So, if we help them make some decisions that are constructive and those pan out, like I said those small victories, then we can work up to bigger things…(Participant 6, Social Services Provider)
When we make decisions for them, it takes that power or control away. Empowering them to be human, to make good decisions. If you're always making a choice for someone, they don't know if they can make good choices…that skill set never develops. (Participant 5, Social Services Provider)
Rapport & Relationship Building
Regardless of what type of trauma a child has been through, what they want to feel is inclusion… And it also gives them a sense of trusting, being able to trust someone, because they feel as though, oh hey, this person cares about my opinion… which allows them to feel as though they matter. (Participant 12, Survivor of CSEC)
Restore Power & Control Taken by the Trafficker
I think the biggest thing about being trauma-informed is not pushing something that somebody's not ready for and trusting that they know themselves and giving them that agency. Because, I mean, trauma happens when people lose control–that's a big part of it–and giving them that control and agency back is really important. (Participant 8, Social Services)
Then, of course, giving youth power in their lives, because traffickers take away power. So the more that we can give them power, it just means that they're more likely to have a sustainable outcome or a longer-term positive outcome than if we force them to do an option that may not be the best option for them. (Participant 16, Other)
Restore Power & Control Taken by Service Systems
That lack of control is how they're driven into their trafficker. It gives them skin in the game. If somebody is always telling me what to do, it's not on me if it doesn't work out. This seems to be a little more collaborative, so decisions are only being made for the child if it's like a safety issue. (Participant 5, Social Services)
I really like that this is giving them all the choices. It's giving them all the positives and the negatives. And essentially it hopefully makes it so that a case manager or person in a position of power couldn't make them or unintentionally or intentionally kind of coerce them into a specific choice. (Participant 16, Other)
Perceived Challenges to Applying the SDM Model to Youth who have experienced CSEC
Trauma-bonds
The problem being, if we are still in that stage that I talked about of "I'm attached and in love with their trafficker," they're going to choose that option that takes them back to that trafficker…. And you got to remember that initially, their decisions aren't their decisions. They're still their trafficker's decisions, whether they are there or not. They're inside their head, making decisions for them. So, there's a period of time that I think we need to be really cautious about, and then I think we can really work on empowering them by allowing them to be a bigger part of process. (Participant 4, Social Services)
They're still either in love with the person who trafficked them or believe that they're in love with the person who trafficked them. Or think that this is all stupid, and we're just a bunch of squares getting in the way of what they want to do. (Participant 11, Social Services)
Distrust in the System

Kids who have been in that life for a while, they are really very savvy and manipulative sometimes. I think they sometimes just tell you what you want to know. I don't know. It's hard, because they're so used to just trying to survive. It requires their buy-in on this, because we want your input on what's going to happen with you, but they really have to be bought into their recovery or their treatment for them to really make real input. (Participant 6, Social Services)

Time & Policy Constraints

"It may affect DCFS and the child welfare agencies in that when they're rushing to prepare a case, they're just trying to comply with the law - "I must find a placement for this child within so much time that meets these legal criteria and I really don't care what you want and what you think." I just need to get it done, so their caseloads and their work burdens really don't provide them the opportunity to discuss with the youth what their wants and needs are. (Participant 1, Legal)

I think the barrier to this process is the time aspect. The time for professionals to engage with the youth in this way and then it's a question of who is the appropriate professional to engage in this way and when is it appropriate to engage this way? For example, in the middle of a court hearing, this maybe really inappropriate because this could take forever - not forever - but it could take a really long time to sit down and say "these are your options. Let's talk about pros and cons, let's write down a little decision tree" or something. That would take a really long time and I think judges would get really impatient. I think District Attorneys and attorneys would get impatient. (Participant 2, Legal)

Lack of Available Options to Choose from

I think if it's done properly, and kids are actually able to participate in the decision making because there's enough resources for them to choose, honestly… I mean, if there isn't more than one option, what kind of decisions can they make? It's either yes or no, but it would be better if they had more options. That would be great, but how often is that really the case? I mean, in a perfect world this is how it should be, but in everyday life it's not always possible. (Participant 6, Social Services)

It's time-consuming. We don't currently have a lot of options, so it's difficult to conceive of "here are three placement options for you," when we're scrambling to find one placement option. There's a tendency to, when you've got the trafficked youth, to try to do everything you can right there and then because you fear you won't see them again. (Participant 15, Medical)

Buy-in & Fidelity Monitoring

So saying they implement it, and not actually doing it. I see that being a huge barrier. Buy-in and actually whether a service provider would follow it. (Participant 5, Social Services)

I think it's possible. I think it would be hard. I mean, there's a lot of people who their role is to be like an authority, and so I think it will be really hard to make the child equal players… you know, like there are a lot of people who are used to their role being to decide what's best. So it's not that they don't listen to children, but it could be challenging to give some of the reigns over. (Participant 8, Social Services)