

# National Colloquium

## 2012 FINAL REPORT

**An Inventory and Evaluation of the Current Shelter and  
Services Response to Domestic Minor Sex Trafficking**

MAY 2013



# National Colloquium 2012 Final Report

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Services Response to Domestic Minor Sex Trafficking



*Although the term  
“victim” is used  
throughout this  
report, we recognize  
that persons who  
have experienced  
trafficking are  
survivors at all  
stages of their abuse  
and recovery.*

## > Letter from Partners

The desperate shortage of shelter and specialized services for victims of sex trafficking, particularly minors, is well known to those of us involved with rescue and restoration. This long-standing problem has recently become more broadly recognized as a result of increased awareness among law enforcement, legislators, child welfare, and the public in general.

In the belief that the timing was right for a national dialogue among those involved with pioneering efforts to minister to this population, and in the hope that documenting such efforts would provide insight for others we held the National Colloquium: Shelter and Services Evaluation for Action in November 2012.

Experts from policy, philanthropy, child welfare, non-governmental organizations and survivor leadership linked their own perspectives to emerging trends and barriers encountered in attempting to assist this victim/survivor population. Topics addressed included placement for identified youth, licensing and maintaining residential facilities and programmatic/therapeutic responses. In addition, a briefing held in coordination with the Congressional Caucus for Victims' Rights and the Congressional Caucus for Women's Issues dealt with the issue of funding and sustaining services and shelters.

The outline for the event took shape at a preparatory meeting of an Advisory Group and a Practitioner Working Group in July 2012. Then, in the months leading up to the National Colloquium, we surveyed as many provider organizations as could be identified in order to gather information about the current state of shelter and services provision and to determine the most compelling topics for discussion. Forty-one organizations responded to the survey. In addition, 33 survivors of sex trafficking replied to a survivor-developed survey that captured their unique experiences and recommendations.

Clearly there is room for multiple models of shelters, programs and therapeutic approaches, and successful outcomes cannot be measured by a single set of standards. This report endeavors to capture the voices of those that are on the ground today, delivering care despite the many obstacles. We hope their experiences, recommendations and cautions will provide a course, or course correction, to others who would venture into this most difficult of endeavors.



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# ➤ Executive Summary

Shelter and services for identified victims and survivors of domestic minor sex trafficking (DMST) are critical for their recovery and success. What has not been immediately available is insight into the actual experience of the individuals and organizations that are attempting to respond to the need, and their insight about possible ways to navigate the obstacles. While a few excellent scholarly articles and manuals on how to implement service provision have recently been published, the noticeable missing ingredient is documentation of lessons learned, success factors and gaps by those on the ground doing the work. To that end, the National Colloquium: Shelter and Services Evaluation for Action was conceived and executed by Shared Hope International, ECPAT-USA and The Protection Project at Johns Hopkins University School of Advanced International Studies, a triumvirate that has in the past cooperated on related research, notably the 2006 Mid-Term Review on the Commercial Sexual Exploitation of Children (CSEC) in America in preparation for the World Congress Against CSEC. Three surveys were designed to capture information that will serve as the foundation for the continuing research, site assessments, and discussions among stakeholders to develop and formalize the shelter and services response for DMST victims. Through these surveys and the subsequent colloquium, knowledge from a growing body of experts with first-hand experience was gathered and shared about the actual provision of restorative services to domestic trafficking victims, with all of its successes and setbacks.

In July 2012 an Advisory Board and a Practitioners Working Group were convened to review project goals for the National Colloquium and vet the survey that would solicit a response from providers across the nation during the upcoming three months. At the same time, survivor leaders developed and administered their own survey instrument to capture the unique experiences and perspectives of individuals who have survived sex trafficking. On November 30, 2012, the National Colloquium: Shelter and Services Evaluation for Action was held, representing a first-ever opportunity for service providers and survivors to hold a structured conversation about the extraordinarily complex and challenging work of DMST victim and survivor care. Acting Assistant Secretary George Sheldon of the Administration for Children and Families, U.S. Department of Health and Human Services, delivered the keynote address that framed the panel discussions that took place. Based on their experiences in the field, participants addressed emerging trends and barriers in three areas: placement for identified youth, licensing and maintaining residential facilities and programmatic and therapeutic approaches. A range of promising practices along with barriers to success were examined through panel discussion and observer interaction.

In addition, in coordination with the Congressional Caucus for Victims' Rights and the Congressional Caucus for Women's Issues, a congressional briefing called "Identifying Sustainable Solutions for Shelter and Restorative Care for Victims of Domestic Minor Sex Trafficking" was held to discuss funding for shelter and services for DMST victims, a priority concern noted by advocacy and funding experts that responded to a third survey designed for this group of stakeholders. The panel for this briefing consisted of human trafficking experts from government, philanthropy, survivor leadership and non-governmental organizations who brought visibility to the critical importance of the funding issue.

Approximately 185 participants filled the U.S. Capitol hearing room and over 500 more attended via a live webcast in order to be part of this unique event. While information exchange was the stated purpose, a collateral benefit for many was the opportunity for providers and survivors to meet and network with others doing similar work in this limited field.

## **Surveys**

In preparation for the National Colloquium three national surveys—for providers, for survivors, and for advocates and funders—were crafted, distributed and completed by over 100 identified expert individuals and organizations.

### **National Colloquium Provider Survey**

Forty-one organizations providing direct care to DMST victims responded to a 93 question survey on service areas, including therapeutic, medical, educational and vocational services provided, licensing and staffing structure, funding mechanisms, capital and operating costs and safety and security. A full survey summary can be found in Appendix C of the full report.

### **National Survivor Survey**

Thirty-three survivors of domestic trafficking responded to a survivor designed and developed survey describing their personal experiences with services and recommendations for service provisions. A full survey summary can be found in Appendix D of the full report.

### **National Advocate and Funder Survey**

Eighteen advocacy and funding experts in the area of human trafficking, especially DMST, provided insight to trends, research and funding priorities for shelter and services for DMST victims. A full survey summary can be found in Appendix E of the full report.

## **Reports from U.S. Government Agencies**

In order to gain a complete understanding of the efforts underway by those federal agencies involved with responding in any way to juvenile sex trafficking in the United States, a short list of questions was crafted to provide these agencies with the opportunity to explain their activities. The complete, unedited responses are contained in Appendix F of the full report. These responses assisted with the discussion at the National Colloquium and provide insight into the scope of federal agency activity.

# ➤ Recommendations

The following recommendations are derived from the discussion at the National Colloquium and serve as the beginning of a framework of core principles in developing shelter and services for victims of domestic minor sex trafficking.

## 1. Placement and Services for Identified Youth

- 1.1 A uniform method of treatment is not applicable to every identified DMST victim, and the treatment environment required will change to the extent the survivor embraces the healing process. Providers must assess the individualized need of the DMST victims and place them into the most suitable emergency or long-term services, always with a plan in place to assist them to full restoration and independence.
- 1.2 Coordinated communication between service providers is necessary in order to share information on available resources and services which will allow involved agencies and providers to provide the services needed at any given point in the restoration process.
- 1.3 Information pertaining to the services available to DMST victims must be made easily accessible to all the involved parties including first line responders, law enforcement, and the service providers.
- 1.4 Placements could range from congregate care and foster care to community based care depending on the specific need and condition of the DMST victim. Treatment and services are not uniform and must be taken on an individualized, case by case basis.
- 1.5 More diverse options for placement are needed to prevent barriers to placement resulting from funding limitations or any one of a number of characteristics of a DMST victim including: history of running away from another program, altercation within a placement, identification in the middle of the night or outside programs operating hours, lack of identification of vital records, unavailable parent or guardian, low IQ, pregnancy, addiction or severe mental or physical health needs.
- 1.6 First line responders, law enforcement, social workers, therapists, and other stakeholders must be trained to identify and respond to DMST in a trauma-informed and victim-centered manner.

## 2. Licensing and Maintaining Shelter and Programs

- 2.1 Licensing agencies should review and amend or enact regulations as necessary to alleviate barriers or restraints that may dissuade or prevent service and shelter providers from serving particular youth.

- 2.2 Licenses must be made available for all types of congregate care facilities to meet the diverse needs of the DMST victim population. This includes emergency, restorative, long term and transitional housing.
- 2.3 Providers need to work closely with licensing authorities to establish realistic licensing and funding contracts for populations served. License parameters often prohibit or fail to encompass vital components of a DMST treatment program, e.g., survivor mentors may be prohibited from serving on staff if they have a criminal record; license may not include the ability to attach to other necessary supports such as education or mental health resources.
- 2.4 Laws that mandate, establish and financially support residential and community-based programs providing treatment and case management for DMST victims across the continuum of care are needed. Service providers are challenged with effective case management when clients are ordered to inappropriate placements, such as ill-equipped foster care, group homes and detention facilities, or they are returned to unsafe home environments.
- 2.5 Service providers who consider offering residential services should engage an individual that has expertise in the regulatory and compliance aspects of licensing. Residential services providers must have staff who are knowledgeable about the state and local child welfare and juvenile justice policies and practices.

### **3. Identifying Sustainable Resources**

- 3.1 Donors and the general public must be educated on the issue of juvenile sex trafficking as distinct from other social problems affecting minors and why it deserves attention and funding. Such education must come from many sectors of society including providers, law enforcement, advocates and the concerned public.
- 3.2 Potential funders must be led to understand why services for DMST victims tend to be expensive due to the complex and often lengthy healing process.
- 3.3 Shelter and services providers need to establish measurable indicators that are both realistic and quantifiable to demonstrate good stewardships to donors and encourage new investment.
- 3.4 Shelter and services providers must diversify funding. Relying solely on government reimbursements or one major funder does not ensure secure sustainable funding.
- 3.5 When securing funding to support services for DMST victims, utilizing or braiding funds from several sources can help support the cost of high quality and appropriate care, rather than limiting service providers to offering just those services covered by a single source.
- 3.6 Residential services providers must have staff who are knowledgeable about the state and local child welfare and juvenile justice policies and practices. If government contracts provide funding for the services, this knowledge can leverage and enhance these revenue streams.

## **4. Programmatic/Therapeutic Response**

- 4.1 Age, socioeconomic status, culture, personality, and other associated factors require that each victim have tailored treatment plans. This necessitates flexible and adaptive programming. Each individual case is unique and must be treated as unique.
- 4.2 Residential facilities need to be staffed with or have regular access to medical and case professionals who can effectively assist the DMST victims through trauma-informed care. In addition, training in trauma-informed care must extend to all staff members, as well as host families or foster families that may open their homes to DMST survivors.
- 4.3 Survivors demonstrating that it is possible to overcome exploitation should be involved in and take leadership roles in programs and mentorship for sex trafficked youth. This involvement will be an example to the newly liberated survivors that they too can turn their experience into assistance for others or powerful advocacy for the cause.
- 4.4 Programming must be strengths-based and assist survivors with accessing the inherent skills, abilities and qualities of character they possess but may not recognize. Educational and vocational opportunities are critical to helping them develop their talents and interests, gain independence and be active members of their communities.
- 4.5 Treatment plans should be designed to lead to self-sufficiency, identifying services that will allow the DMST survivor to transition towards independence. Conversations and formulation of exit plans are necessary to ensure that DMST survivors understand the value of progressing towards independence.
- 4.6 Community and/or family participation is necessary to help in the ultimate success and independence of DMST survivors. Therefore, educational programs, including family counseling, to assist these support systems is imperative.
- 4.7 Service providers should offer the opportunity for the DMST survivor to have spiritual needs met as well as mental, physical and social health needs.

## **5. Safety and Security**

- 5.1 Providers must be equipped to identify and respond to internal security risks, such as victims' high flight risk, potential self-harm, harm to others or internal recruitment. All staff and volunteers must be trained to recognize and de-escalate behavior leading to internal security risks and recognize that these are often symptoms of trauma that require a therapeutic response.
- 5.2 Providers should have a response plan in place for external security threats. Law enforcement should be aware of the program's operation and available to respond if an emergency situation arises.



# ➤ Introduction

Six years after the Mid-term Review on the Commercial Sexual Exploitation of Children in America for the World Congress Against CSEC, Shared Hope International, ECPAT-USA and The Protection Project at Johns Hopkins University School of Advanced International Studies partnered to host the National Colloquium: Shelter and Services Evaluation for Action, an inventory and assessment of United States service response to identified domestic minor sex trafficking (DMST) victims and survivors. The National Colloquium and its corresponding National Surveys brought together the primary voices on shelter and services for victims of DMST to review current provisions and set down principles for future development and delivery.

Lack of appropriate shelter and services for DMST victims has been identified as a major barrier in providing informed and specialized services to victims in their journey to recovery. The ultimate goal in services and shelter provision for victims of DMST is to reduce exploitation and abuse while maximizing the ability to thrive; however, methods to reach these goals vary, and there has been minimal documentation to support best practices in the field. The need for services for DMST victims has been vigorously advocated but there is little data about current availability or access to and delivery of care to support the advocacy. Research and knowledge about the actual provision of restorative shelter to domestic trafficking victims is critical for effective advocacy and development of state level responses.

This report intends to provide a snap shot of the current status of shelter and services delivery to support and guide the direction forward, properly protecting and serving America's trafficked youth and ultimately achieving two goals:

- Provide policy makers, government agencies, service providers and law enforcement a clear understanding of current DMST services and shelter delivery models.
- Design a framework of core principles applicable to the creation and establishment of restorative shelter and services for victims of DMST.





# ➤ Methodology

On November 30, 2012, experts were convened from around the nation to assess current capacity to address the needs of child victims of sex trafficking in the U.S. through the National Colloquium: Shelter and Services Evaluation for Action and a Congressional Briefing: Identifying Sustainable Solutions for Shelter and Restorative Care for Victims of DMST in coordination with the Congressional Caucus for Victims' Rights and the Congressional Caucus for Women's Issues. Experts from policy, philanthropy, child welfare, non-governmental organizations and survivor leadership addressed emerging trends in and barriers to assisting this victim/survivor population. Issues addressed included placement for identified youth, licensing and maintaining residential facilities and programmatic and therapeutic responses. Several steps were taken to prepare for the National Colloquium.

## National Colloquium Advisory Committee and Practitioners Working Group

In preparation for the National Colloquium, an Advisory Committee and Practitioners Working Group were convened to review and provide feedback on the preparatory documents for the National Colloquium and the structure and scope of the outcome documents.<sup>1</sup> A meeting was held in Arlington, Virginia in July 2012, bringing together the 42 members of the Advisory Committee and Practitioners Working Group to share comments and compile information that shaped the National Colloquium in content and format. The Advisory Committee and Practitioners Working Group reviewed and commented on the following organizational documents for the National Colloquium:

- National Colloquium goals and methodology
- Premises
- National Colloquium Report outline
- Framework of Core Principles outline
- Panels
- Concept papers

In addition, the Practitioner Working group, having expertise and direct experience with shelter and services provision, reviewed the National Colloquium Provider Survey and listed possible additions to the group, all with the goal of making the surveys and National Colloquium most effective.

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<sup>1</sup> Full list of Practitioner Working Group and Advisory Committee members listed in Appendix C.

## National Colloquium Panel Preparation

Prior to the National Colloquium all moderators met by conference call with the coordinating team to review goals and objectives for each panel. A subsequent meeting with the complete panel was held to ensure the panel discussion was centered on the necessary elements of the panel topic.

In addition, a premises document and panel concept papers were distributed to all who attended the National Colloquium to stay on point with the deeper, more nuanced discussion that was deemed needed to move the needle on understanding the current state of shelter and services and direction for the future.

## National Surveys

National Surveys were conducted to provide a current snapshot of implementation of and attitudes towards current shelter and services delivery.

Survivor voice and leadership is at the core of creating a successful strategy in the provision of shelter and services to DMST victims and survivors. Therefore, a survey entitled: Survivor Survey: Shelter and Service Response to Commercial Sexual Exploitation of Children, henceforth referred to as the National Colloquium Survivor Survey, was commissioned by the coordinating team in collaboration with survivor advocate and author, Holly Smith, who designed and distributed it through the National Survivor Network with assistance from Shared Hope Policy Assistant and survivor, Shamere McKenzie, and through personal outreach to survivors. Survivors were given the option to keep responses anonymous. Thirty-three domestic sex trafficking survivors responded, 18 of who are DMST survivors.

A second survey was prepared to collect information and inventory the services and shelter available across the nation. The National Colloquium Provider Survey was done in partnership with Children at Risk, an advocacy organization based in Houston, Texas. To determine which organizations would receive this survey, researchers began with Shared Hope International's Restorative Shelter Working Group's database of organizations and individuals currently providing residential services. The Restorative Shelter Working Group, a national network of direct services providers to victims and survivors of domestic sex trafficking convened monthly by Shared Hope International to share information between organizations and continue learning, were provided access to a shared document to input information about shelter and services providers. Children at Risk staff then confirmed whether the organizations listed were currently open or providing services to DMST victims; if it was unclear, the organization remained on the list. This list was further reviewed by the Advisory Committee and Practitioner Working Group, and other service providers were added as a result. Ultimately 43 responded; 41 respondents were determined to be providing or in the process of developing services or shelter for DMST victims specifically. Questions were purposely left open-ended to allow for maximum information; however, this technique made the survey analysis challenging. To provide consistency in the analysis all survey respondents are credited within the report; their inclusion does not represent endorsement of their services or responses.

A third survey was designed to capture information from advocacy and funding organizations to capture their unique perspective regarding shelter and services for victims of domestic minor sex trafficking. The National Advocate and Funder Survey responses are outlined in Appendix E.

## US Government Agency Reports

The coordinating team sought the counsel of relevant government agencies to contribute information for this report. Responses were received from the U.S. Department of Homeland Security and the U.S. Department of Justice and the U.S. Department of State, compiling information from the various sections within the respective agency that deal with issues related to juvenile sex trafficking.<sup>2</sup>

## Online Leader Forum

Yammer.com, an invitation only social networking site that provided a platform for key participants to privately share information, questions and feedback was used to generate discussion before, during and after the National Colloquium. Members of the Advisory Committee, Practitioners Working Group, panelists, and all survey respondents were invited to join and contribute to the discussion. The National Colloquium Yammer site remains active to support continuing discussion and learning from leadership in the DMST shelter and services field.

The National Colloquium was streamed live on the Internet and videotaped and posted online for viewing. This provided a platform to address and respond to questions that could not be addressed during the National Colloquium. These comments also helped inform this report.

## Premises

In order to avoid expending time on introductory or preliminary issues related to DMST, and to leap directly into the most challenging topics related to assessing the delivery of services and shelter, certain premises were presented through a document and in the opening of the National Colloquium. In order not to suppress discussion or inquiry into these premises, sources were provided for independent research and inquiry. This document is laid out *in toto* below and although it does not represent the opinions or beliefs of every member, it was approved by the National Colloquium Advisory Committee and Practitioners Working Group as a base of knowledge that would allow the National Colloquium panel discussions to remain focused on the higher level topics featured.

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<sup>2</sup> Full unedited responses to the National Colloquium U.S. Government Survey are contained in Appendix D.

# ➤ Premises and Sources

The following premises are stated below with select supporting source citations in order to advance the discussion into deeper issues related to restorative shelter and services. This is not a comprehensive bibliography on each premise but can direct those interested in reading more about a particular foundational premise to key source documents.

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1. **Premise:** Domestic minor sex trafficking is the commercial sexual exploitation of children through prostitution, pornography and sexual performance.
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*DEMAND: A Comparative Examination of Sex Tourism and Trafficking in Jamaica, Japan, the Netherlands and the United States*, Shared Hope International, July 2007. <http://sharedhope.org/wp-content/uploads/2012/09/DEMAND.pdf>.

- 
2. **Premise:** Domestic minor sex trafficking victimization is not limited by gender, race or socio-economics.
- 

## Sources:

Williams, L.M. & Frederick, M.E. *Pathways Into and Out of Commercial Sexual Victimization of Children: Understanding and Responding to Sexually Exploited Teens*. Lowell, MA: University of Massachusetts Lowell, 2009. <http://faculty.uml.edu/lwilliams/Williams%20Pathways%20Final%20Report%202006-MU-FX-0060%2010-31-09L.pdf>.

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- 3. Premise:** Data is not sufficient to quantify the exact numbers of trafficked children, but service providers' and first responder information substantiates numbers in the thousands.
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Estes, Richard J. and Neil Alan Weiner. *Executive Summary: Commercial Sexual Exploitation of Children in the U.S., Canada and Mexico*. University of Pennsylvania, February 2002 revision. [http://www.sp2.upenn.edu/restes/CSEC\\_Files/Complete\\_CSEC\\_020220.pdf](http://www.sp2.upenn.edu/restes/CSEC_Files/Complete_CSEC_020220.pdf).

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Small, Kevonne, J.D., Ph.D., William Adams, M.P.P., Colleen Owens, and Kevin Roland. *An Analysis of Federally Prosecuted Commercial Sexual Exploitation of Children (CSEC) Cases since the Passage of the Victims of Trafficking and Violence Protection Act of 2000 Final Report*. Washington, DC: The Urban Institute, Justice Policy Center, February 2008. <https://www.ncjrs.gov/pdffiles1/ojdp/228631.pdf>.

- 
4. **Premise:** Misidentification of domestic minor sex trafficking victims<sup>3</sup> often provides a barrier to receiving services. Many victims and survivors are charged with an array of offenses stemming from the trafficking situation. They often are offered little relevant treatment or care for their trauma during their arrest and/or detention.
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**Sources:**

Farrell, Amy, Jack McDevitt, and Stephanie Fahy. *Where are all the victims? Understanding the determinants of official identification of human trafficking incidents*. 9 CRIMINOLOGY & PUBLIC POLICY 201 (2010) (explaining issues of misidentification for police offices with victims of trafficking).

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5. **Premise:** A victim-centered approach is essential in crafting shelter and services delivery for victims of domestic minor sex trafficking and survivor needs do not stop at the age of 18.
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**Sources:**

Mattar, Mohamed Y., *Incorporating the Five Basic Elements of a Model Antitrafficking in Persons Legislation in Domestic Laws: From the United Nations Protocol to the European Convention*, 14 TUL. J. INT'L & COMP. L. 357, 380 (2006).

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3 Although the term “victim” may be used in these materials, we recognize that persons who have experienced trafficking can be considered survivors at all stages of their abuse and recovery.

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Lynch, Darlene and Kirsten Widner. *Commercial Sexual Exploitation of Children in Georgia: Service Delivery and Legislative Recommendations for State and Local Policy Makers*, EMORY LAW (Barton Child Law and Policy Clinic 2008). [http://bartoncenter.net/uploads/fall2011updates/status\\_other/CSEC-recs-for-policy-makers.pdf](http://bartoncenter.net/uploads/fall2011updates/status_other/CSEC-recs-for-policy-makers.pdf).

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- 6. Premise:** Victims of commercial sexual exploitation often display symptoms of traumatic bonding which make it more difficult for them to separate from the person responsible for their harm. They may be likely to deny victimization and/or abandon/run away from treatment due to this trauma.
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# > Chapter 1

## Placement and Services for Identified Youth

The initial identification of a sex trafficked youth as delinquent or as a victim largely determines placement; the former into detention typically and the latter into some type of emergency or long-term congregate care or community-based program. This identification is often determined by the first responder, e.g., law enforcement or child welfare, or in some instances by family or self-identification. The level of trauma-informed training a first responder has received can greatly impact the identification and referral process.

After identification, other conditions of the youth such as family involvement, drug dependency, criminal or status charges, or flight risk as well as the availability of appropriate programs influence the service response.

**“In regard to assessing the proper placement, it’s really done individually. At this point, no case has been the same.”**

—Tammy Sneed, Connecticut Child Welfare Girls Program

Efforts to increase awareness and improve system responses on the part of first responders may increase the likelihood of victim identification, but in the absence of trusted services and shelter placements, law enforcement and other first line responders may feel constrained. This can be exacerbated by the need to retain the victim as a witness in any prosecution. Child welfare agencies may have services and shelter available, but not all states offer specialized placements for DMST victims. Family or self-identification necessitates placement options that may not be system involved, such as voluntary treatment and residential programs.

To evaluate the best available service resources and prioritize the immediate and long-term needs of the individual, a collaborative community response that may include law enforcement, child welfare, service providers, parents, caretakers, mentors and the identified youth is ideal.<sup>4</sup> At the same time, DMST restorative services providers need to be aware of state law and policy that may restrict or serve as barriers to a placement that may seem to be most appropriate.

Finally, collaboration amongst law enforcement, child welfare agencies and other first responders is critical to establish confidence and trust in the services and shelter being offered, and to facilitate the communications necessary to bring about referrals. In a survey taken in preparation for the National Colloquium, 75% of practitioners providing direct services to survivors of DMST reported that they receive juvenile probation referrals, 88% received referrals from child protective services and 97% received referrals from law enforcement directly. Eighty-four percent can receive family or self-identified referrals.

<sup>4</sup> Remarks by Withelma TiOra “T” Ortiz Walker Pettigrew, Human Rights Project for Girls and Tammy Sneed, Connecticut Child Welfare Girls Program at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

**“To be able to assess [a victim’s needs] in a team effort is what’s best because you’re assessing her mentality, her physical health; you’re assessing the safety and self-development and really a lot of her goals and challenges.”**

– Withelma TiOra “T” Ortiz Walker Pettigrew, Human Rights Project for Girls

## **1. Types of Placements and Services**

System and program responses vary from state to state making it challenging to categorize or classify the types of placement and services. This section is broken down into emergency care and long-term care; however, the two types can overlap. For example, a community group home may be available to serve as an emergency placement and a runaway and homeless youth center may be able to provide long-term care.

When referring a child to services, it is ideal to have a constant point of contact that can help guide the child through the system.

**“You have to be with them all the way, every step of the way and that’s the biggest problem that I find. The fragmentation is disjointed... when we say we’re going to do something we’re going to do something, because if you don’t do that then all is lost in their mind, and we’ve seen this time and time again.”**

–Detective Andy Conner, King County Sheriff’s Office

### **1.1 Emergency Care**

When a child is identified as a victim of DMST, both immediate and long-term needs must be assessed. If a victim is identified by law enforcement or child protective services, or is in immediate danger, there may need to be an emergency placement before a needs assessment and long-term shelter or services referral can be made. Child welfare and law enforcement interviews tend to be a long and stressful process for the victim. Youth-friendly programs that allow for space, rest and a calm and safe atmosphere are ideal and reinforce to the youth that they are receiving services, not being punished as they navigate this process.<sup>5</sup> A nurturing environment may encourage a victim of DMST to share more information, and may ultimately help guide a more appropriate placement option in which the youth is more engaged and committed to the treatment plan.<sup>6</sup>

5 Remarks by Renee Murrell, FBI Victim Witness Specialist and Withelma TiOra “T” Ortiz Walker Pettigrew, Human Rights Project for Girls at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

6 Remarks by Melissa Snow, TurnAround, Inc. at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

**“The reality is we need to continue to change these structures so that it is not based on one individual judge or one individual, fantastic law enforcement officer. It has to be a system that allows for these individuals to be identified and responded to properly as a survivor of DMST every time.”**

—Melissa Snow, TurnAround, Inc.

### 1.1.1 Child Assessment and Advocacy Centers

Although titles may differ from state to state, child welfare emergency shelters and child advocacy centers are available in most communities across the country. These facilities are generally equipped with a medical staff and therapeutic staff, as well as trained forensic interviewers, enabling comprehensive services in a single location available at any hour. These facilities are equipped to respond to sexually abused youth. Currently several centers are working on trauma-informed responses specifically for DMST victims.<sup>7</sup> These centers often provide the ability for a collaborative response to placement involving family, social workers and law enforcement or child protective services.<sup>8</sup> A placement at this type of emergency service provider is usually limited to several hours or days.

### 1.1.2 Runaway and Homeless Youth Facilities

Runaway and homeless youth facilities can often provide immediate support to an identified youth without some of the limitations of other residential options. They often do not require vital records, have the ability to do intake in the middle of the night and are often the only longer term placements that will accept transgender youth and boys.<sup>9</sup> However, because the intake process is less restrictive some safety concerns may arise such as recruitment within the facilities.<sup>10</sup>

Programs at runaway and homeless youth centers tend not to be DMST-specific, and may be less able to cater to the individual needs of the trafficked youth. However runaway homeless youth field is very knowledgeable on the issue of DMST and continues to develop more tailored responses for this population.<sup>11</sup>

7 Remarks by Sandy Skelaney, Kristi House, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

8 Remarks by Withelma TiOra “T” Ortiz Walker Pettigrew, Human Rights Project for Girls, Sandy Skelaney, Kristi House, and Tammy Sneed, Connecticut Child Welfare Girls Program, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

9 Remarks by Sandy Skelaney, Kristi House, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

10 Remarks by Melissa Snow, Turnaround, Inc., at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012. *See infra* Chapter 5.

11 Remarks by Sandy Skelaney, Kristi House, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

### 1.1.3 Juvenile Detention

Although highly controversial, many youth are still placed in detention in response to their trafficking victimization or offenses related to it. In a survey specifically for survivors taken in preparation for the National Colloquium, 55% of respondents had been arrested on prostitution-related charges and one-half of those individuals were sentenced to incarceration for some period of time.<sup>12</sup> Fifty percent of those identifying as DMST survivors had been arrested; 58% were placed in detention.<sup>13</sup>

Detention is often recommended when the victim is a flight risk or is at risk for re-exploitation or self-harm. Alternatively, there are some prosecutors and judges that may not identify the child as a victim, and instead consider their actions criminal behavior. Opponents to detention for victims of DMST emphasize that detention does not foster an environment that promotes healing.<sup>14</sup> Detention reinforces a victim's self-perception as an offender and deepens their mistrust of law enforcement.

The current reality is that many DMST victims are being placed in detention, and many youth in detention on unrelated charges are sex trafficking victims. Therefore, it is critical that detention facility staff is trained to identify DMST and to respond in a trauma-informed manner.<sup>15</sup> A handful of detention programs have begun crafting programs that provide counseling, goal planning and trauma-informed care specifically tailored to respond to the needs of sex trafficked youth within their population.

**“I am an advocate for victims of DMST. So what I will assure you of is that the State of Maryland will treat these girls like victims if they are in detention in the juvenile system.”**

—Trina Lyles, Young Women's Facility of Maryland

Detention, and the debate around DMST victims being placed there, will be further examined in Chapter 5: Safety and Security.

## 1.2 Long-term care

The transition to a long-term service or shelter program relies heavily on the information learned through the interview or intake process for emergency placement. However, the DMST victim may not be completely forthcoming during his or her initial emergency placement interviews making the placement decision difficult.<sup>16</sup> It may take a significant amount of time, and several placements or referrals to identify the most appropriate treatment plan for a sex trafficked youth. The first placement may not always be the right one,

12 33 survivors responded to the survey; 18 were first trafficked when they were a minor.

13 It is unclear from survey data if the arrest or detention happened while the individual was a minor.

14 Remarks by Renee Murrell, FBI Victim Witness Specialist, and Sandy Skelaney, Kristi House, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

15 Remarks by Melinda Giovengo, PhD, YouthCare, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

16 Remarks by Sandy Skelaney, Kristi House, and Renee Murrell, FBI Victim Witness Specialist, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

so ongoing monitoring of the youth's response and success is critical to providing the most appropriate services for that individual's unique experience and healing process.<sup>17</sup> If a DMST victim receives residential or intensive services, it is also important that the he or she is equipped with ongoing support and a gradual step down process to nurture continued success.<sup>18</sup>

Long-term placement can take many forms and DMST victim may need to be enrolled in more than one type of long-term program.

### 1.2.1 Congregate Care

Forty-nine percent of organizations responding to the National Colloquium Provider Survey offer residential congregate care either in a group homes setting or through a residential facility.

It is critical that a long-term care plan is implemented when referring a young person to these types of shelter services. The unique nature of DMST trauma and the complex recovery process advocates for specialized residential group care that has staff equipped to meet the intensive needs of the victim before placement in a home or foster care setting. Transitioning from a highly therapeutic environment to a home or foster care placement should be done gradually, and with a support plan in place to help prepare the youth for a permanent home placement.<sup>19</sup>



The Administration for Children and Families categorize three types of congregate care: **community-based group homes, campus-style residential facilities,** and **secure facilities.** In the context of this report, it is defined as a non-family based facility with a provision for specialized care identified as a responsive tool to the unique and specific needs and circumstance of the child victim.

*See <https://www.childwelfare.gov/outofhome/types/>*

Forty-seven percent of organizations responding to the National Colloquium Provider Survey offer residential congregate care either in a group home setting or through a residential mental health facility.<sup>20</sup>

17 Remarks by Det. Andy Conner, King County Sheriff's Office, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

18 Remarks by Withelma TiOra "T" Ortiz Walker Pettigrew, Human Rights Project for Girls, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

19 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.

20 Congregate care can be beneficial for the youth that have a deeply ingrained traumatic history and are more prone to self-harm, return to exploiters or flight risks.

## 1.2.2 Individual Foster Family or Host Family Placements

Recently, promising results with specialized identification and training for foster families geared towards parenting sex trafficked youth have been realized.<sup>21</sup> Sixteen percent of organizations responding to the National Colloquium Provider Survey offer foster care support. In addition, state child welfare agencies are implementing training and identification protocols for DMST-specific treatment foster care.<sup>22</sup>



A DMST victim who does not have a safe or stable home environment to return to may be placed in foster care. The Administration for Children and Families refers to this type of specialized foster care as “treatment foster care.”

See <https://www.childwelfare.gov/outofhome/types/>

Specialized foster families of DMST victims should be equipped with a trauma-informed understanding of the complex challenges and healing process that trafficked youth face and must be committed to working with the victim. A long-term, stable environment is ultimately the ideal placement for a trafficked youth; therefore, the commitment to the youth is essential for success. A foster family must be prepared for the likelihood of the youth running from the home as a symptom of the trauma, and be prepared to welcome that child back openly and without judgment.<sup>23</sup>

**“I would love to get a handful of really good foster care families that are committed to this population versus just a large number of caring people that aren’t prepared for some of the dynamics that play out working with this population.”**

—Tammy Sneed, Connecticut Child Welfare Girls Program

## 1.2.3 Community-based Care

Not all DMST victims require a residential program. If the youth is in a stable home environment community-based care may be a more appropriate and cost effective service option. Community-based care may include a structured curriculum, group counseling program, individual counseling sessions, and case management. Seventy-eight percent of providers surveyed for the National Colloquium provided community-based case management and services, most of which provide regular operating hours, and emergency on-call or individual case management. Seventy percent also provided drop-in services.<sup>24</sup>

21 Remarks by Tammy Sneed, Connecticut Child Welfare Girls Program, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012 and responses in National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.

22 Id.

23 Id.

24 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.



Ninety-five percent of survey respondents that are providing community-based care were accessible by public transportation. In some cases the staff actually goes to the client.<sup>25</sup>

## 2. Considerations for Placement

**“The context in which a child is exploited informs her or his path to healing. Mine was very tied to my father and family, whereas a child who has experienced poverty will have had a very different experience than mine. One size does not fit all, although I would anticipate a lot of overlapping services since exploitation, in my experience, is about power and control.”**

—Kate Price, M.A., National Colloquium Survivor Survey

In considering placement for identified DMST victims, constraints within state law, regulations and funding can prevent survivors from receiving specialized services. However, addressing these system constraints will not be sufficient alone, as considerations related to the individual survivor must be factors in the placement decisions as well.

### 2.1 Youth's Preferences

When considering placement for a DMST victim, the client should be empowered to have a voice in the placement process whenever possible. Demonstrating that the placement is intended to serve, not punish, will lead to greater engagement and commitment on the part of the youth to the identified treatment plan.<sup>26</sup> An individual's willingness or desire to participate in the program was listed as critical by several DMST-specific program providers.<sup>27</sup>

**“Every victim and survivor of trafficking has their own unique experience so of course services would and should be tailored to fit each different scenario.”**

—Barbara Amaya, National Colloquium Survivor Survey

<sup>25</sup> Id.

<sup>26</sup> Remarks by Tammy Sneed, Connecticut Child Welfare Girls Program, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

<sup>27</sup> National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.

### 2.1.1 Victim's Relationship with Exploiter

A DMST victim may not immediately identify as a victim and often has a strong attachment to the trafficker. This attachment, sometimes referred to as trauma-bonding or Stockholm syndrome, can result in the youth being a higher flight risk and resistant to initial counseling and other treatment.<sup>28</sup> In addition, the youth may have been instructed by the trafficker to recruit other youth into the trafficking situation as a demonstration of loyalty to the trafficker, making the safety of the other children in the potential placement a consideration.

If the trafficker is not incarcerated, the trafficker may be a continuing safety threat to the victim, making geographic location and secrecy important.<sup>29</sup>

## 2.2 Custody and Home Situation

The individual or agency that has custody of a trafficked youth greatly determines where and how the youth will be placed. If the young person is under parental custody, the parent may have to sign permission for the child to receive services. Sixty-nine percent of providers surveyed for the National Colloquium require guardian consent or assignment by the state to provide services to DMST victims.<sup>30</sup>

If the parents cannot be reached or the custody cannot be immediately determined, the first responder may need to declare the child a homeless youth to gain immediate access to services.<sup>31</sup> Some state laws permit a young person to receive shelter as long as there is an attempt to contact the parent or guardian. If the youth does not want the parents to be contacted or if the parents are a potential safety risk, some states allow a child to remain at a residential program for a certain amount of time without contacting a parent until the situation is further assessed.<sup>32</sup>

If the child is under parental custody or the custody of a foster parent, it is critical that the home situation be investigated for safety. It is possible that the home situation was a catalyst for the child's departure or exploitation.<sup>33</sup> Thirty-five percent of DMST survivors surveyed for the National Colloquium were first trafficked by a family member or foster parent.<sup>34</sup> In some cultures, it may even be dangerous for a youth to return to the home after being identified as a sex trafficking victim because, despite being compelled, sexual behavior is considered taboo for unmarried and underage individuals regardless of the circumstance.<sup>35</sup>

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28 Remarks by Sandy Skelaney, Kristi House, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

29 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.

30 Id.

31 Remarks by Renee Murrell, FBI Victim Witness Specialist, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

32 Remarks by Melissa Snow, TurnAround, Inc., at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

33 Remarks by Renee Murrell, FBI Victim Witness Specialist, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

34 National Colloquium: Shelter and Services Evaluation for Action Survivor Survey, November 30, 2012.

35 Remarks by Stephanie Holt, Mission 21, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

## 2.3 Geography

Trafficked youth identified in a state other than the state of residence will require special permission to stay and receive services in a recommended placement outside of the state of residence or will need to be returned pursuant to the Interstate Compact for Juveniles.<sup>36</sup> Forty-seven percent of providers responding to the National Colloquium Provider Survey felt that children should be removed from the original geographic area of their exploitation during restorative services, generally referring to safety concerns and the ability to separate from triggers and the place or trauma for initial healing. It was pointed out however that for emergency placement a shelter needs to be immediately available in the geographic location. Eleven percent of respondents felt that it was better for the child to learn coping skills within the environment where the exploitation took place. Forty-two percent responded that this should be determined on a case by case basis.<sup>37</sup>

“Generally, the ICPC applies to out of state foster care placements. The ICJ applies to the return of youth to their home state when they have run away and were on probation or parole. However, both compacts seem to apply when youth under state supervision need of out of state residential treatment.”

*American Bar Association, “The Interstate Compact on the Placement of Children and Status Offense Advocacy” Fact Sheet, citing Interstate Commission for Juveniles, 2010 Rules of the Interstate Compact for Juveniles, Rule 4-101, available at <http://www.juvenilecompact.org/LinkClick.aspx?fileticket=hvMqJ-56kQk%3d&tabid=648>.*

Trafficked youth identified in a state other than the state of residence will require special permission to stay and receive services in a recommended placement outside of the state of residence or will need to be returned pursuant to the Interstate Compact for Juveniles.<sup>38</sup>

**“We are siloed both in our organizations and our agencies in our state and the reality is this issue crosses jurisdiction. It crosses boundaries and we have to figure out better systems that allow for that coordination and cooperation.”**

—Melissa Snow, TurnAround, Inc.

36 Remarks by Trina Lyles, Young Women’s Facility of Maryland, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

37 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.

38 Remarks by Trina Lyles, Young Women’s Facility of Maryland, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

## 2.4 Age, Gender and Sexual Orientation

Boys and transgender youth are victimized through DMST, but little information is known about the scope and response to this trafficking. It is clear there is a lack of identified services available for boys.<sup>39</sup> Similarly, there is a lack of services for transgender and LGBT youth who often refuse to disclose their gender or sexual orientation for fear of stigmatization.<sup>40</sup> Even if they self-identify as female, in some cases by law they cannot be placed with female youth.<sup>41</sup>

None of the organizations that responded to the National Colloquium Provider Survey provide specialized services exclusively for male victims of DMST; 36% provide services for females only. Fifty-eight percent of responding organizations could provide services to males, females and transgender youth. Six percent stated they could provide services to male and female youth but did not indicate they serve transgender youth.<sup>42</sup> The survey results did not reveal exactly how many programs offer residential services for males and transgender youth, but the clear majority of programs provide treatment specifically for female victims.

Sixty-seven percent of providers indicated that their program had age restrictions. Thirty eight percent of service providers transition youth to other programs after they turn 18. Fourteen percent will continue services to age 21-22 under certain circumstances.<sup>43</sup>

## 2.5 System Involvement

Various rules regarding system involvement operate to limit access to services. A trafficked youth in the custody of or receiving services from one state system may be limited or precluded from receiving services from other systems to prevent the perceived double dipping of funding sources. For instance, if a young person is receiving services from child protective services, he or she may be prohibited from also receiving services at a runaway and homeless youth shelter.<sup>44</sup> In addition, if the young person ran away, recruited another child into a trafficking situation or violated rules in a former placement, placement options become further limited.<sup>45</sup>

### 2.5.1 Access to Child Welfare

In many states, child sex trafficking is classified as a form of child abuse. Such classification can open the door to services through the child welfare system. However, an additional hurdle for many states is the requirement that the abuse be perpetrated on the child by a member of the family or household. This can

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39 Remarks by Tina Frundt, Courtney's House and Sandy Skelaney, Kristi House, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

40 See *supra* Premise 2, pg. 12.

41 Remarks by Sandy Skelaney, Kristi House, Withelma TiOra "T" Ortiz Walker Pettigrew, Human Rights Project for Girls and Trina Lyles, Young Women's Facility of Maryland, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

42 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.

43 Id.

44 Remarks by Melissa Snow, TurnAround, Inc., at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

45 Id.

preclude child protective services investigation and intervention in cases where a child is residing with a non-familial trafficker.<sup>46</sup>

In a limited number of states with advanced development in the responses to trafficked minors, DMST victims can receive free services from child welfare agencies without having to have a case open with child protective services or juvenile justice department.<sup>47</sup>

**“In Connecticut, law enforcement can refer to the Department of Children and Families without making an arrest, and a child does not have to be a part of the Department of Children and Families for the DCF to respond.”**

—Tammy Sneed, Connecticut Child Welfare Girls Program

### 2.5.2 Criminal Charges or Material Witness Holds

It is not uncommon for DMST victims to be charged, prosecuted and detained for ancillary offenses such as drug procession, theft assault and truancy. A DMST victim who has a warrant for a prior arrest or has a record for status offenses may be placed in detention until the court hearing, unless there is a court order for the warrant to be quashed.<sup>48</sup> If the warrant or runaway status is in another state, it may be mandatory pursuant to the Interstate Compact on Juveniles for the child to be returned home.<sup>49</sup> Detention can continue as part of adjudication for the offense.

Another way a DMST victim may be held in detention is under a material witness hold requested by a prosecutor to ensure the victim-witness is available for testimony in the prosecution of the trafficker or buyer.<sup>50</sup>

**“The government has the ability for any case to get a material witness hold whether it’s a rape victim, a robbery victim, a murder witness, if that person is not cooperating and not going to be available to testify, the government can get a material witness hold.”**

—Susan Roske, Clark County (Las Vegas), Nevada Public Defenders Office

<sup>46</sup> See Appendix G.

<sup>47</sup> Remarks by Tammy Sneed, Connecticut Child Welfare Girls Program, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

<sup>48</sup> Remarks by Det. Andy Conner, King County Sheriff’s Office, and Susan Roske, Clark County Public Defender’s Office, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

<sup>49</sup> Remarks by Melissa Snow, Turnaround, Inc., at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

<sup>50</sup> Remarks by Susan Roske, Esq. Clark County (Las Vegas), Nevada Public Defender’s Office, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

Involvement in the juvenile justice system through detention can result in a juvenile criminal record. This record can present a barrier to collecting crime victim compensation that can fund services and shelter. “Dual jurisdiction” or “cross-over kids” who have committed some offense but also are victims of the crime of trafficking receive disparate responses, ranging from punitive detention without services to diversion to complete victim services and placement in a therapeutic environment through a child welfare system.

## 2.6 Quality and Availability of Services

In determining placement for a DMST victim, a key consideration is the capacity of a facility to provide appropriate care for the specific child taking into account the particular needs of that child. There is little longitudinal or evidence-based research to assess the quality of programs. This makes it challenging to determine best practices in programming. While well intentioned, many programs may not have the knowledge or experience to provide quality care to DMST victims.<sup>51</sup> When referring a sex trafficked youth to services it is important to prioritize programs that incorporate the core principals of programming outlined in Chapter 5: victim centered, trauma-informed, strengths-based and culturally sensitive.

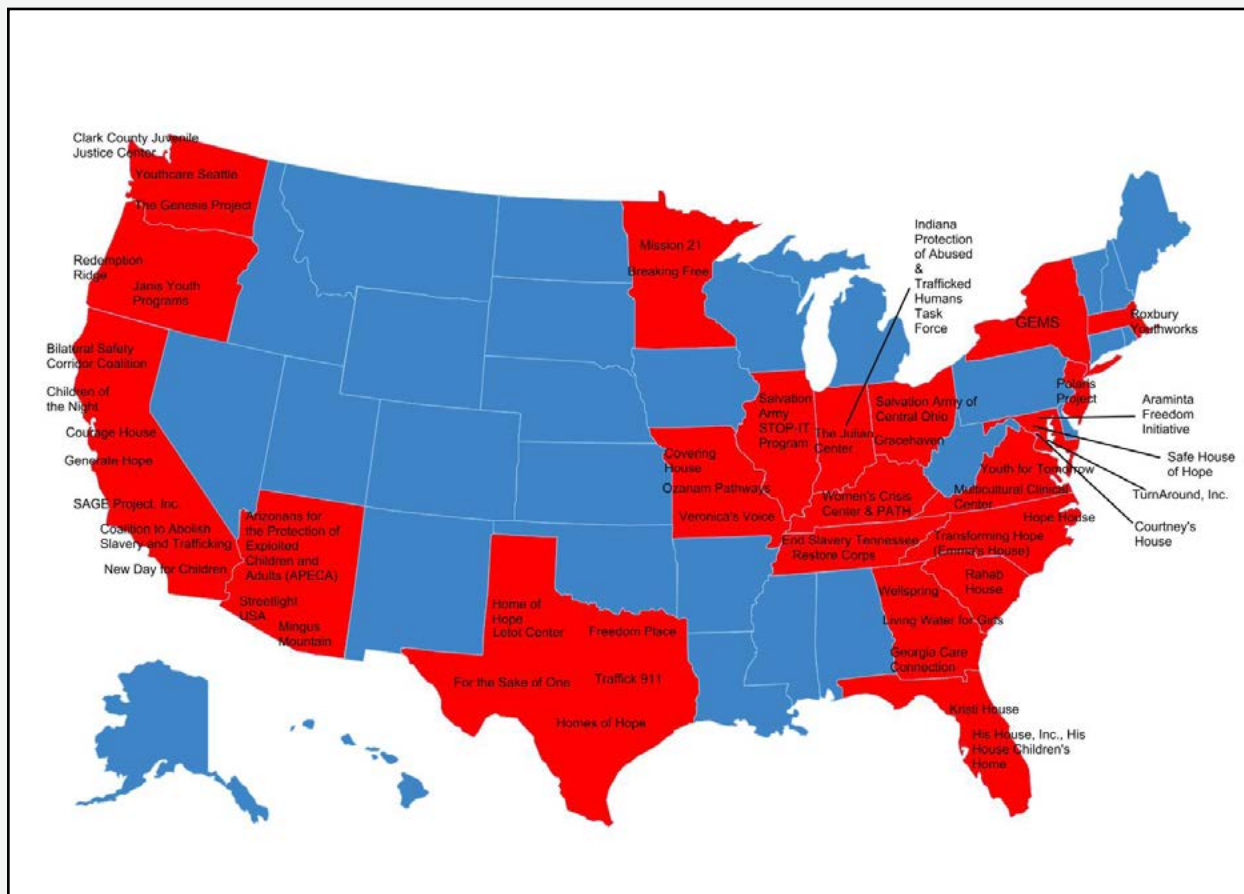
**“I was kidnapped and tortured multiple times and suffer from PTSD and terrible anxiety and there just were no counselors in our small town area that could even relate... specialized help is so needed and people that have special training not just regular counseling...”**

—Wanda Williams, National Colloquium Survivor Survey

In some locations, there is simply no DMST-specific program available, or the victim does not qualify for the services. In the National Colloquium Provider Survey, the following were listed as reasons for denying a child services: special health needs, suicidal symptoms, drug addiction, severe mental health diagnosis, pregnancy, low IQ level, history of violence, history of recruitment, sexual offender or arson history.<sup>52</sup>

<sup>51</sup> Remarks by Melinda Giovengo, PhD, YouthCare, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

<sup>52</sup> National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.



## 2.7 Access to Identification and Records

Access to services and shelter can be difficult for DMST victims who are not in possession of identification or vital records. Identification is required to obtain vital records and social services. Identification is often taken away from a victim of trafficking as part of the control imposed by the trafficker. A victim's identification is often seized for evidence as part of an investigation and if parents are unavailable or uncooperative in assisting with securing new identification documents then a victim can be turned away from critical services and shelter.<sup>53</sup> Also, especially without cooperation from a parent or guardian, it can be challenging to obtain permission for access to a child's mental health records which can be extremely informative when identifying a placement. Twenty-one percent of respondents to the National Colloquium Provider Survey are unable to accept DMST referrals without certain permissions and documentation.<sup>54</sup>

<sup>53</sup> Remarks by Renee Murrell, FBI Victim Witness Specialist and Melissa Snow, Turnaround, Inc., at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

<sup>54</sup> National Colloquium: Shelter and Services Evaluation for Action Advocate and Funder Survey, November 30, 2012.



## 2.8 Funding

Funding is noted as a critical barrier to long-term shelter and services for DMST victims. Funding can be tied to the child if system-involved. In this case, if the victim's custodian is in a state other than where the ideal placement is identified, or if the child is not system involved, it may be hard to find funding to pay for his or her treatment.

There are very few states that will fund services for children that are not system involved, although state policy is beginning to change.<sup>55</sup> A facility may not be able to accept a child if there is not a mechanism to pay for the child's services.<sup>56</sup> Quality services may be very expensive. Identifying resources to fund a child's services was listed as the biggest barrier by every advocacy and funding organization surveyed for the National Colloquium.<sup>57</sup>

## 2.9 Medical Needs

Victims' physical and mental health needs must be considered, both for emergency and long-term placements. Obtaining a victim's health records will help identify what medications the youth may take, and any particular type of needs he or she may have. For instance if the client has been diagnosed as bipolar, a program should be equipped to provide prescribed medication and access mental health needs.<sup>58</sup>

### 2.9.1 Physical and Mental Health

Program referrals must be equipped to respond to all physical and mental health needs that the young person may have. If the child is suicidal, or has particularly severe mental or physical health challenge a specialized program may be needed. Thirty-one percent of the respondent organizations provide medical care on site. Sixty-nine percent of the respondent organizations do not provide medical care on site.

### 2.9.2 Pregnancy and Childcare

If a referred DMST victim is pregnant or in custody of a child, services become even more tailored and limited. Twenty-five percent of the organizations surveyed in the National Colloquium Provider Survey do not serve pregnant individuals or individuals with children.

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55 Remarks by Tammy Sneed, Connecticut Child Welfare Girls Program, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

56 Remarks by Renee Murrell, FBI Victim Witness Specialist, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

57 National Colloquium: Shelter and Services Evaluation for Action Advocate and Funder Survey, November 30, 2012.

58 Remarks by Det. Andy Conner, King County Sheriff's Office, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.



Seventy-five percent of the organizations surveyed do provide services for pregnant individuals or individuals with children. Relevant policies relate to the length of time during pregnancy that care will be provided, and then development of a post-childbirth plan for the care of both mother and child. This may include referral to a maternity home, adoption program or relative as part of their case management. Alternatively, it may involve connecting the mother to community-based resources such as childcare agencies, medical care, child welfare support or parenting resources. In addition, some organizations provide childcare (through volunteers and interns) so that parents can attend work, classes or parenting groups (some of which are on-site support groups providing psycho-education around parenting issues). Some organizations also provide prenatal care or connect pregnant girls with prenatal programs in the community.<sup>59</sup>

### 2.9.3 Addiction

If the DMST victim presents substance dependencies, availability of a substance abuse program is critical. Thirty-eight percent of organizations responding to the National Colloquium Provider Survey provide treatment for individuals with substance abuse issues. However, over half of these organizations specifically noted that they do not provide detox services on site. Sixty-two percent of respondents only provide referrals or provide no treatment for substance abuse at all.<sup>60</sup>

Thirty percent of survivors surveyed for the National Colloquium (40% of survivors that were first trafficked as minors), received services related to addiction.<sup>61</sup> Ninety-two percent of survivors surveyed felt that this was moderately or very important in a services response.<sup>62</sup>

## 2.10 Education

If a DMST victim has been out of school for a significant amount of time or is not currently enrolled in school, educational opportunities and support are major placement considerations.<sup>63</sup>

Many residential facilities also provide an opportunity to take classes, complete high school level by taking the GEDs and continue on to higher education.<sup>64</sup>

**“It is also important to understand what we have done is not who we are.”**

—Anonymous, National Colloquium Provider Survey

59 National Colloquium: Shelter and Services Evaluation for Action Survivor Survey, November 30, 2012.

60 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.

61 55% of the National Colloquium Survivor Survey respondents were first trafficked as a minor.

62 National Colloquium: Shelter and Services Evaluation for Action Survivor Survey, November 30, 2012.

63 Id.

64 Id.

## Recommendations:

1. A uniform method of treatment is not applicable to every identified DMST victim, and the treatment environment required will change to the extent the survivor embraces the healing process. Providers must assess the individualized need of the DMST victims and place them into the most suitable emergency or long-term services, always with a plan in place to assist them to full restoration and independence.
2. Coordinated communication between service providers is necessary in order to share information on available resources and services which will allow involved agencies and providers to provide the services needed at any given point in the restoration process.
3. Information pertaining to the services available to DMST victims must be made easily accessible to all the involved parties including first line responders, law enforcement, and the service providers.
4. Placements could range from congregate and foster care to community-based care which can be identified based on the specific story of each DMST victim. Treatment and services are not uniform and must be considered on an individualized, case by case basis.
5. More diverse options and broader policies are needed to overcome identified barriers to placement such as: funding limitations, history of running away from another program or altercation within a placement, identification in the middle of the night or outside programs operating hours, lack of identification of vital records, unavailable parent or guardian, lack of trauma-informed understanding for first line responders, low IQ, pregnancy, addiction or severe mental or physical health needs.
6. First line responders, law enforcement, social workers, therapists, etc. must be trained on how to identify and respond to DMST and be familiar with resources in their area.
7. Licensing requirements and program policies should consider current barriers to placement and amend or expand programs to streamline all DMST victims into appropriate care.



## Note on Definitions

The Child Welfare League of America further defines types of services as: Supervised/ staffed apartments, Group homes, Residential treatment, Emergency shelter care, Short-term/ diagnostic care, Detention, and Secure treatment. Each of the services listed can be made relevant to the victim based on their unique needs.

**Supervised/staffed apartments** are small group living arrangements that are semi or fully supervised by live-in staff or shift coverage. Such arrangements provide an opportunity to transition into independent living and integrating into the community with provision for supervision as needed. DMST victims that have demonstrated maturity and independence and need an intimate living environment without intensive supervision will benefit from this type of services.

**Group Homes** are defined as “detached homes housing twelve or fewer children in a residential setting that offer an opportunity for the youth to interact fully with the community.” Youth who are unable to return to their homes but require more supervision than foster care are generally served by group homes. Group homes should serve DMST victims that are stable enough to utilize the resources available in the community with limited supervision.

**Residential treatment programs** provide services ranging from educational, therapeutic, and recreational services in a well structured environment by a professional and interdisciplinary team. Such treatment should be available to DMST victims who need supervised living environment with opportunities to interact with the community.

**Emergency shelter care** would be most appropriate for a victim who is in crisis and need immediate emergency care including basic necessities such as food, clothing, shelter and medical care. Emergency shelters ensure that youth receive immediate care that are not available at home or foster care.

**Short-term/diagnostic care** provides services that start with a time limited assessment process that evaluates the need of the youth and the family involved. These services should be provided to DMST victims whose history of abuse starts at home, whether it is sexual or domestic abuse and must be separated from their families and home for their safety.

**Detention** is mandated by the law and provides short term care to youth that are detained by the justice system or are waiting adjudication or status hearing. DMST informed care should be available at detention centers to correctly identify DMST victims and provide the appropriate service while in detention.

**Secure treatment** provides residential treatment in a secure facility that may include restrictive feature such as “locked doors and barred windows”. These types of facilities are recommended for DMST victims that are at a high risk for flight, self-harm and re-exploitation and will benefit from a self-contained and secure residential treatment.

“CWLA Standards of Excellence for Residential Services.” *Child Welfare League of America*. Revised Edition. (2004)



# > Chapter 2

## Licensing and Maintaining Programs

**“It is time to create a continuum of care that provides safe, licensed and supportive shelters. It is time to get licensing and policy decisions right so that we do not subject victims of trafficking to re-abuse. It is time to create therapeutic interventions and services that meet the diversities of individual victims.”**

—Acting Assistant Secretary George Sheldon, Administration for Children and Families, U.S. Department of Health and Human Services

Components to licensing and maintaining shelter and services for DMST victims will vary by location and population served. In most states, a license must be secured in order to legally provide residential services to any population of minors, including DMST victims and survivors. Licensing provides residential programs with established guidelines intended to keep youth healthy and safe. However, there are few, if any, state licenses with provisions informed by the comprehensive needs of DMST victims. Types of licensing available to service providers seeking to open and maintain a residential facility for survivors varies by state and categories of licenses offered. Not all types of programs are appropriate for every DMST victim. Programs and licensing at all levels—emergency care, long-term residential, short term residential, specialized foster care, etc.—must have a plan for sustainability and the ability to maintain qualified staff that can address the specialized needs of trafficked youth. Additionally, ongoing success of the program will require the support of the community and a network through which to both refer and receive placements that are a good fit for services offered.

### 1.1 Licensing Considerations

Variations between types of licenses can impact the access and delivery of residential services to the victims and survivors of DMST. Considerations for determining what license is most appropriate is largely determined by the number and population of youth served.<sup>65</sup>

When establishing residential services, providers should research other care models to determine the most appropriate for the population they are serving and community in which they are operating, and take into account what license makes sense for their current capacity and funding availability. Licensing impacts

<sup>65</sup> Remarks by Kellie Armstrong, Shelter Development Consultant, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

residential facilities and programs from start to finish; for example, zoning and construction licenses dictate the type and physical layout of residential facilities, while program licenses dictate requirements regarding staffing, education, therapy, and other service provisions. Licensing can render efforts to provide comprehensive services within a residential facility cost prohibitive. They also may limit how long the young person is able to receive residential services from the provider.

## 1.2 Types of Licensing

Residential service providers surveyed to inform the National Colloquium operated under various licensing classifications, including group home, non-public home school, general residential operation, boarding school, domestic violence shelter, residential child care agency, residential care facility and children's home. Names of licensure and child welfare agencies vary from state to state, and names may mean different things, but 50% of providers surveyed operated under some type of group home license and 19% operated under a residential license. Most of the licenses, 82%, were issued by the state's health and human services agencies.<sup>66</sup>

Although each state has comprehensive licensing requirements for each type of congregate care, licensing authorities are only beginning to tailor licensing requirements and agency funding contracts to specifically serve DMST victims. Given the diverse background and nature of the DMST victims, it will be important to identify appropriate services based on the victim's individualized need. All the services referred and provided should be equipped to meet the complex needs of DMST victims.

Along with the listed services, it is important to establish a continuum of care—a tailored set of services specific to a victim's needs, often including residential care—that ensures a smooth transition from identification to services to a successful transition to independence.<sup>67</sup>

## 1.3 Licensing Constraints

Licensing restrictions can effectively prevent victims classified as non-qualifying youth from gaining access to a residential facility and the programs provided within it. Licensing may present age and gender restrictions, limitations on length of services and requirements around the number of children served. All of these components should be considered when a service provider chooses the type of license required.<sup>68</sup>

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<sup>66</sup> National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

<sup>67</sup> Responses from Georgia Care Connection to the National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

<sup>68</sup> Remarks by Kellie Armstrong, Shelter Development Consultant at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

**“We need to be educating the licensers just like we’re educating everybody else about these programs... Part of what we’re looking at here is it doesn’t attach to a boarding school or a mental health and that’s going to be part of our advocacy.”**

–Dennis Morrow, Janus Youth Programs, Inc.

Current state agency licensing regulations may impose barriers to creation of or access to programs that promote the most constructive environment for providing services to DMST victims because traditional licensing models designed for services to youth are often not informed by the specific needs of DMST victims. For instance, a child in foster care may not be able to receive services from a transitional living program because a runaway and homeless youth licensed program cannot serve a child that is in child welfare custody.<sup>69</sup> Additionally, in some states referring agencies require specific residential licenses for victim referral, blocking DMST-specific shelters with different types of licenses from providing services.<sup>70</sup> Several other providers surveyed noted frustration with the inability to incorporate qualified sex trafficking survivors as staff because of hiring restrictions related to their previous criminal convictions.<sup>71</sup>

A working understanding of the licensing process and strong relationship with the licensing authority may help overcome some of these barriers.<sup>72</sup> Some licensing restrictions are state law, some are code and some parameters are departmental policy. There may be opportunities to amend or waive departmental policy through contractual agreements.<sup>73</sup>

## 1.4 Licensing Acquisition

At least one staff member at a residential facility must have a working knowledge of the child welfare agency’s guidelines and policy.<sup>74</sup> The process for obtaining a residential license can be tedious, costly and complicated. One provider responding to the National Colloquium Provider Survey described its administrative licensing paperwork to be in excess of 800 pages.<sup>75</sup> A missing stairwell, incorrect square footage, inadequate staff credentials or outdated heating system may be the difference between a facility being approved or denied for a license.<sup>76</sup>

69 Remarks by Melinda Giovengo, PhD, YouthCare, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

70 Remarks by Emily Fitchpatrick, Hope House, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

71 Id.

72 Remarks by Kellie Armstrong, Shelter Development Consultant, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

73 Remarks by Kellie Armstrong, Shelter Development Consultant and Dennis Morrow, Janus Youth Programs, Inc., at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

74 Remarks by Kellie Armstrong, Shelter Development Consultant and Melinda Giovengo, PhD, YouthCare, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

75 Response from Courage House, National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

76 Remarks by Jean Caceres Gonzalez, The Garden at His House, Emily Fitchpatrick, Hope House and Tina Frundt, Courtney’s House, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

Preparing a facility for residential licensing requires significant capital costs for hiring staff and preparing the facility.<sup>77</sup> For instance, if a license requires the facility have the capacity to serve at least six children, there must be enough staff and physical capacity to accommodate six children, even if there are fewer than six in the program. With this model, especially if funding is reliant on a per diem reimbursement, a program may not be able to meet funding requirements if it is not operating at capacity.<sup>78</sup>

**“If you want to go out and open up a hospital, a medical doctor is not necessarily the person you need. There’s a specialty for that. The same thing is true within child welfare and social work. You have clinicians and therapists that can provide excellent treatment, but are not trained or credentialed in opening or operating a residential program. Childcare licensing is a distinct field and partnering with an agency or individual that has this expertise will save you months and months of time, money, and headaches.”**

-Kellie Armstrong, DMST Shelter Consultant

Successful models exist despite these challenges. Residential facilities can be found as stand-alone, nongovernmental or faith-based shelters. They can also be found integrated within the child welfare residential treatment facilities, group homes or foster home structures. Residential facilities might also be created within the juvenile justice system, carving out part of the juvenile detention facility to specialize in providing shelter and services to survivors of DMST placed in detention.

Several programs specialized in serving DMST victims partnered with established licensed residential facilities to create their programs.<sup>79</sup> An organization that has specific knowledge in providing services to DMST victims can in turn, contribute specialized program components to an organization that already has the expertise around staffing and licensing requirements.<sup>80</sup>

77 Remarks by Tina Frundt, Courtney’s House, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

78 Remarks by Kellie Armstrong, Shelter Development Consultant and Kaffie McCullough, youthSpark, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

79 Remarks by Kaffie McCullough, youthSpark, Kellie Armstrong, Shelter Development Consultant, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012. National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

80 Remarks by Marlene Carson, Rahab’s Hideaway, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.



## 2. Maintaining Facilities

An ongoing program strategy should be maintained and updated to ensure long-term success.

Once a residential program is established there are several important components to maintaining the facility such as engaging youth in the program and maintaining funding resources and community relationships.

### 2.1 Government Contracts

To receive government funding a provider must develop a funding contract with the state, city or county in which they are located. These contracts come with their own set of requirements beyond the licensing regulations such as deliverable expectations, policy requirements and requirements related to vocational and therapeutic programming.<sup>81</sup> Again, not all state agencies have requirements tailored to serve DMST survivors so it is important to work with the licensing agency to navigate barriers or contract requirements that may not be appropriate for serving DMST victims.<sup>82</sup> For instance, funding through government contracts is usually time restricted, although providers agree that services for DMST victims usually take longer than a traditional three to six month residential program.<sup>83</sup> Providers should look for other resources and staff or mentorship commitment to work with DMST victims outside of time restrictions imposed by the funding source.

Although there are noted barriers, licensing contracts provide important guidance and direction to providers. Many well intentioned organizations want to create programs for sex trafficked youth, and licensing guidelines ensure that they have the qualifications to provide safe and appropriate care.

From the outset, providers and state agencies should have realistic expectations of required outcomes in residential licensing contracts to avoid setting programs up for failure.<sup>84</sup> Relationships with licensing and contracting authorities should remain consistent and transparent.<sup>85</sup> Service providers and state agencies are learning from each other the best processes for providing shelter and services to identified DMST survivors. Ten years ago in this country there were only a handful of organizations providing services targeted to DMST victims, so some licensing authorities may simply not have knowledge concerning the most appropriate approach to serving this population.<sup>86</sup>

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81 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012, Response from Mission 21.

82 Remarks by Kellie Armstrong, Shelter Development Consultant, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

83 Remarks by Kaffie McCullough, youthSpark, and Deepa Patel, Multicultural Clinical Center, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

84 Remarks by Kellie Armstrong, Shelter Development Consultant at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

85 Remarks by Jean Caceres Gonzalez, The Garden at His House at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

86 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012

**“So I think that I get cautious about just throwing out the standards because there are a lot of folks out there that would really like to do good work with these kids and to me it’s a re-victimization if we can go too far that way.”**

–Dennis Morrow, Janus Youth Programs, Inc.

## 2.2 Referrals and Participation

Even with the identified need for more appropriate placement options for DMST victims, some currently remain below capacity and have challenges receiving referrals at all. Only 17% of respondents to the National Colloquium Provider Survey indicated they had a waiting list for services. Maintaining a solid relationship with the community, earning the trust of first line responders who make placements, and reliably providing the appropriate services can help overcome these barriers. Respondents also noted that outreach to juvenile justice centers and child welfare agencies may help transition youth into programs.<sup>87</sup>

Once in a program, peer motivation, stipend programs, rewards for participation, staff relationships, opportunity to participate in events and recreational activities may encourage the youth to stay engaged in a program.<sup>88</sup> Sixty-five community-based programs surveyed reported that they operate with an attendance requirement. Awards or graduation programs were listed as incentives that encourage continued participation as was an underlying theme of trust, mentorship and support conveyed by the staff.

## 2.3 Staff Dynamics and Preparedness

**“People connect to people, not programs.”**

–Rachel Lloyd, GEMS

Staff training and preparedness are critical when responding to DMST survivors.<sup>89</sup> Staff should have familiarity with the complex trauma experienced by trafficked youth and be provided with introductory and ongoing training in the area.<sup>90</sup> Staff should understand that if a child or young adult in a DMST program “lashes out,” it is often in response to his or her own trauma, and not in response to the staff

<sup>87</sup> National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

<sup>88</sup> Id.

<sup>89</sup> Remarks by Mary Frances Bowley, Wellspring Living Melinda Giovengo, PhD, Youth Care and Courtney Gaskins, PhD, Youth For Tomorrow at the National Colloquium: Shelter and Services Evaluation for Action, November 2012. National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

<sup>90</sup> Remarks by Courtney Gaskins, PhD, Youth For Tomorrow at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

member.<sup>91</sup> In addition, staff should be trained in and have a working knowledge of the youth's background and culture. For example, when working with gang trafficked youth, staff should have an understanding of gang dynamics.<sup>92</sup> However, training alone may not be adequate in quality care; hiring the right people must be part of the process. Even highly accredited professionals with relevant experience in working with sexually abused and vulnerable youth indicated that when first developing DMST-specific programs, they simply were not prepared for the complex needs and trauma response of DMST survivors. It is important that all staff, including teachers, house staff and volunteers, receive training in the manifestations of trauma and practice in trauma-informed care.<sup>93</sup> The staff should also have a passion and desire to learn about the dynamics of working with DMST victims.<sup>94</sup>

Staff should be prepared for potential vicarious and secondary trauma that can result from working with DMST survivors. This potential may be greater for program staff who are survivors of traumas, particularly sex trafficking. Although nurturing relationships are a key component in providing quality care to DMST victims, programs should also prioritize the importance of boundary setting. Several programs serving DMST victims provide therapy for program staff.<sup>95</sup>

**“... In every other form of child abuse everyone looks at the victim as a victim and they feel appropriately empathetic and sympathetic. But in this form of child abuse, we have to continue to do staff training even in medical settings, just simply because people have preconceived biases that require a great deal of demystification, I call it demystification.”**

– Dr. Sharon Cooper, Developmental & Forensic Pediatrics, PA,  
University of North Carolina Chapel Hill

91 Remarks by Melinda Giovengo, PhD, Youth Care at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

92 Remarks by Deepa Patel, Multicultural Clinical Center at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

93 Remarks by Mary Frances Bowley, Wellspring Living Courtney Gaskins, PhD, Youth For Tomorrow Melinda Giovengo, PhD, Youth Care at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

94 Remarks by Deepa Patel, Multicultural Clinical Center at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

95 Remarks by Mary Frances Bowley, Wellspring Living and Courtney Gaskins, PhD, Youth For Tomorrow at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

### 2.3.1 Survivor Informed/Survivor Led

Although most DMST programs make an effort to provide survivor informed care to DMST victims, there is not a general consensus regarding the role of survivors in providing restorative services within programs.

Twenty eight percent of National Colloquium Provider Survey respondents prioritized having survivors on staff; 7% discouraged having survivors on staff.<sup>96</sup>

If survivor leadership is prioritized or is a component of program development, the survivor should feel confident, and the staff should take care to evaluate whether that individual is in a healthy place to serve in a leadership role. Not all survivors want to tell their story or work on this issue. Survivors working in sex trafficking restorative programs should be prepared and self-motivated,<sup>97</sup> and staff leadership should take care to determine what readiness looks like. Providers surveyed for the National Colloquium noted several specific policies regarding survivors including: mandatory survivor roles on board or staff, survivor staff having been a certain number of years out of the life (ranging from 1-5) and required counseling for survivor staff before working with victims.<sup>98</sup>

Because survivors may have criminal records as a result of their trafficking exploitation, it is also important to know the restrictions and limitations that a criminal record and sex offender registration requirement may impose on employment of an encumbered survivor.<sup>99</sup>

Survivors who are part of program staff can serve as effective role models, demonstrating to DMST victims that individuals who have shared experiences have the ability to overcome and thrive after exploitation. In addition, providing survivors with staff positions offers them viable economic opportunities as they transition to independence and adulthood.<sup>100</sup>

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96 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

97 Remarks by Tina Frundt, Courtney's House at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

98 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

99 Remarks by Mary Frances Bowley, Wellspring Living and Melinda Giovengo, PhD, Youth Care at the National Colloquium: Shelter and Services Evaluation for Action, November 2012. National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

100 Remarks by Rachel Lloyd, GEMS at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

## Recommendations:

1. Licensing agencies should review and amend or enact regulations as necessary to alleviate barriers or restraints that may dissuade or prevent service and shelter providers from serving particular youth.
2. Licenses must be made available for all types of congregate care facilities to meet the diverse needs of the DMST victim population. This includes emergency, restorative, long term and transitional housing.
3. Providers need to work closely with licensing authorities to establish realistic licensing and funding contracts for populations served. License parameters often prohibit or fail to encompass vital components of a DMST treatment program, e.g., survivor mentors may be prohibited from serving on staff if they have a criminal record; license may not include the ability to attach to other necessary supports such as education or mental health resources.
4. Laws that mandate, establish and financially support residential and community-based programs providing treatment and case management for DMST victims across the continuum of care are needed. Service providers are challenged with effective case management when clients are ordered to inappropriate placements, such as ill-equipped foster care, group homes and detention facilities, or they are returned to unsafe home environments.
5. Service providers who consider offering residential services should engage an individual that has expertise in the regulatory and compliance aspects of licensing. Residential services providers must have staff who are knowledgeable about the state and local child welfare and juvenile justice policies and practices.



## > Chapter 3

### Funding

**“The enormity of this issue requires an equally enormous response of committed resources and action. Child sex trafficking is one of humanity’s greatest forms of violence.”**

—Lee Roper-Batker, Women’s Foundation of Minnesota

Services must have committed, sustainable funding to ensure consistent and quality care to youth recovering from trauma associated with sex trafficking. This can be a very expensive process and achievable deliverables are challenging to define. In a survey distributed to expert funding and advocacy organizations in preparation for the National Colloquium, 100% of respondents listed funding or lack of resources as the biggest barrier to adequate shelter and services provision to DMST victims.<sup>101</sup>

Shrinking this gap will require unprecedented cooperation amongst governments at various levels and the private sector. Philanthropic investments must prioritize restorative services for DMST victims and survivors; federal and state legislation is needed to generate more funding mechanisms and push existing infrastructure responses; state, federal and local funding agencies must continue to develop policy requirements that encompass DMST-specialized restorative services and shelter. At the same time providers need to develop methods to reduce costs while maintaining the integrity of programs tailored to address the complex restorative needs of DMST victims. No one approach is the right one; we need all of them.

**“Everyone deserves the same opportunity to succeed. What should determine services is what they NEED help with...If we limit the services, we limit their healing process. They’ve been imprisoned enough! It’s time to set them free!”**

—Anna Beard, Survivor Survey

101 National Colloquium: Shelter and Services Evaluation for Action Provider Advocacy and Funding Organization Expert Survey, November 2012.

## 1. Cost of Programs

One of the most critical components in establishing services is identifying and securing funds to pay for the program. Both a capital budget and operating budget must be developed and secured before a program is launched.

### 1.1 Capital Costs

Raising capital is the first step in establishing shelter and services for DMST-specific restorative programs. Capital expenses include costs associated with securing a venue and facility, preparing it for operation, hiring staff, etc. For residential services, capital needs to be raised to prepare both facility and staff to meet qualifications for licensure.<sup>102</sup> Some of these expenses may be mitigated if a program is structured within a larger youth serving organization that already has the appropriate space, trained staff and appropriate licensure. Practitioners delivering residential services to DMST victims who responded to a survey in preparation for the National Colloquium saw varying capital fundraising costs ranging from \$250,000 for a 1-year pilot to \$4 million. Capital costs for residential providers tended to be much higher than community-based providers that listed capital costs ranging from \$2,100 to \$350,000.<sup>103</sup>

### 1.2 Operating Budget

It is imperative for shelter and services programs to have a sustainable operating budget, with enough funding reserves and diversified funding mechanisms. The range of responses regarding operating costs to the National Colloquium Provider Survey made it difficult to determine the cost of a child served. Annual costs listed per child in a residential facility ranged from \$24,000–\$50,000.

Operating budgets include staff salary, supplies, basic needs, utilities and repair costs. Seventy-eight percent of licensed providers surveyed for the National Colloquium indicated that employment and staffing requirements went beyond traditional child welfare requirement.<sup>104</sup>

**“When I went to this county and I went to open up this program and said you have to get me two deals. One: you have to give me enough to run it for a year ..., and secondly: you can’t give it to me for one year and then take it away from me the next year because these girls have already lost too much.”**

—Dennis Morrow, Janus Youth Programs, Inc.

<sup>102</sup> Remarks by Tina Frundt, Courtney’s House, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

<sup>103</sup> National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

<sup>104</sup> Id.



## 2. Available Resources

Providers surveyed in the National Colloquium Provider Survey listed various funding mechanisms for their programs which included funding from the Office of Refugee Resettlement, county juvenile probation contracts, state child welfare contracts, Runaway and Homeless Youth Departments, Office of Violence Against Women, State Governor's Office, Office of Victims of Crime (OVC), Office on Violence Against Women (OVW) and Victims of Crime Act (VOCA) along with traditional forms of fundraising within the private sector. Considering how expensive restorative programs for DMST victims can be, priority must be given to identifying sustainable resources.

Organizations that are solely privately funded may have challenges when accepting government referrals while organizations that are under government contracts may be unable to accept victims that do not have a source of funding associated with their placement. Diversifying funds and maintaining relationships with a variety of funding stakeholders is critical to fiscal sustainability.<sup>105</sup> Braided funding from federal, state, local and private sources is a fiscal strategy that has been implemented by several organizations. This can be achieved through contracts with the facility or through actual funding streams associated with the placement following the individual as opposed to the program. In addition, a trending approach involves tailoring existing programs with established funding to be DMST-specific.<sup>106</sup>

**“The most important thing is that you have an ongoing relationship with all the different entities that are funding, that are working towards solving an issue. And you keep that relationship cherished.”**

—Alex Trouteaud, Harold and Kayrita Anderson Family Foundation

### 2.1 Government Funding

**“It is not inaccurate to say that one role of the federal government is to prioritize issues, to make decisions on behalf of the nation, and to act broadly in creating better policies and affecting systems’ change... the federal government cannot and should not shoulder this burden alone... NGOs like Breaking Free must partner at every level, spreading awareness and cultivating support with public and private partners to affect sustainable, systematic change.”**

—Vednita Carter, Breaking Free

105 Remarks by Alex Trouteaud, Harold and Kayrita Anderson Family Foundation, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

106 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

Government contracts from federal, state and local resources may be available to qualified providers.<sup>107</sup> For residential services, programs must be licensed to enter into a government funding contract. Government grants and issuing agencies are also limited by their own funding allocations. To maximize impact of limited dollars, government agencies must be strategic with what programs they fund and ensure that they meet certain deliverables to justify grant allocations. This makes bids for government grant dollars very competitive.<sup>108</sup> Sixty-four percent of providers responding to the National Colloquium Provider Survey received funding through government sources including contracts with state child welfare agencies, county juvenile probation, city runaway and homeless youth funding, state governor's office, Federal Office for Victims of Crime/ Federal Victims of Crime Act and the Office of Refugee Resettlement.<sup>109</sup>



According to the Interstate Compact for Juveniles, both the sending and receiving states have the authority to enforce terms and conditions of probation and parole. The receiving state has the responsibility of ensuring that the juvenile receives any treatment services ordered, but if they are not available through an agency of the receiving state, the sending state must pay for them.

*Interstate Compact for Juveniles (ICJ) of 1955, revised 2008. <http://www.juvenilecompact.org/>. All fifty states, the District of Columbia, Guam, and the Virgin Islands are participants in this compact.*

Identifying funding resources is not only a challenge to providers, but also to first line responders searching for appropriate placement for DMST victims. Because dedicated funding for DMST restoration programs is limited, it may be difficult to identify what agency or state is responsible for funding the victim's care.<sup>110</sup> If a child is in another state's custody rather than the state in which he or she was identified for services, the state agency of residence may be unable or unwilling to pay for the recommended services.<sup>111</sup> In addition, if a youth is receiving services under the custody of one state agency, they may not be able to receive funding and services from another program because this would be interpreted as "double-dipping."<sup>112</sup>

Many government contracts provide funding reimbursements on a per diem basis from an entity such as Medicaid, reinforcing the need for both supplemental funding and funding reserves. Per diem funding mechanisms are challenging for organizations that are in the process of establishing programs and problematic for program participants that may run away and therefore receive care intermittently.<sup>113</sup>

Fortunately, more and more state legislation includes line item budget for services and shelter.

107 See Appendix D for U.S. Government agency reports.

108 Remarks by Joye Frost, U.S. Department of Justice, Office for Victims of Crimes at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

109 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.

110 Remarks by Renee Murrell, FBI Victim Witness Specialist, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

111 Id.

112 Remarks by Melissa Snow, TurnAround, Inc., at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

113 Remarks Dennis Morrow, Janus Youth Programs, Inc., at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

**“The Crime Victims Fund is not made of taxpayer dollars; it’s fines, penalties and assessments from convicted federal offenders. The amount of funding in the fund is not inconsequential. We don’t have unfettered access to it, but it certainly goes a long way towards providing services to crime victims in this country and, increasingly, victims of human trafficking.”**

—Joye Frost, Principal Deputy Director, Office for Victims of Crimes,  
U.S. Department of Justice

## 2.2 Private Funding

Private funding, from groups like corporations, foundations, individuals or the faith community, may present fewer restrictions or requirements for oversight than with traditional government funding depending on the source. Foundations may choose to fund research or advocacy that can help encourage the government to put more dollars into restorative programs for DMST victims<sup>114</sup> or they may be able to provide some of the capital costs to meet government funding requirements.<sup>115</sup> Additionally, private grants can meet needs that may not qualify for traditional government contracts including additional staff, training and programmatic resources. Sources of private funds include family foundations, public foundations, corporations or corporate foundations, faith communities and individual donors.

While philanthropic funders sometimes have specific expected deliverables and reporting requirements similar to government funding, they tend to have greater flexibility to tailor funding to a specific program. Some private grants are unrestricted, and can be put towards overhead or any other need prioritized by the provider.

DMST restorative care is certainly a developing field and lack of empirical evidence and longitudinal data make it difficult to define best practices. Only five respondents to the National Colloquium Provider Survey have been open for more than ten years; over 75% have been open for less than five years. New information regarding the most effective approaches in the field is still being developed often refining the definition of a successful outcomes. Data needs to be methodically gathered as a critical component to service expansion. Funding must be available throughout the process as organizations strive to create the best models to provide care. During this learning process, private funding sources can play a strong role in development as best approaches are formulated.<sup>116</sup>

114 Remarks by Alex Trouteaud, PhD, Harold and Kayrita Anderson Family Foundation, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

115 Remarks by Lee Roper-Batker, Women’s Foundation of Minnesota, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

116 Remarks by Alex Trouteaud, PhD, Harold and Kayrita Anderson Family Foundation, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

When providing services, programs must have enough capital and committed funds to ensure ongoing financial viability, even if deliverables are not immediate. If a program closes during a survivor's recovery, it could have detrimental effects on that victim already struggling to overcome instability.<sup>117</sup> With proper licensing a residential shelter may choose the option to be completely privately funded, allowing for a greater level of flexibility in service provision. Philanthropic funders and providers should work together and educate each other to create the most strategic and targeted funding agreements.

## 2.3 Public-Private Partnerships

**“A private investment can provide the platform to prepare an organization to receive government funding.”**

—Vednita Carter, Breaking Free

Braiding of government, state and local funding along with private funding resources may help offer a more sustainable and comprehensive solution to providing care. Because of the complex needs of DMST victims, braided funds can provide for more well-rounded and comprehensive services. City and county may be able to allocate funds in a way that is not as restricted as state funding mechanisms, and federal funds can help mitigate the limitations of state budgets. Private sources can also be used to fund more exploratory costs.

Government contracts ensure a level of oversight and sustainability. Also, while no funding is guaranteed, government funding once approved and braided with private funds provides a safety net if there is a shift in a funding source.

**“Because there’s a lot of instances where, a lot of challenges within the funding community that need to be addressed that maybe aren’t the right types of places for government to step up right off the bat. For example, if we’re looking at something new, something unproven, something with a high probability of failure, something that you may not want to take credit for if it doesn’t work out the way you want... That’s a great role for a private philanthropist or a group of philanthropists maybe to get together to fund.”**

—Alex Trouteaud, PhD, Harold and Kayrita Anderson Family Foundation

117 Remarks by Dennis Morrow, Janus Youth Programs, Inc., at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

### 3. Identifying Realistic Deliverables

**“And as society’s understanding of human trafficking has matured and evolved, so has OVC’s strategy to take care of human trafficking victims.”**

—Joye Frost, Principal Deputy Director, U.S. Department of Justice,  
Office for Victims of Crime

Traditionally government funding requires statistics on certain deliverables such as number of individuals served, success rates defined by completion of the program, high school graduation and reduced recidivism to juvenile justice or child protective services. There is also an increased focus in private philanthropy on the requirement for specific reporting of programs and deliverables within their funding mechanisms.

The funding community requires quantifiable and measurable data to meet strategic goals, but providers often talk about the importance of success through incremental changes in a long-term process. Organizations are beginning to develop models to meet this gap. GEMS in New York and Kristi House in Florida use a “stages of change” model, where they are actually able to measure pre-contemplative and contemplative preparation. However, documenting this type of abstract change is costly and time consuming.<sup>118</sup>

Defining success within a program can be difficult. It is important that funders understand the nature of the healing process for commercially sexually exploited children. The healing process often takes longer, and the deliverables may look different. Not all victims who receive services proceed through restoration: quantifying victims served may not equal those restored.

**“It takes a lot of energy to do that. But I think we can begin to shift funders in recognizing the value and the quality of love and heart and compassion and the sense of community. And those things don’t always translate well in a government proposal, but I think we have to start pushing people to actually. There’s the status quo and it’s set up the way it is, but we know what works and we need to start pushing the folks who fund what works to get on board.”**

—Rachel Lloyd, GEMS

118 Remarks by Rachel Lloyd, GEMS, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

## Recommendations

1. Donors and the general public must be educated on the issue of juvenile sex trafficking as distinct from other social problems affecting minors and why it deserves attention and funding. Such education must come from many sectors of society including providers, law enforcement, advocates and the concerned public.
2. Potential funders must be led to understand why services for DMST victims tend to be expensive due to the complex and often lengthy healing process.
3. Shelter and Services providers should identify realistic, quantifiable deliverables to encourage funding streams and prove good stewardships to donors.
4. Shelter and Services providers must diversify funding. Relying solely on government reimbursements or one major funder does not ensure secure sustainable funding.
5. When securing funding to support placement for identified youth, utilizing or braiding funds from several sources can help ensure the highest quality and most appropriate care, alleviating the burden of settling for what the individual can afford.
6. Residential services providers must have staff who are knowledgeable about the state and local child welfare and juvenile justice policies and practices. If government contracts provide funding for the services, this knowledge can leverage and enhance these revenue streams.

## > Chapter 4

### Therapeutic/Programmatic Responses

Programs for sex trafficked youth must address immediate physical and mental health needs while empowering them to grow and thrive. Because of the complexity of the trauma incurred during a trafficking situation, these programs may look different from traditional programmatic responses to child abuse. Providers with established restorative programs geared toward sexually abused and neglected youth acknowledge that traditional program responses may not be adequate to address the complex trauma recovery needs of DMST victims.<sup>119</sup> It is critical that therapeutic services designed for DMST victims simultaneously provide trauma-focused therapy for the child while focusing on his or her unique resiliencies.

Lacking a strong evidence-based model for therapeutic interventions focused on DMST victims and survivors or DMST-specific longitudinal research, it is impossible to categorically enumerate best practices within programmatic responses. However, there are several important constructs that must be incorporated into restorative programs for trafficked youth.

**“...it is the program that keeps me up at night. It is the program that worries me the most. It is the program that is the highest liability for my agency and we serve over 2,500 young people a year.”**

—Melinda Giovengo, PhD, YouthCare

#### 1. Victim-Centered Approach

**“There’s no cookie-cutter [approach], these children are individuals.”**

—Courtney Gaskins, PhD, Youth For Tomorrow

Programs and program staff must understand that DMST victims, while recovering from trauma, are not wholly defined by that trauma. DMST victims come into programs with a host of previous experiences, including but not limited to: gang affiliation, substance abuse issues, familial abuse and unique social and cultural considerations. How the child was trafficked—familial trafficking, gang control, pimp control or

119 National Colloquium: Shelter and Services Evaluation for Action, Therapeutic and Programmatic Responses Panel Discussion, November 2012. National Colloquium Practitioners Working Group Meeting, July 2012.

survival sex—may determine how a youth presents and the response required.<sup>120</sup> While DMST-specific programs allow a safe space to address a very unique and complex trauma, these programs should also be developed to meet the needs of individual children who will present individual needs.

**“So that we will not look at these children as a one-time, you’ve just dropped into my clinic and your life started when you ran away from home. But instead we will try to provide very, very thorough comprehensive care in addition to all the forensic work...”**

—Dr. Sharon Cooper, Developmental & Forensic Pediatrics,  
University of North Carolina Chapel Hill

## 1.1 Age/Developmentally Appropriate

Programs designed for DMST victims should be age and developmentally appropriate. Program staff must understand the unique developmental stages of these children and young adults, and clinicians must assist them by providing services that meet the specific cognitive, social, and emotional needs of these youth.

A program that has been developed for trafficked adults may not be appropriate for trafficked youth, and must be tailored accordingly.<sup>121</sup> In fact, a program may look very different for children 11–15 years of age than those 16–20.<sup>122</sup> Children that have been victimized through sex trafficking often present as more mature, and it can often be challenging for staff and caregivers to remember that the individual served is a child, one who is recovering from a unique and devastating form of trauma.<sup>123</sup>

Programs should provide the youth with opportunities to engage in age appropriate experiences that they may have missed due to their abuse and may have to account for the uneven maturation of DMST survivors.

## 1.2 Cultural Competence

**“For the girls that we work with, culture is our strength. Reconnecting them with their culture, with their tribe. Getting them to understand who they are as native women.”**

—Suzanne Koeplinger, Minnesota Indian Women’s Resource Center

120 Remarks by Tina Frundt, Courtney’s House, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

121 Remarks by Mary Frances Bowley, Wellspring Living, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

122 Remarks by Suzanne Koeplinger, Minnesota Indian Women’s Resource Center, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

123 Remarks by Dr. Sharon Cooper, PhD Developmental & Forensic Pediatrics, University of North Carolina Chapel Hill and Melinda Giovengo, PhD, YouthCare, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.



Cultural competence is an important aspect of successful treatment when working with DMST victims. Service providers must acknowledge the individual cultural and ethnic backgrounds of the youth they serve and be willing to become educated about various cultural practices.<sup>124</sup> Many service providers emphasized the importance of hiring staff members of the same race, gender or cultural histories as the youth in the program.<sup>125</sup> In addition, staff need to be sensitized to phenomena not traditionally seen as culture, such as gang family. Young women who have been trafficked into the sex trade through gang affiliations will often retain those connections; therefore, service providers who work with gang-affiliated youth must have an understanding of gang cultural practices.<sup>126</sup>

Staff members who understand the culture of the youth they serve and their history will be effective at reinforcing trust, safety, security and nurture within the program.

### 1.3 Gender Considerations

There is no consensus within community-based service providers on the appropriateness of DMST programs being gender specific throughout the treatment process. However, there is agreement amongst those with residential programs that at least part of the programming must be gender specific. In addition, safety concerns in residential treatment encourage gender separation, a principle that also extends to staff.

Mixed gender programs may provide a normalizing experience<sup>127</sup> while gender specific programs can nurture brotherhood or sisterhood and gender strengths within the program. A gender specific program may nurture a sense of safety and security.<sup>128</sup> On the other hand, because boys and girls may be trafficked together, a gender-integrated program may reflect a reality that creates honest dialogue within the program.<sup>129</sup>

Of organizations surveyed for the National Colloquium, none had programs exclusively for boys; 36% were female only, 6% were male and female, and 58% provided services for males, females and transgender youth.<sup>130</sup>

### 1.4 Family Considerations

When providing restorative services to DMST victims, the client's family dynamic must be considered. Housing, family structure, stability and safety are critical factors in tailoring treatment to achieve successful program independence. Parents or caregivers may not understand the victimization the child has endured, and may view the trafficking as a result of the child's "bad behavior." A young trafficking victim returning to an environment with no plan in place for ongoing education is at far greater risk of re-victimization.<sup>131</sup>

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124 Remarks by Patel Deepa Patel Clinical, Multicultural Clinical Center, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

125 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.

126 Remarks by Deepa Patel, Multicultural Clinical Center, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

127 Remarks by Tina Frundt, Courtney's House, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

128 Remarks by Rachel Lloyd, GEMS, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

129 Remarks by Tina Frundt, Courtney's House, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

130 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

131 TurnAround, Inc. Response, National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

Moreover, a youth entering a treatment program from a home environment in which he or she was victimized may require therapeutic interventions that focus on reshaping family dynamics.<sup>132</sup> In any case, it is necessary for child welfare to assess the survivor's home environment as a possible contributory factor in the youth's running away or victimization.<sup>133</sup>

**“When I was younger I got arrested for being a runaway child. I was placed back in the home where I was being trafficked.”**

—Ashley Cacho, National Colloquium Survivor Survey

Eighty-four percent of service provider survey respondents incorporate training or therapy for family members, particularly parents or guardians, as part of their programs. Several of the responding organizations not currently providing family focused services expressed a desire to do so if capacity would allow. However, it was noted that engaging family in the recovery process can often be a challenge, and can even prove to be a barrier to long-term success in cases where the family is unsupportive or has played a role in the abuse.<sup>134</sup>

In the specific instance of gang controlled trafficking, the close tie to the gang family must be considered, though of course that family will not be involved in a therapeutic intervention. DMST victims that are part of a gang must have supportive contact with resources that don't threaten that it is “either-or.”

**“They want to go out there and build something, let them build something. They want to paint, fine. Do it. But you build on those things without dropping out their family. That's extremely important for us.”**

—Deepa Patel, Multicultural Clinical Center

## 2. Trauma-informed

Services developed for DMST victims must be informed on how trauma presents, and how to respond to the unique trauma endured by DMST victims. Given the nature of trafficking and how the youth were trafficked, a “trauma bond” between the victim and trafficker typically occurs and imposes an immediate obstacle to services because the victim vigorously denies victimization.<sup>135</sup>

132 Georgia Care Connection GCCO, Mission 21 Responses, Clark County Juvenile Justice Responses, National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

133 TurnAround, Inc. Response, National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

134 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

135 See *supra* Premise 6, pg. 15.

**“In order to provide proper and necessary services it is important to address the immediate effects of their experience. From there, providers must understand the survivor’s core issue and create wrap around services based upon those issues.”**

—Anonymous, National Colloquium Survivor Survey

Trauma-informed care includes understanding the history of abuse and the role violence has played in the life of the youth.<sup>136</sup> Trauma-informed services are most effective when implemented in each aspect of a child’s recovery—educational, counseling, and familial.<sup>137</sup> Service providers must take care not to re-traumatize the youth or replicate the power hierarchy of the trafficking situation from which the survivor has been removed.<sup>138</sup> Moreover, recognizing that survivors may have had all personal agency removed, trauma-informed programs must endeavor to create new ways for DMST victims to empower themselves and acquire agency.<sup>139</sup> Respondents to the National Colloquium Survivor Survey had varied opinions as to whether services should be guided by the type of trauma the trafficking victim endured, however all respondents indicated that all survivors deserve and benefit from services tailored to their experience.<sup>140</sup>

Trauma can manifest as physical and psychological symptoms such as anxiety, panic disorder, depression, substance abuse, or stress-related illness such as body pain, stomach ache, etc., which deter their participation in the available services. DMST victims also suffer from Post-Traumatic Stress Disorder (PTSD) and Disorders of Extreme Stress Not Otherwise Specified (DESNOS) that lead to further impairments such as disassociation, aggression against self and others, affect dysregulation, and character pathology.

Miller-Karas, E. & Leitch, L.,  
*Trauma Resiliency Model* (2009).  
Trauma Resource Institute.  
Santa Fe, NM.

**“All services should be client-centered and take into consideration the individual’s history, but it is important to recognize what survivors have in common and encourage a collective response to this issue.”**

—Brooke, National Colloquium Survivor Survey

136 See *Supra* Premise 7, pg. 16.

137 Remarks by Dr. Sharon Cooper, PhD, Developmental & Forensic Pediatrics, University of North Carolina, Chapel Hill at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

138 Remarks by Rachel Lloyd, GEMS and Melinda Giovengo, PhD YouthCare, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

139 Remarks by Dr. Sharon Cooper, PhD, Developmental & Forensic Pediatrics, University of North Carolina Chapel Hill at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

140 National Colloquium: Shelter and Services Evaluation for Action Survivor Survey, November 2012.

Clinicians and all staff should have an understanding of the dynamics and practice of trauma-informed care and how to create and maintain a nurturing environment for the youth, with an understanding of coping mechanisms and trauma responses. It is also important to remember that trauma-informed treatments require more time and effort and thus may not produce immediate results.

**“Like early childhood sexual abuse, I believe that counseling for all types of sexual assaults, including statutory rape, should be included in programs for victims of child sex trafficking. Many victims have been assaulted and don’t even realize it because they have not learned about personal boundaries or positive sexual health.”**

—Holly Austin Smith, National Colloquium Survivor Survey

### 3. Strengths-based

**So, at “hello” we’re not telling them, “what you did was wrong, you don’t love your boyfriend.” We don’t do any of that. But [instead] we pull out the pieces, how smart they were. “You were so smart to throw your clothes out the window and hide them so that you could leave.”**

—Tina Frundt, Courtney’s House

As a result of concerns about behaviors that are often a response to trauma such as flight, internal recruitment, and disruptive or destructive behavior, service providers may have a tendency to implement fear-based programming that requires constant monitoring or watchfulness instead of a program that seeks to nurture and build upon strengths. While these approaches may address immediate safety concerns, they may not engender optimal therapeutic or healing outcomes if implemented without a strengths-based approach.<sup>141</sup> Programs developed to serve DMST victims should emphasize resilience, leadership opportunities, educational and vocational pursuits, reinforcement of social skills, and recognition of youth’s talents. Strengths-based programming acknowledges that survivors have the power to make choices that are conducive to healing; they are not defined solely by their experiential traumas.<sup>142</sup> Programs that incorporate community services,

<sup>141</sup> Remarks by Rachel Lloyd, GEMS at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

<sup>142</sup> Remarks by Dr. Sharon Cooper, PhD, Developmental & Forensic Pediatrics, University of North Carolina Chapel Hill at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

for example, allow DMST victims the opportunity to “feel that they are not just takers of service, but givers of service.”<sup>143</sup> It is also important to recognize that DMST victims and survivors, like all individuals, have different strengths, and programs should be flexible to encourage children to succeed in multiple areas.<sup>144</sup>

**“We need to create a culture where children are heard and their experiences honored.”**

—Margaret Howard, National Colloquium Survivor Survey

Programs, agencies and caregivers should have realistic expectations for DMST victims where successes are celebrated as opposed to unrealistic expectations that set the child or young adult up for, or focus on, failures.<sup>145</sup> The youth should also feel they have an active role in their goal setting and recovery plan. Several organizations even included the program participants in the interview process for hiring program staff, encouraging ownership of their program.<sup>146</sup>

**“Fear and liability can be a barrier to strengths-based programs.”**

—Rachel Lloyd, GEMS

## **4. Therapeutic Response**

**“Listen, believe, validate, and make sure that counseling happens.”**

—Barbara Amaya, National Colloquium Survivor Survey

One hundred percent of practitioners providing services to DMST survivors indicated in the National Colloquium Provider Survey that therapy was a critical component in the provision of restorative programs. However, several providers noted therapeutic readiness cannot be forced, but rather it is a process that must be mediated by both the clinician or staff and the youth. All of the following therapeutic approaches were listed by survey respondents as core components to therapeutic services: cognitive therapy, eye movement desensitization and reprocessing (EMDR), transcendental meditation, trauma-informed therapy, trauma focused therapy, recreational therapy, problem solving activities, anger management techniques, release

143 Remarks by Melinda Giovengo, PhD, YouthCare at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

144 Remarks by Tina Frundt, Courtney’s House and Deepa Patel, Multicultural Clinical Center at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

145 Remarks by Dr. Sharon Cooper, PhD Developmental & Forensic Pediatrics, University of North Carolina Chapel Hill at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

146 Remarks by Mary Frances Bowley, Wellspring Living and Tina Frundt, Courtney’s House at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

therapy, group therapy, individual therapy, survivor lead, gender specific group therapy, trust based relational interventions (TBRI), motivational interviewing, family therapy, art therapy, psychophysiological trauma treatment, safety and empathy based therapy, culturally sensitive therapy, yoga and equine therapy. Individual therapists also listed integrative or humanistic models that include: Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Multi-cultural/Feminist Theory, Art-based Therapy, Family Therapy, Narrative and Existential Therapy.<sup>147</sup> Among these EMDR and Trauma Focused/Trauma-informed Cognitive Behavior Therapy were predominant trends among survey respondents.<sup>148</sup>

One hundred percent of domestic trafficking survivors surveyed to inform the National Colloquium felt that counseling services were a critical part of the recovery process. Thirty-three percent of survivors (41% of DMST survivors), received services for child sexual abuse. All survivors surveyed thought these services were important, 96% listing as very important and 4% listing as moderately important. Nineteen percent of trafficking survivors surveyed (18% of DMST survivors) received counseling or services in response to rape/ sexual assault trauma. Ninety-four percent of survivors surveyed felt that this type of services is very important and 6% felt it was slightly important. Fifty-two percent of survivor respondents (47% of DMST survivors) participated in programs to build self-esteem/self-value, and all survivors surveyed felt that this component to restorative care is very important.<sup>149</sup>

While many service providers outsourced their therapy, several felt strongly that therapy should be provided in-house, ensuring that the therapy component was an intimate part of the day to day operations of the organization.<sup>150</sup>

**“Many programs say they have therapeutic services, but many aren’t clinically grounded or evidence based. In fact, much of what is offered would be considered adjunct or supportive therapy programs or activities.”**

—Dr. Rebecca Johnson, Yammer, posted December 16, 2012

## **5. Educational/ Vocational/Spiritual Program Components**

Sixty-seven percent of providers responding to the National Colloquium Provider Survey provide education on site with programs ranging from licensed schools on campus to the facilitation of independent education plans through home schooling.<sup>151</sup> Independent education plans or on site individualized tutoring provides DMST victims with educational access that may be interrupted in school settings due to the specialized

<sup>147</sup> National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

<sup>148</sup> Id.

<sup>149</sup> National Colloquium: Shelter and Services Evaluation for Action Survivor Survey, November 2012.

<sup>150</sup> Id.

<sup>151</sup> Id.

needs of many of these youth.<sup>152</sup> However, there can also be challenges within residential programs in providing education in an on-campus school setting, as some participants may be highly functioning while others have intellectual challenges that may require special considerations.<sup>153</sup>

The Georgia Care Connection in Atlanta, Georgia described youth in their program as generally being a year and a half behind in school due to truancy and poor attendance, often a result of their trafficking victimization. If a youth re-engages in a school system and is placed in a grade below peers at their age level, they may feel embarrassed and may not desire to engage in school.<sup>154</sup> It is important to note that trauma responses may present challenges in adjusting to a traditional school environment. For instance, a DMST victim may appear to present as inattentive or demonstrate symptoms of ADHD in a classroom setting, when in reality he or she is having intrusive thoughts as a result of the trauma experienced.<sup>155</sup>

Because of the educational hurdles that may face DMST victims, several programs incentivize education as part of their programs.<sup>156</sup> For example, GEMS in New York encourages girls to attend classes and workshops with monetary compensation.<sup>157</sup> This financial incentive can be the beginning of engagement for a DMST survivor who has not been raised in an environment in which education was prioritized. Several programs also provide GED prep and tutoring as part of their educational services.<sup>158</sup>

**“One day I hope to provide a scholarship for HT victims for college or grad school. I believe we have so much untapped potential beyond what happened to us.”**

—Anonymous, National Colloquium Survivor Survey

Ninety-four percent of service providers answering the National Colloquium Provider Survey emphasize life skills training or vocational training in their programming. These programs reinforce the leadership and strengths-based program dynamics, and direct children to develop healthy behaviors. These skills also make them more employable adults. Mission 21 in Minnesota points out these programs have the long-term capability of breaking the cycle of poverty.<sup>159</sup>

152 Remarks by Melinda Giovengo, PhD, YouthCare at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

153 Remarks by Courtney Gaskins PhD, Youth For Tomorrow, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

154 Response, Georgia Care Connection, National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

155 Remarks by Sharon Cooper, PhD, Developmental & Forensic Pediatrics, University of North Carolina, Chapel Hill at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

156 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

157 Remarks by Rachel Lloyd, GEMS at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

158 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

159 Id.

**“The ladies I work with are victims of lack of information on improving their situation therefor it’s harder for them to remove themselves from the environments that traffickers and sexual predators recruit. Lack of knowledge on available resources reduces hope which causes at-risk youth to become victims.”**

–Antonia “Neet” Childs

Forty-seven percent of service providers responding to the National Colloquium Provider Survey identified as faith based; 46% of organizations provide spiritual care as part of their curriculum, however the majority of these respondents suggested that participation is optional. Fourteen percent of organizations offer availability to attend worship services as part of their programming both on and off site, and 21% of organizations provide referrals to spiritual care upon request.<sup>160</sup>

## **6. Mentorship and Ongoing Relationships**

**“Success in a program breeds more success. So when girls see other girls being successful, over time that begins... positive peer culture.”**

–Rachel Lloyd, GEMS

A mentor can provide inspiration and encouragement to a survivor in a DMST program, and can also provide an ongoing support system to keep the youth connected and engaged beyond the program. If a DMST victim leaves a residential program, a mentor can often be a bridge to support and safety when facing challenges that accompany greater independence.<sup>161</sup>

Success stories, especially from an individual that has overcome a shared or similar experience to the DMST victim can encourage self-esteem and hope.<sup>162</sup>

<sup>160</sup> Id.

<sup>161</sup> Remarks by Withelma TiOra “T” Ortiz Walker Pettigrew, Human Rights Project for Girls and Melinda Giovengo, PhD, YouthCare at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

<sup>162</sup> Remarks by Deepa Patel, Multicultural Clinical Center at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.



## 7. Measuring Success/Program Completion

The ultimate goal of a DMST program is to promote the youth's "ability to have a self-sustaining life while lowering the risk of re-victimization."<sup>163</sup> Programs vary in terms of length of stay and measurement of success. National Colloquium Provider Survey respondents have programs ranging from a few days to many years depending on which particular aspect of victim recovery or restoration they endeavor to, are funded for, or are licensed to address. When survey respondents were asked what determined completion of a program, 33% listed program length, 80% listed child's wellbeing and mental state, 23% listed funding and 40% listed age. Several providers also listed there was no limit to the length of services or the length of services was determined by the desire of the client to participate.<sup>164</sup> Thirty eight percent of service providers transition youth to other programs after they turn 18. Fourteen percent will continue services to age 21-22 under certain circumstances. Two groups mentioned that they might transition a youth home if appropriate.

**“We contracted with the mainstream evaluation agency and the girls would look at the evaluation forms and go, well, this is stupid, I’m not filling this out. And so then we hired ... Dr. Alexandra Pierce, who is the author of our Shattered Hearts report, and she developed the evaluation form, and now we get good evaluation outcomes because she knows what the girls will respond to.”**

—Suzanne Koeplinger, Minnesota Indian Women's Resource Center

For programs that did have a defined end, very few had structured models for monitoring DMST survivors after program completion.

Success in a program serving DMST victims and survivors may look different than traditional restorative child abuse and neglect programs. When developing evaluation tools, there must be an understanding of the unique experiences of DMST victims and survivors.<sup>165</sup> Re-traumatization and recidivism are unfortunate realities for many DMST victims. Programs should have prepared responses if the child runs or is re-exploited. Many programs that did not have set end dates measured success through program participation and low turnover rate, because the child could return even if he or she went “back to the life.”<sup>166</sup> Service providers use a wide range of indicators to determine whether a youth has successfully transitioned to independence. The indicators range from external factors such as being connected to community support systems to more personal considerations such as displaying self-care and healthy boundaries.<sup>167</sup>

163 Response, Restore Corps, National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

164 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

165 Remarks by Suzanne Koeplinger, Minnesota Indian Women's Resource Center at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

166 Remarks by Tina Frundt, Courtney's House, Suzanne Koeplinger, Minnesota Indian Women's Resource Center and Rachel Lloyd, GEMS, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

167 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 2012.

Practitioners surveyed had varied responses when responding to the question: “How do you define success and how do you measure it?” They ranged from youth walking in the door, to graduating from a safe home or program, to not running or being involved in the juvenile justice systems or not returning to the life. Several organizations also listed therapeutic assessments throughout stages of the program, education or employment attainment and meeting planned goals.<sup>168</sup> Incremental changes should be celebrated, and there is a general understanding that achieving small goals can plant the seeds for long-term success.<sup>169</sup> However, these changes are often hard to quantify when working to meet grant requirements. As tailored shelter and services models are prioritized within DMST responses, it will be critical to monitor and evaluate programs and their long-term efficacy, but also critical that these evaluating agencies have a better understanding of the complexity and long-term needs of DMST victims and survivors.<sup>170</sup>

**“Pain didn’t happen overnight and neither will the healing.”**

—GEMS, National Service Provider Survey (in reference to the stages of change model)

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<sup>168</sup> Id.

<sup>169</sup> Remarks, National Colloquium Therapeutic and Programmatic Response Panel, 2012.

<sup>170</sup> Remarks by Rachel Lloyd, GEMS, at the National Colloquium: Shelter and Services Evaluation for Action, November 2012.

## Recommendations:

1. Age, socioeconomic status, culture, personality, and other associated factors require that each victim have tailored treatment plans. This necessitates flexible and adaptive programming. Each individual case is unique and must be treated as unique.
2. Residential facilities need to be staffed with or have regular access to medical and case professionals who can effectively assist the DMST victims through trauma-informed care. In addition, training in trauma-informed care must extend to all staff members, as well as host families or foster families that may open their homes to DMST survivors.
3. Survivors demonstrating that it is possible to overcome exploitation should be involved in and take leadership roles in programs and mentorship for sex trafficked youth. This involvement will be an example to the newly liberated survivors that they too can turn their experience into assistance for others or powerful advocacy for the cause.
4. Programming must be strengths-based and assist survivors with accessing the inherent skills, abilities and qualities of character they possess but may not recognize. Educational and vocational opportunities are critical to helping them develop their talents and interests, gain independence and be active members of their communities.
5. Treatment plans should be designed to lead to self-sufficiency, identifying services that will allow the DMST survivor to transition towards independence. Conversations and formulation of exit plans are necessary to ensure that DMST survivors understand the value of progressing towards independence.
6. Community and/or family participation is necessary to help in the ultimate success and independence of DMST survivors. Therefore, educational programs, including family counseling, to assist these support systems is imperative.
7. Service providers should offer the opportunity for the DMST survivor to have spiritual needs met as well as mental, physical and social health needs.



## > Chapter 5

### Safety and Security

Safety and security issues should be considered when planning shelter or service programs for victims of sex trafficking. Both internal and external threats exist that are inherent to the dynamics of DMST. Victims of trafficking often bring with them routines and behaviors that can be dangerous to them as well as the other program participants. Victims of DMST are often high flight risks. Traffickers can maintain control over the victim from afar and manipulate and commercially sexually exploit them, coerce their return and pressure them to recruit others. Disclosed locations of shelters and centers can lead to traffickers using them as recruiting grounds and can result in re-exploitation of the victims.

Creating a safe, nurturing environment is essential to providing services to DMST survivors. Healing is an extensive process. Several attempts to break trauma bonds and equip the youth with appropriate coping mechanisms and life skills may be needed before the youth commits to leave the cycle of exploitation. Programs must be prepared to respond to these challenges.<sup>171</sup>

**“I firmly believe the issues of power and control in relationships must be addressed. CSEC [commercially sexually exploited children] who have been sexually abused (most often by someone they know and trust) have a relational template based on betrayal and violence, which ‘normalizes’ the dynamics of exploitation.”**

—Kate Price, National Colloquium Survivor Survey

There is not a clear consensus as to what level of security is appropriate when serving trafficked youth, and there is often contention in the child advocacy field as to whether it is ever appropriate for a young person to be required to participate in restorative services. Notwithstanding the identification, referral and treatment process must be made as smooth and supportive as possible to avoid triggering a situation that would impinge upon the victim’s and program’s safety and security.<sup>172</sup>

171 Remarks by Tammy Sneed, Connecticut Child Welfare Girls Program, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

172 Remarks by Renee Murrell, FBI Victim Witness Specialist, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

**“By nature, children and teens, especially those at-risk, may not realize they are being coerced, manipulated, and misled. As a result, they are often unable to recognize that they have been victimized.”**

—Holly Smith, Author & Survivor Advocate (FVTC Training)

## 1. Safety Concerns

### 1.1 Flight Risk

There are many reasons why victims of DMST tend to be high flight risks, whether from their families, foster placements or a residential program. They have often been conditioned by the trafficker to trust no one on the outside, and the trauma bond formed from life under the trafficker’s power and control creates a fierce loyalty. Settings that provide structure and discipline quite different from the type to which they have become accustomed cause them to flee to the familiar. Simply the stress of the referral process to services once a child is identified may trigger a youth to flee.<sup>173</sup> Programs should be developed in a way that the victim sees the program as a place of refuge and healing, somewhere they want to go.

An environment of safety should not feel clinical or institutional but instead should be as close as possible to a home like environment that conveys a sense of dignity and comfort, with age appropriate furniture and décor.

“CWLA Standards of Excellence for Residential Services.” *Child Welfare League of America*. Revised Edition. (2004)

Responses to the National Colloquium Provider Survey revealed that most residential programs serving DMST victims had clients desert the program, although many noted that most of these clients had returned. Experts advise that the response to elopement from a program should be that the youth made a bad choice, not that the youth is a bad person. As in domestic violence situations, DMST victims may return to being exploited several times before committing to a healing process. By welcoming a survivor back after a departure, caregivers are able to build healthy relationships and connections to recovery programs with the ultimate goal of a firm commitment to success by the survivor.<sup>174</sup>

Nonetheless, avoiding elopement should be a top priority for all programs. When a survivor leaves a residential program without a safe and secure alternative that youth is extremely vulnerable to re-exploitation. A survivor’s sense of safety is integral to a commitment to stay in the program. Programs should not focus

<sup>173</sup> Remarks by Sandy Skelaney, Kristi House, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

<sup>174</sup> Remarks by Dennis Morrow, Janus Youth Programs, Inc., at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

solely on what happened to the youth, but rather bring a strengths-based approach to crafting a hopeful future. Streamlining the process of placement, ongoing support services and treating youth like survivors nurturing their strengths over challenges will encourage DMST victims to participate in a restorative process.<sup>175</sup>

**“They’re in school and they’re starting to be really successful... I can show you a sheet that will show you almost all of them had six to eight episodes, two or three days here, four or five days there, a month in a month out, before they finally landed.”**

—Dennis Morrow, Janus Youth Programs, Inc.

## 1.2 Internal and External Recruitment

Internal and external recruitment is a security concern for service providers. Traffickers may attempt to recruit youth as they are entering or exiting the program or residential facility. Also, recruitment by trafficked youth within restorative shelter and services programs may occur, especially when a commercially sexually exploited minor is still in contact with his or her trafficker. In these cases, a trafficking victim may attempt to convince or recruit other youth in a restorative program to join his or her stable, a term used in trafficking to describe a group of commercially sexually exploited individuals under the control of one trafficker.<sup>176</sup> Traffickers may know the location of the programs and have been known to loiter nearby to pressure the victim to recruit others in the program.<sup>177</sup> The reason for this is rooted in the trauma bond a victim has with a trafficker, which exert control over the youth even in the trafficker’s absence. The victim may be physically free from the bonds, but not mentally.<sup>178</sup> The victim has been trained through cycles of fear and love to do things that will please the trafficker; bringing in new recruits to the business will generate more money for the trafficker.

Program staff should be prepared to address internal and external recruitment with the knowledge that this behavior is a result of the youth’s trauma and trauma bonding to his or her abuser. This knowledge can shape the program rules or responses. However, for the protection of other youth receiving services, some programs have adopted a policy making internal recruitment grounds for dismissal from a program. A victim who has recruited another youth within a program may face barriers to entry into other programs.<sup>179</sup>

175 Remarks by Renee Murrell, FBI Victim Witness Specialist, and Mary Frances Bowley, Wellspring Living, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

176 National Colloquium Placement Panel, November 30, 2012.

177 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.

178 Remarks by Trina Lyles, Young Women’s Facility of Maryland, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

179 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.

## 1.3 Violence and Self Harm

The chronic nature of violence associated with DMST, and the effects of previously experienced abuse that is so common among sex trafficked youth often brings about neurological disruption. The result is a chronic state of nervous system arousal known as hyper-arousal which presents with symptoms such as anger, panic and phobias, irritability, hyperactivity, frequent crying and temper tantrums, night terrors, regressive behavior, increase in clinging behavior and running away. Especially in the case of prolonged trauma which is consistent with the type of abuse DMST victims experience, many DMST victims may be diagnosed with “Disorders of Extreme Stress Not Otherwise Specified” (DESNOS), which symptoms include, but are not limited to, self-destructive behavior and aggression towards others.<sup>180</sup>

Many programs listed violent behavior and suicidal tendency as a reason to deny services. If a program does not have the licensing requirements or capacity to respond appropriately to these frequent behaviors, the program should refer the victim to one equipped to meet these specific clinical needs.

## 2. Security Measures

### 2.1 Geography

Several providers recommend running restorative shelter programs in rural or residential environments as a way to provide security. Geographically secure shelters are harder to access or find by individuals who might want to harm the victim, especially the trafficker. A geographically secure shelter could minimize a survivor’s flight risk as the youth is removed from potential triggers and the shelter’s remote location makes it difficult.<sup>181</sup> Forty-seven percent of organizations responding to the National Colloquium Provider Survey felt that DMST victims should be removed from the geographic area of their victimization to avoid trauma triggers and protect against traffickers or others that may have been involved in the trafficking of the youth. On the other hand, several service providers noted surprise at how many children still run away from geographically secure settings.<sup>182</sup> Forty-two percent of respondents felt that this should be decided on a case by case basis, while 11% of respondents did not think victims should be removed from the area of their victimization.

Thirty-eight percent of provider respondents are located in rural areas and suggested that shelters located in rural areas may reduce flight risks of youth served. However, some providers noted that rural environments pose the challenge of disconnection from referral services. One organization previously located in a rural area indicated that staff felt unsafe “being in the middle of nowhere” and the shelter has since relocated to an urban area.<sup>183</sup> Sixty-five percent of programs are located in urban environments and indicated that it is more feasible to access resources in urban areas and that provide greater accessibility to service referrals.

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180 See *reference*, text box pg. 61.

181 Id.

182 Remarks by Kellie Armstrong, Shelter Development Consultant, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

183 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.



However, some of the service providers in urban areas noted a challenge with traffickers having easier access to the program participants for possible recruitment into another exploitative situation. For community-based programs and drop-in centers, transportation to the program can be challenging. Unless locations are accessible by public transportation or convenient for transportation by the youth's guardian, the youth's participation will depend upon finding alternate forms of transportations. This can be a barrier to access.

Several providers indicated that although having programs in areas of high exploitation may make the program more accessible, proximity can make the youth feel unsafe, undermining the program's effectiveness.<sup>184</sup>

## **2.2 Undisclosed Location**

Over half of the providers responding to the National Colloquium Provider Survey identified the importance of a private, undisclosed location in order to maintain the safety and security of a program. Several drop-in centers that promote their location to youth use cameras and increase police monitoring to address potential security threats.

During participation in restorative programs, survivors may want to have friends or family come to visit. These visits may pose safety risks for the residents at the home, especially if friends or family contributed to the survivor's abuse. Sixty-eight percent of respondents allow program participants to have visitors, however 31% of these indicated that the visits tend to or must take place off site and 69% indicated the visitors must be screened and approved, often limited to family, social workers, probation officers or others with a legitimate need to visit with the child.<sup>185</sup>

### **2.2.1 Internet/Phone Policies**

Ninety-two percent of organizations responding to the National Colloquium Provider Survey allow survivors in their program to have access to phones and/or the Internet; however, most reported that this access is monitored for security. For example, a participant's contact with a trafficker could put the program's location at risk, especially if a program is in a secure location. On the other hand, programs like TurnAround, Inc. in Baltimore provide program participants with cellphones so that they can stay connected to the program or use it in case of an emergency.<sup>186</sup>

## **2.3 Security Equipment**

Security equipment is important to the security of a shelter. Cameras, inside and outside a facility can help to keep staff and clients safe from potential harm, reduce flight risk of children, and deter loitering by possible

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<sup>184</sup> Id.

<sup>185</sup> Id.

<sup>186</sup> Id.

recruiters or threatening traffickers.<sup>187</sup> Fencing and alarm systems were also listed by several providers as mechanisms to improve security. Some organizations even have an emergency alarm button that sends a call directly to the police if a security threat arises.<sup>188</sup>

## 2.4 Possessions

Because DMST victims may be at risk for self-harm or may be violent, dangerous items like sharp objects, heating elements, and toxic chemicals, must be kept out of reach to prevent injury.<sup>189</sup> Programs also need to consider what items the youth are allowed to possess within a facility. Some programs indicated that they require a search of the youth for weapons or illegal substances before entering a program.<sup>190</sup> Other programs do not allow cell phones.<sup>191</sup> In addition, if the victim requires medication, many programs require them to be locked and managed by staff.

## 2.5 Staff Secure Programs

Programs providing services to DMST victims should be staff secure, meaning that there is awake staff prepared to respond to a safety or security situation available any time a youth is present; this means twenty-four hours per day, seven days per week for residential programs. In this model, staffing structure and practice may help mitigate internal recruitment, flight risk and violence. For instance, one practice is that when staff enters a victim's room in a residential program another staff member must also be present. Staff can also monitor conversation and share notes to identify and respond to potential internal recruitment situations. Staff to client ratios for respondents to the National Colloquium Provider Survey ranged from one staff person to each client to one staff person to eighteen clients. Residential programs had much lower staff to youth ratio, with the highest listed being one staff member to six youth.<sup>192</sup> It is desirable to have more staff available to help de-escalate high risk situations and to support the development of healthy nurturing relationships, which may decrease a victim's flight risk and support the development of healthy relationships. To maintain staff secure programs, many residential programs surveyed operated with either live-in or shift model staff. Of the 45% of respondents that utilized live-in staff, many explained that this model further reinforces a family-like environment for the youth to thrive. Of the 55%percent of residential programs that provide shift model staffing many elaborated that this approach reduces the staff burn-out that is seen quite frequently with live-in staff members.

Certainly an important component of responding to situations that may threaten safety or security of a facility is ensuring that staff understands the dynamics of DMST and how to maintain a safe, secure environment. One hundred percent of service providers surveyed by the National Colloquium Provider Survey required

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187 Remarks by Jean Caceres Gonzalez, The Garden at His House, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

188 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.

189 Id.

190 Remarks by Det. Andy Conner, King County Sherrif's Office. The Genesis Project and Kings County Sheriffs Office, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

191 National Colloquium: Shelter and Services Evaluation for Action Provider Survey, November 30, 2012.

192 Id.

training for staff and volunteers. In addition, staff and volunteers should have appropriate background checks to ensure safety of the youth.<sup>193</sup> Several providers noted frustration with some licensing restrictions for background check clearances, because it may limit the hiring of survivors who may have incurred criminal records as a result of having committed offenses while being trafficked.<sup>194</sup>

## 2.6 Restraint

Physically restraining a victim should always be a last resort in responding to a safety or security situation, and many providers have an emergency response plan to call 911 instead of physically restraining a young person. Physical restraint responses are often dictated by a program's license. If a victim begins acting in a violent manner either to himself/herself or others, 44% of providers responding to the National Colloquium Provider Survey will implement a physical restraint on the youth, although it was noted again that this should be a last resort.<sup>195</sup> Many providers emphasized the importance of training non-violent conflict resolution for staff and ensuring that staff is aware of how to respond to potential situations that may trigger a traumatic response from a victim. Trained and capable staff can help de-escalate a volatile situation before a safety threat warrants physical restraints.

## 2.7 Lockdown/Detention

**“They are victims of crime, and they do not need or should be placed in the criminal justice system and the excuse should not be made, we don’t have a place for them so we’re putting them in the criminal justice system.”**

—U.S. Representative Judge Ted Poe (TX)

Various states' laws dictate the extent to which detention may be used as placement for a commercially sexually exploited minor. DMST victims who are placed in detention are not likely to receive the specialized services required by a DMST survivor. However, many service providers believe forcing a victim to participate in a treatment program does not promote a healing environment, and will ultimately inhibit the healing process.<sup>196</sup> Advocates have even asserted that a lockdown or forced program reinforces the hierarchy and control situation of the victim's trafficker.<sup>197</sup>

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193 Id.

194 Id.

195 Id.

196 Id.

197 Remarks by Melinda Giovengo, PhD, YouthCare, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

While some providers argue that you cannot create a nurturing environment if a young person is forced to participate in a program, judges and probation officers are faced with the reality that a victim's safety and protection is at risk if they run. Several judges related that if they see children coming into their court multiple times on the same charges they feel there is no other placement option to detention or a lockdown therapeutic facility.<sup>198</sup> Critics argue that this response treats victims as criminals. Prosecutors and judges will often argue that detention or a lockdown facility may be the only available option to keep a victim safe, especially if there is a high likelihood of the victim returning to a trafficking situation, or if self-harm is likely. Also, many first line responders tend to believe that detention is not the best option, but feel that it is better than the youth returning to the streets.<sup>199</sup> In addition, law enforcement are invested in successful investigations and prosecution so they will often view the victim as critical testimony in a case against a trafficker, leading them to request detention to ensure the victim-witness is available to testify at trial.<sup>200</sup>

Youth advocates at the other end of the spectrum argue that detention can be very unsafe and a traumatic experience for the child.<sup>201</sup> Internal recruitment and violence has been reported within juvenile detention centers, and sometimes detaining the victims creates a risk for them since they are housed with the general population of juvenile offenders.<sup>202</sup>

Nonetheless, commercially sexually exploited children are frequently placed in detention for other reasons such as drug possession, truancy and trespass. Juvenile detention systems should be equipped to address trauma recovery needs of detained DMST survivors during the period of detention and preferably beyond.<sup>203</sup> In most states, children in detention have access to emergency mental and medical health services, and in some places programs are beginning to develop providing specialized therapeutic services to trafficking victims in detention.<sup>204</sup>

**“Well, if we don’t trust that they’re going to make these kinds of decisions to stick around voluntarily, how are they ever going to get out of the life and move on, right?”**

—Sandy Skelaney, Kristi House, Project GOLD

198 Remarks by Kellie Armstrong, Shelter Development Consultant and Susan Roske, Clark County (Las Vegas), Nevada, Public Defender's Office, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

199 Remarks by Det. Andy Conner, King County Sheriff's Office, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

200 Remarks by Susan Roske, Clark County (Las Vegas), Nevada, Public Defender's Office, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

201 Remarks by Sandy Skelaney, Kristi House, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

202 Id.

203 Remarks by Trina Lyles, Young Women's Facility of Maryland, at the National Colloquium: Shelter and Services Evaluation for Action, November 30, 2012.

204 Id.

## Recommendations:

1. Providers must be equipped to identify and respond to internal security risks, such as victims' high flight risk, potential self-harm, harm to others or internal recruitment. All staff must be trained to recognize and de-escalate behavior leading to internal security risks and recognize that these are often symptoms of trauma that require a therapeutic response.
2. Providers should have a response plan in place to prepare for external security threats. Law enforcement should be aware of the program's operation and available to respond if an emergency situation arises.



# > Appendix A

## National Colloquium: Shelter and Services Evaluation for Action Agenda

**November 30, 2012**

**Rayburn 2237 - Judiciary Committee Room**

### **8:30 am – Opening**

Linda Smith (U.S. Congress 1995-99), Founder and President, Shared Hope International

International Perspective

Dr. Mohamed Mattar, Executive Director, The Protection Project, Johns Hopkins University School of Advanced International Studies

### **9:00 am – Introduction of the Premises**

Carol Smolenski, Executive Director, ECPAT-USA

#### **Survey Findings**

Holly Smith, Survivor Advocate and Fox Valley Technical College Amber Alert TTA consultant

### **9:30–11:45 am**

#### **Panel 1: Placement for Identified Youth**

Panel discussion summary: This panel will discuss placement options for identified DMST survivors, considerations driving placement, and how successful these placements have been.

#### **Moderator:**

Melissa Snow (TurnAround, Inc., MD)

#### **Panelists:**

1. Renee Murrell (FBI Victim Witness Specialist, Baltimore, MD)
2. Det. Andy Conner (King County Sheriff's Office, WA)
3. Sandy Skelaney (Kristi House, FL)
4. Tammy M. Sneed (Connecticut Child Welfare Girls Program, CT)
5. Trina Lyles (Young Women's Facility of Maryland, MD)
6. Withelma TiOra "T" Ortiz Walker Pettigrew (Human Rights Project for Girls, CA)
7. Susan Roske, Esq. (Clark County Public Defender's Office, NV)

### 11:45–12:30 – Lunch on your own

*Rayburn cafeteria is on Level B*

### 12:30–1:30 pm: Briefing—“Identifying Sustainable Resources for Shelter and Restorative Care for Victims of DMST”

Shared Hope International, ECPAT USA, and The Protection Project at Johns Hopkins University School of Advanced International Studies in coordination with **Reps. Ted Poe and John Costa, Co-Chairs of the Congressional Caucus for Victims’ Rights, and Reps. Cynthia Lummis and Gwen Moore, Co-Chairs, and Reps. Jaime Herrera Beutler and Debbie Wasserman Schultz, Vice-Chairs, of the Congressional Caucus for Women’s Issues** invite you to attend a briefing to discuss the pressing need to identify sustainable resources for the provision of shelter and services for victims and survivors of DMST.

Experts estimate that each year at least 100,000 children in the United States are exploited through prostitution; yet the number of specialized residential services and community-based services remains below what is needed to provide quality care and restoration to survivors when they are identified. Private philanthropy is being encouraged at the same time federal and state legislation is being debated to push existing infrastructure responses. No one approach is the right one; we need all of them.

Experts in policy, philanthropy and provision of restorative services will come together to discuss: “How do we pay for the restoration of our children victimized by DMST?”

**Speakers:**      **Congresswoman Linda Smith (U.S. Congress 1995-99)**, *Founder and President, Shared Hope International*  
                     **Congressman Ted Poe (R-TX)**  
                     **Congressmember Karen Bass (D-CA)**<sup>205</sup>  
                     **Deborah Richardson**, *Executive Vice President, Center for Civil and Human Rights*,  
                     **Lee Roper-Batker**, *President, Women’s Foundation of Minnesota*  
                     **Vednita Carter**, *Founder and Executive Director, Breaking Free*  
                     **Alex Trouteaud, PhD**, *Harold and Kayrita Anderson Family Foundation*  
                     **Joye Frost**, *Acting Director, Office for Victims of Crime, U.S. Dept. of Justice*

### 1:45pm–2:15 pm

**National Colloquium Keynote**—George Sheldon, Acting Assistant Secretary for the Administration for Children and Families under the U.S. Department of Health and Human Services

**A Demand Perspective**—Ambassador Swanee Hunt, Founder and President of Hunt Alternatives Fund

### 2:15 pm–3:15 pm

#### **Panel 2: Licensing and Maintaining Residential Facilities**

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<sup>205</sup> Congressmember Bass was unable to attend National Colloquium. She was represented by Jenny Wood, Director of Operations, Office of Congressmember Karen Bass (CA-33).



Panel discussion summary: This panel will discuss the challenges experienced in obtaining and operating under particular licensing, difficulties establishing and sustaining independent initiatives, and benefits of integration into existing infrastructure and the formal child welfare system.

**Moderator:**

Amy O'Neill Richard (U.S. Department of State, Office to Monitor and Combat Trafficking in Persons)

**Panelists:**

1. Kaffie McCullough (youthSpark (formerly Juvenile Justice Fund)/A Future. Not A Past., GA)
2. Kellie Armstrong (Shelter development consultant, TX)
3. Emily Fitchpatrick (Hope House, NC)
4. Marlene Carson (Rahab's Hideaway, OH)
5. Dennis Morrow (Janus Youth Programs, Inc., OR)
6. Jean Caceres-Gonzalez (The Garden at His House, FL)

**3:20–4:45 pm**

**Panel 3: Therapeutic and Programmatic Responses**

Panel discussion summary: This panel will explore/debate promising practices and how/if they are being measured? What does successful completion of a program mean and how are exit strategies developed?

**Moderator:**

Rachel Lloyd (GEMS, NY)

**Panelists:**

1. Dr. Sharon Cooper (NC)
2. Dr. Courtney Gaskins (Youth For Tomorrow, VA)
3. Mary Frances Bowley (Wellspring Living, GA)
4. Suzanne Koeplinger (Minnesota Indian Women's Resource Center, MN)
5. Melinda Giovengo, Ph.D (YouthCare, WA)
6. Deepa Patel (Multicultural Clinical Center, VA)
7. Tina Frundt (Courtney's House, DC)

**4:45–5 pm**

Next steps and wrap-up

Linda Smith (U.S. Congress 10995-99), Founder and President, Shared Hope International



# > Appendix B

## Practitioners Working Group and Advisory Committee Members

### Practitioners Working Group

**Dale Alton**, Georgia Care Connection Office

**Kellie Armstrong**, Arrow Ministries/  
Freedom Place

**Michelle Atkins**, San Diego Youth Services

**Det. Joel Banks**, The Genesis Project

**Jeff Bauer**, The Family Partnership

**Lea Benson**, StreetLight

**Leslie Briner**, YouthCare

**Jean Caceres-Gonzalez**, His House

**Kevin Donegan**, Janus Youth

**Sophia Erez**

**Emily Fitchpatrick**, Hope House

**Jeremy Franker**, Office of the Attorney  
General, Florida

**Kara Franker**, South Florida CSEC  
Working Group

**Dr. Courtney Gaskins**, Youth For Tomorrow

**Dr. Melinda Giovengo**, YouthCare

**Dr. Rebecca Johnson**

**Abigail Kuzma**, Office of the Attorney  
General, Indiana

**Rachel Lloyd**, GEMS

**Kaffie McCullough**, youthSpark

**Andrea Powell**, Fair Girls

**Sandy Skelaney**, Kristi House

**Melissa Snow**, TurnAround, Inc.

**Alexandra Snyder**, Courage House

**Tei Spaine**, Courtney's House

**Marsha Gilmer Tullis**, National Center  
for Missing and Exploited Children

**Kay Vail**, Probation Counselor,  
Clark County, Washington

**Jenny Williamson**, Courage to Be You

## Advisory Committee

**Jayne Bigelsen**, Covenant House

**Mary Frances Bowley**, Wellspring Living

**Karen Walker Bryce**, U.S. Department of Health and Human Services

**Katherine Chon**, Abolition International

**Lucreda Cobbs**, Catholic Charities

**Dr. Sharon Cooper**

**Ryan Dalton**, Restore Corps

**Howard Davidson**, ABA Center on Children and the Law

**Sarah Jakiel**, The Polaris Project

**Judy McKee**, National Association of Attorneys General

**Dawn Lew**, Children at Risk

**Carol Peck**, Catholic Charities

**Deborah Richardson**, National Center for Civil and Human Rights

**Suzanna Tiapula**, National District Attorneys Association

**Lisa Thompson**, Salvation Army

**Shakira Washington**, Human Rights Project for Girls

# ➤ Appendix C

## National Colloquium Provider Survey

### Methodology

- The National Colloquium Provider Survey was done in partnership with Children at Risk, an advocacy organization based in Houston, Texas.
- To determine which organizations would receive the National Colloquium Provider Survey, researchers began with Shared Hope International's Restorative Shelter Working Group's database of providers currently providing residential services. The Restorative Shelter working group, a national network of direct services providers to victims and survivors of domestic sex trafficking convened monthly by Shared Hope International to share information between organizations and continue learning, were provided access to a shared document to input information about shelter and services providers. Children at Risk staff then confirmed whether the organizations listed were currently open or providing services to DMST victims; if it was unclear, the organization remained on the list. This list was further reviewed by the Advisory Committee and Practitioner working group, and other service providers were added as a result.
- Ultimately 43 organizations responded; 41 of which respondents were determined to be providing or in the process of developing services or shelter to DMST victims specifically.<sup>206</sup> Questions were purposely left open-ended to allow for maximum information; however this technique made the survey analysis challenging. The following measures were taken to provide consistency in the analysis:
  - Percentages and survey analysis only represented providers currently providing services to DMST victims. However, providers that are currently developing shelter and services were represented in expanded responses if they provided information not included in general analysis.
  - Some organizations responded more comprehensively to certain questions or provided responses that did not clearly fit into the summary analysis. In this case, the respondents full written response was included under "Expanded Responses."<sup>207</sup> Not all providers responded to every question. Percentages represented only the organizations that responded to the questions.
  - Some organizations answered questions not only detailing what services they are currently providing, but also services they intend to provide. To ensure that analysis only represented services currently provide, if an answer was written in a future tense it is not included in percentage calculations. However, if the response was particularly relevant or informative, it may still be included in highlighted responses.

206 Restore New York was not included in survey analysis because they do not provide services to minors. Salvation Army NETS program was not included in survey analysis because they do not provide services to domestic victims.

207 Note: an expanded response does not mean the report endorses this answer.

- If a question was specifically targeted to information about residential services, organizations that did not indicate they provided this type of service were not included in summary analysis, however they may be represented in the expanded responses section of the report.
- A follow-up survey was sent in March 2013 to providers to clarify certain responses. Several providers completed the survey that did not respond to the original survey distributed in July 2012 including Breaking Free, Coalition to Abolish Slavery and Trafficking, Gracehaven, Letot Center, Mingus Mountain, New Day for Children, Ozanam, Rahab's House, SAGE Project, Inc., The Julian Center. Their responses are represented in section 1.7 and 1.8 of this summary.

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## 1. Placement

### 1.1 Location

- Survey respondents represented
  - 8. APECA: Maricopa County, AZ
  - 9. Araminta Freedom Initiative: Baltimore, MD
  - 10. Bilateral Safety Corridor Coalition: San Diego, CA
  - 11. Children of the Night: Van Nuys, CA (Headquarters)
  - 12. Clark County Juvenile Justice: Vancouver, WA
  - 13. Courage House: Rocklin, CA
  - 14. Covering House: St. Louis, MO
  - 15. Courtney's House: Washington, DC
  - 16. Emma's Home: Durham, NC
  - 17. End Slavery Tennessee: Nashville, TN

18. For the Sake of One: Dallas, TX
19. Freedom Place: Spring, TX
20. GEMS: New York, NY
21. Generate Hope: San Diego, CA
22. The Genesis Project: Seatac, WA
23. Georgia Care Connection Office: Atlanta, GA
24. His House Inc. dba, His House Children's Home: Miami, FL
25. Home of Hope: Spring, TX
26. Homes of Hope: Houston, TX
27. Hope House: Ashville, NC
28. Indiana Protection of Abused and Trafficked Humans Task Force: Indianapolis, IN
29. Janus Youth Programs, Inc.: Portland, OR
30. Kristi House: Miami, FL
31. Living Water for Girls: Peachtree City, GA
32. Mission 21: Rochester, MN
33. Multicultural Clinical Center: Springfield, VA
34. Restore Corps: Memphis, TN
35. Polaris Project: Washington, DC (Headquarters) and NJ
36. Redemption Ridge: Medford, OR
37. Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow): Boston, MA
38. Safe House of Hope, Inc. (SHO Hope): Baltimore and Catonsville, MD
39. Street Light USA: Peoria, AZ
40. San Diego Youth Services: San Diego, CA
41. The Salvation Army of Central Ohio: Columbus, OH
42. The Salvation Army STOP-IT Program: Chicago, IL
43. Traffick911: Dallas, TX
44. TurnAround, Inc.: Baltimore, MD
45. Veronica's Voice: Kansas City, MO
46. Wellspring Living: Metro Atlanta, GA
47. Women's Crisis Center & PATH: Covington, KY
48. Youth For Tomorrow: Bristow, Virginia
49. Youthcare Seattle Seattle, WA

## 1.2 Ages Served<sup>208</sup>

- 33% serve only minors under 18.
- 67% serve adults and minors.

## 1.3 Gender

- 36% of providers serve females only.
- 0% serve males only.
- 0% serve transgender youth only.
- 6% serve males and females only.
- 58% serve males, females and transgender youth.

## 1.4 DMST-specific<sup>209</sup>

- 100% of respondent organizations were DMST informed.
- 42% of programs exclusively serve DMST victims.
- 52% of respondent organizations have a program (among other programs) that is specific to the needs of DMST victims.
- 13% of respondent organizations serve DMST victims by addressing it within the context of their overall program.
- 9% of respondent organizations do not have program components specific to DMST, but serve individuals that are at risk or have been victims of commercial sexual exploitation.

## 1.5 Type of Service

- 78% of respondent organizations provide community-based care or case management.
- 19% of respondent organizations provide foster care support.
- 47% of respondent organizations provide residential care.
- 28% of respondent organizations indicate that they provide a type of service other than the options provided. Responses included below.

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<sup>208</sup> Although they responded to the survey, Restore NYC was not included in survey analysis or responses because they do not serve minors.

<sup>209</sup> Although they responded to the survey, Salvation Army was not included because their services are specifically geared toward international trafficking victims.



Community-based care/case management	Foster Care Support
<ol style="list-style-type: none"> <li>1. Bilateral Safety Corridor Coalition</li> <li>2. Clark County Juvenile Justice</li> <li>3. Courage House</li> <li>4. Courtney's House</li> <li>5. End Slavery Tennessee</li> <li>6. For the Sake of One</li> <li>7. GEMS</li> <li>8. The Genesis Project</li> <li>9. Georgia Care Connection Office</li> <li>10. His House Inc. dba His House Children's Home</li> <li>11. Indiana Protection of Abused and Trafficked Humans Task Force</li> <li>12. Kristi House</li> <li>13. Living Water for Girls</li> <li>14. Mission 21</li> <li>15. Multicultural Clinical Center</li> <li>16. Restore Corps</li> <li>17. Polaris Project</li> <li>18. Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow)</li> <li>19. Safe House of Hope, Inc. (SHO Hope)</li> <li>20. San Diego Youth Services</li> <li>21. Street Light USA</li> <li>22. The Salvation Army of Central Ohio</li> <li>23. The Salvation Army STOP-IT Program</li> <li>24. Traffick911<sup>210</sup></li> <li>25. TurnAround,Inc</li> <li>26. Veronica's Voice<sup>211</sup></li> <li>27. Wellspring Living</li> <li>28. Women's Crisis Center &amp; PATH</li> </ol> <p><i>Unopened as of July 2012</i></p> <ol style="list-style-type: none"> <li>29. The Covering House</li> <li>30. Home of Hope</li> </ol>	<ol style="list-style-type: none"> <li>1. Courage House</li> <li>2. End Slavery Tennessee</li> <li>3. Georgia Care Connection Office</li> <li>4. Kristi House</li> <li>5. Multicultural Clinical Center</li> <li>6. Restore Corps</li> <li>7. StreetLight USA</li> </ol>

<sup>210</sup> In response to this question Traffick911 listed that they are working to open Triumph House, a 168-acre ranch that will be turned into a safe home for victims of domestic minor sex trafficking

<sup>211</sup> In response to this question Veronica's Voice noted the following: We are in partnership with an organization that does the residential care piece for those under 23. We serve adult women victims, many were victims of DMST. The brutality and trauma of trafficking/ prostitution does not change at age 18. When organizations act as though there's a big difference in the effects of trafficking/prostitution whether over or under 18 it further marginalizes the victims and sends the message that they are less worthy of help than those 18 years old and under.

Residential Care	Other
<ol style="list-style-type: none"> <li>1. <b>Children of the Night</b></li> <li>2. <b>Courage House</b></li> <li>3. <b>Emma's Home</b></li> <li>4. <b>Freedom Place</b></li> <li>5. <b>GEMS</b></li> <li>6. <b>Generate Hope</b></li> <li>7. <b>Georgia Care Connection Office</b></li> <li>8. <b>Hope House</b></li> <li>9. <b>Janus Youth Programs, Inc.</b></li> <li>10. <b>Kristi House</b></li> <li>11. <b>Living Water for Girls</b></li> <li>12. <b>Restore Corps</b></li> <li>13. <b>Safe House of Hope, Inc. (SHO Hope)</b></li> <li>14. <b>StreetLight USA</b></li> <li>15. <b>Youth For Tomorrow</b></li> <li>16. <b>Youthcare Seattle</b> (emergency shelter and long term recovery services)</li> <li>17. <b>Wellspring Living</b></li> </ol> <p><i>Unopened as of July 2012</i></p> <ol style="list-style-type: none"> <li>18. <b>APECA</b></li> <li>19. <b>Home of Hope</b></li> <li>20. <b>Redemption Ridge</b></li> </ol>	<ol style="list-style-type: none"> <li>1. <b>Courtney's House:</b> Support Groups/Survivor Events</li> <li>2. <b>For the Sake of One:</b> Plan to have a home open by fourth quarter 2012</li> <li>3. <b>GEMS:</b> Education, employment, leadership programming</li> <li>4. <b>Georgia Care Connection Office:</b> Survivor mentorship, coordination and linkage to emergency/crisis beds</li> <li>5. <b>Indiana Protection of Abused and Trafficked Humans Task Force:</b> The residential care provided is in a DV shelter or other housing obtained for specific victims. We have no shelters for DMST victims exclusively.)<sup>211</sup></li> <li>6. <b>Kristi House:</b> Emergency Shelter to open in January 2013</li> <li>7. <b>Mission 21:</b> Actively fundraising to open residential</li> <li>8. <b>Restore Corps:</b> All of above hopefully in 6-8 months</li> <li>9. <b>Safe House of Hope, Inc. (SHO Hope):</b> Provide Host Family Care that is similar to Foster Care. Host families are completely volunteer and receive no money for their housing.</li> </ol> <p><i>Unopened as of July 2012</i></p> <ol style="list-style-type: none"> <li>10. <b>Araminta Freedom Initiative:</b> Working with TurnAround, Inc which provides case management for DMST victims, but are developing a program to include both foster care support and residential care.</li> </ol>

<sup>212</sup> Original response was under "residential services." Moved to other for consistency within survey.

## 1.6 Time program has been serving DMST victims

- 12% of respondent organizations plan to open shelter or services within the next year.
- 10% of respondent organizations have been open for more than 1 year.
- 56% of respondent organizations have been open 1–5 years.
- 22% of respondent organization have been open for more than 5 years.

### Unopened as of July 2012<sup>212</sup>

1. **APECA**
2. **Araminta Freedom Initiative:** Our program currently provides prevention and intervention education in schools, hospitality venues and community groups. Araminta Freedom Initiative trains community members to volunteer in these areas, as well as mentors and advocates for survivors in TurnAround's anti-trafficking program. Araminta Freedom Initiative plans on implementing a foster care program in the second quarter of 2012, and plans on offering residential services by 2014.
3. **Covering House:** Covering House plans to begin offering clients services in November 2012 and open a residential home in 2013.
4. **Home of Hope:** Plan to open October 2012.
5. **Redemption Ridge:** 2013

### Less than 1 Year

1. **Emma's Home:** Since July 4, 2012
2. **End Slavery Tennessee:** (adults- 4 years) Minors <1 year
3. **Freedom Place:** Freedom Place opened its doors in May 2012
4. **Generate Hope:** 2½ years serving sexually trafficked adults; just starting program for minors

<sup>212</sup> The assumption was made if the organization did not respond that they are not currently providing services.

## 5 years

1. **Clark County Juvenile Justice:** 2 Years
2. **Courage House:** Open since August 2010 serving minors.
3. **Courtney's House:** Since 2009
4. **For the Sake of One:** For the Sake of One is survivor led and has been working in DMST for the past several years but our nonprofit for the past year
5. **The Genesis Project:** Opened in August 2011.
6. **Georgia Care Connection Office:** Since June 2009.
7. **Hope House:** In 2008, we started a strip club outreach. Opened Hope House mid-way through 2009 by leasing a house
8. **Indiana Protection of Abused and Trafficked Humans Task Force:** Our human trafficking task force has provided victim services since 2005. However, we did not have minor sex trafficking victims until 2007.
9. **Janus Youth Programs, Inc.:** We started seeing DMST youth about 5 years ago coming through our services and in October of 2011 were able to create a residential program specific to DMST.
10. **Kristi House:** Since 2008 5 years
11. **Living Water for Girls:** 2007
12. **Mission 21:** September 2010
13. **Restore Corps:** The ant-trafficking department of our organization began in summer 2010, and started working with victimized individuals in December 2010.
14. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** 4+ years (July 2008)
15. **Safe House of Hope, Inc. (SHO Hope):** Since November 2010
16. **San Diego Youth Services:** 5 years
17. **Street Light USA:** Awareness – 2009; Prevention – 2009; Direct Care - 2011
18. **The Salvation Army of Central Ohio:** Our program specializes in serving adult victims of trafficking, but we also serve minors on an as needed basis since there is a local agency that specializes in this population. We began our AHT efforts in 2007.
19. **Traffick911:** 1 year
20. **TurnAround, Inc.:** The TurnAround Anti-Trafficking Program launched in July 2011 and provides comprehensive services, from emergency response to ongoing care to survivors of sex trafficking ages 12-30.
21. **Wellspring Living:** 11 years for adults, 4 years for minors.
22. **Women's Crisis Center & PATH:** Note: At the Women's Crisis Center most of our services are to adult survivors of DMST. There are very low instances at this time of minors in our region being identified as DMST. We hope to see that increase with further direct training in partnership with PATH. WCC has worked with victims and survivors of sexual assault for the past 30 years. WCC has begun using the term DMST for about the past 4.5 years with case management and assistance.
23. **Youth For Tomorrow:** 2008

## More than 5 years

1. **Bilateral Safety Corridor Coalition:** Since 1997
2. **Children of the Night:** For adults & children since 1975; For children since 1979.
3. **GEMS:** 15 years
4. **His House Inc. dba His House Children's Home:** Over 10 years
5. **Multicultural Clinical Center:** 2005
6. **Polaris Project:** We have been serving clients in our Washington, DC office since 2004. Our New Jersey Office has been serving minors of domestic sex trafficking since 2005.
7. **The Salvation Army STOP-IT Program:** Since the inception of the program in 2006.
8. **Veronica's Voice:** Since 2000
9. **Youthcare Seattle - The Bridge Program** (for sexually exploited youth): Began in May, 2010.

*YouthCare ran programs dedicated to this population in the 1980's and 1990's that eventually lost funding.*

## 1.7 Number of DMST victims served

- At the time of the survey the 51 respondent organizations that responded to a follow-up survey had the capacity to provide shelter services to 226 DMST victims and were actually providing shelter services to 168 DMST victims and survivors.
- At the time of the survey the 51 respondent organizations that responded to a follow-up survey had the capacity to provide DMST-specific community-based services to 1684 clients and were actually providing community-based services to 1063 DMST victims and survivors.

## 1.8 Length of Services

- 10% of respondent organizations provide emergency shelter up to 24 hours.
- 10% of respondent organizations provide emergency shelter for up to one week.
- 15% of respondent organizations provide shelter services up to 30 days.
- 5% of respondent organizations provide shelter services up to 90 days.
- 15% of respondent organizations provide shelter services up to 6 months.
- 39% of respondent organizations provide shelter services for up to 1 year.
- 17% of respondent organizations provide shelter services for up to 2 years.
- 10% of respondent organizations provide shelter services for over 2 years.

## 1.9 Provision of Medical Care

- 31% provide some medical care onsite.
- 69% do not provide medical care onsite.

**Expanded Responses to:** *Do you provide medical care on site? If not, how do victims receive medical care? Please describe the routine medical procedures that individuals participating in your program go through.*

1. **Bilateral Safety Corridor Coalition:** Yes they do we have MOU's with several health clinics that provide health and mental health. Within 72 hours victims are tested for HIV, hepatitis B and tuberculosis. Arrangements for counseling are made in the second week to give our guests the time to stabilize. Full medical checkup is done if the client feels she needs this health screening is part of our procedure.
2. **Clark County Juvenile Justice:** We do have medical available for all, for rape exams the youth is taken to the hospital.
3. **Courage House:** We do not provide medical care on-site. Girls go to doctors as approved by their county of origin. We provide comprehensive assessments towards the girls physical health before entering our program and provide appropriate medical, dental, vision, and gynecological services as fit.
4. **End Slavery Tennessee:** Clinics, area doctors who donate pro bono or reduced rate services, ER, other area service providers- varies from case to case. Child advocacy centers provide forensic exams for, minors, local ER provides for adults.
5. **Mission 21:** Within the first 48 hours, all children must have a medical evaluation by a public health nurse or higher. Practitioner would come to site and do a medical evaluation. Routine medical procedures are done at the Mayo Clinic.
6. **Polaris Project:** We do not provide onsite medical care. However, we refer clients to community clinics and encourage clients to have a primary care physician when possible. We address any medical needs through our initial self-assessment and weekly case management meetings with clients. We also provide accompaniment to the appointments when requested by the client.
7. **Safe House of Hope, Inc. (SHO Hope):** We partner with Heath Care for the Homeless and apply for Medicaid and PAC.
8. **San Diego Youth Services:** We provide case management to connect them with resources. General check-ups, tattoo removal, STD testing and care.
9. **Street Light USA:** No, the medical procedure is sometimes dictated by the placement agency. Normally, and as a policy, at a minimum a girl placed in our facility receives care immediately if necessary through urgent care or one of our partnering agencies or if not urgent, within 72 hours of entering our program.

**10. TurnAround, Inc.:** Emergency medical care is provided through the ER. However, ongoing medical care is one of the biggest challenges we face. Most survivors do not have access to any of their vital records thus rebuilding these documents can be a nearly impossible process. As a result the ER is the only location we can access for health care and the ER is not a quick or survivor friendly process (on most occasions).

We have recently established a partnership with a local NGO Health Care for the Homeless. A Nurse Practitioner visits the drop-in center each week and provides individual assessments and health classes. Additionally she can make appointments for survivors and their children ages 0-22 at Health Care for the Homeless' pediatric and adolescent clinic.

**11. Veronica's Voice:** HIV/STD testing, blood sugar and pressure and several other health related partners come in to do testing and health groups. We have a partnership with Hope Family Center but we do not have the funds to send clients there even though they go by a person's income, they do have a fee. Our clients receive most of their medical care through the ER.

**12. Women's Crisis Center & PATH:** No onsite services- partnerships with local clinics, health departments, & hospitals - depending on client & need. Also partner with Sexual Assault Nurse Examiners and Children's Advocacy Center for crisis needs.

**13. Youth For Tomorrow:** Yes – three full-time nursing staff. Initial and annual physical. Regular check-ups/follow-up as directed by medical staff.

## 1.10 Services to pregnant individuals

- 75% of respondent organizations provide services to individuals who are pregnant or have children. Of these, 38% are currently providing residential treatment.
- 25% of organizations do not provide services to individuals who are pregnant or have children. 28% of these respondents are actively considering whether they should.

**Expanded Responses to: *Do you serve pregnant individuals or individuals with children? If so, what policies do you have in place to provide services to these individuals?***

- 1. Clark County Juvenile Justice:** Yes, no detention options for babies to be with parent.
- 2. Courage House:** We have served pregnant minors in the past year. They are unable to stay past 8.5 months per licensing requirements. We hope to be able to have a cottage for pregnant minors as we expand appropriately.
- 3. Kristi House:** Yes. Our shelter will have accommodations for clients if they come in with small children. They will have a room separate from the other residents. We also will connect them to healthy pregnancy/child agencies, medical care and parenting resources.

4. **Multicultural Clinical Center:** Yes, specific therapeutic services can focus towards meeting the needs of individuals that are pregnant and/or individuals that have children. This includes mental health treatment and providing psycho-education.
5. **Safe House of Hope, Inc. (SHO Hope):** We see women in the drop-in center and in street outreach that are pregnant. We have a partnership with CAP at John's Hopkins and encourage our women to go and will go with them and provide transportation. We help any pregnant woman with referrals for healthcare and housing. We would consider a woman for Host family program if she met the intake requirements to be in a host family but have not had any pregnant woman apply. We have had many clients with children and have helped our clients at CPS and referred to New Life for Girls for help them. We have also had parenting classes for our women and for high risk neighborhoods to help prevent DMST.
6. **TurnAround, Inc.:** Yes and yes. Girls who are pregnant are connected with WIC and other teen pregnancy resources. Additionally, we provide comprehensive services for the survivor and her children. Girls who are pregnant or with children who are applying for our transitional home (18+) are required to take parenting classes.
7. **Youth For Tomorrow:** Yes. In addition to clinical and education services, we provide child care while they are at work or in school, parenting classes, and training from nursing staff on nutrition. We also have a home for pregnant teens.
8. **Youthcare Seattle:** We can serve youth that are pregnant but not after she has given birth. If we serve a pregnant youth we would be planning for teen parent housing and support immediately upon placement to make sure she has a solid plan in place prior to delivery.

## 1.11 Reproductive health service

- 97% of organizations have policies regarding and/or provide reproductive health services or education.

## 1.12 Services for substance abuse

- 38% of organizations do provide treatment for individuals with substance abuse issues. However, over half of these organizations specifically noted that they do not provide detox on site.
- 62% of organizations only provide referrals or provide no treatment for substance abuse at all.

**Expanded Responses to:** *Do you feel that therapy is a critical component of providing restorative services? What are the core components of providing therapeutic care to a DMST victim?*

1. **Kristi House:** We have collaborative partnerships with programs that work with substance abuse so that we can manage co-occurring disorders. We will screen for priority concerns as to which residential setting would be most appropriate in the immediate term and triage clients appropriately.



2. **Multicultural Clinical Center:** Yes, we have a specific Substance Abuse Program within the organization. This provides individual, group and family counseling and random urine screens to meet the needs of the client and/or family. Substance abuse treatment is provided on an outpatient basis and is implemented through all of the Programs (i.e. Sex Offender Treatment, Gang Intervention Services (including DMST victims), etc.
3. **Polaris Project:** We do not provide direct treatment for individuals with substance abuse issues. However, while conducting an initial needs assessment if substance abuse issues arise we provide referrals and encourage clients to go through a detoxification program before continuing to address other case management goals
4. **Safe House of Hope, Inc. (SHO Hope):** We have a partnership with Hopkins Detox and New Life for Girls and refer clients to many area residential and Intensive Outpatient services.
5. **San Diego Youth Services:** We are dual-diagnosis aware and know that youth will come into program under the influence. We ask that they maintain in group. No specific tx is given other than through referrals.
6. **TurnAround, Inc.:** Yes, substance abuse and trauma are intrinsically linked. However, it is important to assess the level and reasoning driving the substance abuse because yanking this maladaptive coping mechanism away without the proper support or treatment plan for the root trauma can cause an increase in unsafe and high risk behavior. While detox for harder drugs (meth, crack, PCP, and H) is necessary we work to establish rapport and support with the survivor before, during and after detox because getting clean means a surfacing of feelings that they have been trying to numb through the drugs. Without support to deal with these feelings, getting clean can actually be a trigger to relapse back to prostitution or harder drug use. We have established a partnership with a substance abuse program and after survivors have successfully completed detox and stabilization they are allowing them to join our program at the drop-in center to address the trafficking trauma.
7. **Youth For Tomorrow:** Yes, but if substance is a primary or secondary diagnosis, only as step-down, after they have completed a treatment program. We offer group and individual substance abuse counseling on site.
8. **Youthcare Seattle:** The program(s) have a full time Chemical Dependency Professional. However, we do not detox youth in the residential program. Youth needing detox would be sent to a detox bed for 10-14 days (at another agency) prior to being placed with our program.
9. **Redemption Ridge:** Yes, Most substance abuse is a form of self-medicating to dull the pain of abuse. Once the abuse is removed, safety is provided, the young women don't abuse substances. Drug education is part of the Individual Life Skills education given to each young woman.

### 1.13 Age Restrictions

- 67% of organizations have some type of age restriction for their programs.
- 33% of organizations do not have any age restrictions.

**Expanded Answers to: *Are there age restrictions in the program? If so, please explain.***

1. **Courtney's House:** Yes. primarily we work with 12-21yr olds
2. **GEMS:**12-24
3. **The Genesis Project:** No – we accept minors and adults – our general listed age group is 11-24 (those outside the age parameters will be assessed on a case by case basis).
4. **Georgia Care Connection Office:** GCCO serves 18 and under youth. We link 18 and over youth to other partners.
5. **Janus Youth Programs, Inc.:** 17 and younger for our residential program.
6. **Kristi House:** 11-18. Once clients turn 18 and over, if they are already in our program, their case will not be closed until they are stable and engaged in adult services.
7. **Mission 21:** 15 and younger
8. **Restore Corps:** The residential facility will accept minors age 12-17.
9. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** 12-22
10. **San Diego Youth Services:** Yes, 12-21
11. **Traffick911 :** Under 18.
12. **Redemption Ridge:** Yes - according to our licensing requirements: 11 – 17

### 1.14 Intake Referral Process

- 75% of organizations receive DMST victims through juvenile probation.
- 88% of organizations receive DMST victims through child protective services.
- 97% of organizations receive DMST victims through law enforcement referrals.
- 84% of organizations receive DMST victims through an application submitted by the victim or victim's family.
- 38% of organizations receive DMST victims through other mechanisms including:
  - Church organizations
  - Other organization or community agencies<sup>214</sup>

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<sup>214</sup> Five organizations provided this response.

- Outreach: detention, group home, school, street<sup>215</sup>
- National Human Trafficking Resource Center or other hotlines
- Peer or self-referral<sup>216</sup>
- Schools

## 1.15 Intake management

- The following positions or agencies managed referral/intake:
  - Administrative assistant and program coordinator
  - Admission office
  - Case manager<sup>217</sup>
  - Case managers and advocates
  - Case manager with final determination on placement by program manager and potentially DSHS and/or probation or legal representative
  - Center director
  - Departmental Director and Aftercare Coordinator
  - Intake coordinator
  - Joint approach with resident director and executive director
  - Joint approach with therapist, peer mentor and social worker
  - LCSW
  - Program Director
  - Triage Coordinator
  - Trained childcare worker
- The following reasons were giving for denial of services:
  - Determined not to be a victim/survivor of DMST or human trafficking<sup>218</sup>
  - Determined not to be high risk for DMST
  - Funding
  - Services not available to that specific gender or gender identification<sup>219</sup>
  - Organization is at capacity
  - Victim is outside age requirements<sup>220</sup>
  - Victim has a previous history of recruitment
  - Victim has a previous history of recruitment within the program<sup>221</sup>

215 Two organizations provided this response.

216 Four organizations provided this response.

217 Three organizations provided this response.

218 Nine organizations provided this response.

219 Two organizations provided this response.

220 Four organizations provided this response.

221 Three organizations provided this response.

- Victim has a recruitment history and may have had a relationship with any of the current residents
- Victim has an IQ under 70
- Victim has service needs not provided by the organization: extreme health needs, suicidal, needs detox or has severe drug dependency, severe mental health needs<sup>222</sup>
- Victim is intoxicated
- Victim is pregnant
- Victim is violent on site or has a recent history of violence, sexual offending, or fire starting<sup>223</sup>
- Victim refuses to comply with policies
- Victim unwilling to acknowledge his or her victimization
- Victim's desire to participate<sup>224</sup>

**Expanded Responses to: *Who operates your intake screen process? What criteria would cause you to refuse admittance/service?***

1. **The Genesis Project:** Initially police screen in the field or back at the station after what is usually a thorough interview. If they are interested in coming to the center, the center director takes over once they enter – the girls come to the center on a voluntary basis – if they are violent, or try and recruit out of the center they will be denied access. However, since the center is voluntary 99% of the time the girls that come into the center want and gladly accept our help and abide by the rules.
2. **Georgia Care Connection Office:** GCCO's two CSEC Service Coordinators screen the referrals sent to GCCO. There is not any criteria that would cause GCCO to refuse services, since GCCO's role is to link to and coordinate services depending upon the needs of the youth.
3. **His House Inc. dba His House Children's Home:** JAC (Juvenile Assessment Center) provides initial screening, using Shared Hope Tool. The local CBC lead agency discusses with protective investigator best plan for individual (long or short term care).
4. **Hope House:** The intake process is very lengthy and can take 10 days – two weeks to complete. Typically by the time they receive the referral, the child has already been picked up by law enforcement. They do not have legal custody of the child, but do have temporary guardianship. The application is filled out by the legal guardian. There is also an application that the child fills out. They are picky about who they take because they are a level one facility and a voluntary program. They are not equipped to handle extreme mental health issues. They are not a locked facility. They are staff secure. They have an extensive interview with the child, more focused on safety issues and her willingness to come to the program.
5. **Kristi House:** CM / Advocates. All staff are trained to conduct the initial intake to determine whether client meets criteria for full assessment and if they have other more pressing needs or crises that need attending to first such as suicidal ideation or need for detox.

<sup>222</sup> Ten organizations provided this response.

<sup>223</sup> Six organizations provided this response.

<sup>224</sup> Six organizations provided this response.

6. **Polaris Project:** Intake and screening process depends on the mode of case referral to our program. We only serve clients who have suffered under the TVPRA's definition of severe forms of human trafficking. Therefore, if law enforcement refers a client and a human trafficking assessment has already been done and has been found a victim of human trafficking then our focus will be addressing case management goals and needs with the client. To this extent we do an initial needs assessment to address any urgent basic needs, included but not limited to shelter, food, clothing or medical care. If a client is referred by another social service agency, juvenile probation office, child protective services or through a self-referral we perform a human trafficking assessment to determine whether or not we can effectively assist the potential victim or if their case should be refer to another social service agency. Once a human trafficking assessment and needs assessment are completed if the client does not meet the criteria of being a victim of severe form of human trafficking then we may deny service and refer the client to other appropriate services. Additionally, if a client has a known substance abuse or severe mental health illness we recommend that the client address these issues before beginning case management services with the client. This is done to assist the client in their recovery process and to ensure that we are maintaining a safe environment for other clients and staff members in the office.
7. **Safe House of Hope, Inc. (SHO Hope):** Executive Director, Client must be drug free before entering someone's home. Both the client and the Host family must be willing to meet and decide if they are a good fit.
8. **TurnAround, Inc.:** Our case managers complete the HT assessment process. Survivors outside of our age range of 12-30 would be considered on a case by case basis. If a survivor meets the state and/or federal definition for sex trafficking they would be offered service through our program. Level of services and engagement would be based on their need, interest and our capacity to serve. Meaning sometimes we receive referrals for survivors from DJS who are being relocated out of state or to a northern/southern part of MD. In these cases we would admit them to our program and then work to align the proper referrals for services in their location. We are currently not set-up to provide services to boys.
9. **Wellspring Living:** We work in cooperation with the GA Care Connection for referrals. If she needed more intense mental services or pregnant.
10. **Youthcare Seattle:** The case manager is primarily responsible for coordinating the screening, interview and intake process. However, the final determination on placement includes input from the Program Manager and potentially, DSHS and/or Probation or Legal Representative.
  - a. Youth are not eligible if they:
    - i. Do not have a history of exploitation/trafficking (we do not blend "at-risk" in this program milieu)
    - ii. Youth with fire-starting history or registered sex offenders
    - iii. Youth with a known history of promoting/pimping (this is tricky and a case by case judgment call)
    - iv. Youth under the age of 14 or over 18 years old

## 1.16 Requirements for service and shelter provision

- 69% of organizations require parental or guardian consent for victims to enter their programs.
- 58% of organizations require victims to complete an application process before entering their programs.
- 35% of organizations require victims to participate in substance abuse treatment to enter their programs.

## 1.17 Vital Records

- 21% of organizations do require a victim's vital records before accepting him/her into their program.
- 79% of organizations do not require a victim's vital records before accepting him/her into their program.

**Expanded Responses to:** *Do you require a victim's vital records before accepting him or her into your programming? Is it hard to obtain these vital records?*

1. **Youthcare Seattle:** If the youth is in the foster care system we attempt to obtain the ISP (Independent Service Plan). We try to learn as much as possible about the youth prior to placement however, it often comes through informal channels. Obtaining official records is difficult.
2. **End Slavery Tennessee:** Not when referred by law enforcement as the vast majority of our clients are. Yes, very [hard to obtain].
3. **His House Inc. dba His House Children's Home:** Protective investigator will retrieve vital records prior to placement in long term care, therefore it is not required. Obtaining vital records depends on the situation and individual
4. **Multicultural Clinical Center:** No, these records typically are not difficult to obtain as other agencies are often willing to share information with consent forms completed.
5. **Polaris Project:** No we do not require vital records. However, we may assist clients in the event that vital records need to be obtained

## 1.18 Waiting list for services

- 17% of organizations currently or occasionally have waiting lists.
- 83% of organizations do not have a waiting list.

**Expanded Responses to:** *Do you have a waiting list for services?*

1. **Georgia Care Connection Office:** No, although there are CSEC youth who need residential placement, who do not fit the criteria of the safe home. GCCO is building relationships with other group homes and partners to meet those needs, with the goal of building a continuum of care to meet the needs of all CSEC youth.

## 1.19 Community Based Public Transportation Accessibility

- 95% of organizations are public transit accessible.
- 5% of organizations are not public transit accessible.

### Expanded Responses to: *Are you public transit accessible?*

1. **Georgia Care Connection Office:** Georgia Care Connection GCCO is public transit accessible, even though the team usually goes to the youth. Access is sometimes a challenge to the services GCCO links the youth and their family to, depending on the situation we may assist with gas cards, MARTA cards, or coordinate someone on GCCO's team to assist them.

## 1.20 Method of Transportation to Community-Based Services

- The following were listed by community based services providers as methods of transportation to services:
  - Law enforcement<sup>225</sup>
  - Public transportation: bus, metro<sup>226</sup>
  - Parents/self-transport<sup>227</sup>
  - Staff goes to the survivor<sup>228</sup>
  - Staff transports them<sup>229</sup>
  - Therapist/social worker<sup>230</sup>
  - Advocate/Volunteer/Mentor drivers<sup>231</sup>

## 2. Licensing and Maintaining

### 2.1 Types of Licenses<sup>232</sup>

The majority of shelters were either listed as group homes or residential facilities. Other licenses listed included emergency shelter and domestic violence shelter. It was also noted the need to have licensed clinicians.

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225 Four organizations listed this response.

226 Twelve organizations listed this response.

227 Ten organizations listed this response.

228 Four organizations listed this response.

229 Three organizations listed this response.

230 Two organizations listed this response.

231 Four organizations listed this response.

232 21 organizations did not respond to this question or listed the question not applicable as it applies to residential; 3 of the organization not currently providing services to DMST victims did not respond. Two organizations that responded are not currently providing residential treatment to DMST victims. Percentages are divided out of 16.

- 50% of respondents currently providing residential services to victims of DMST operate under a group home license.
- 19% of respondents currently providing residential services to victims of DMST operate under a residential license.
- 31% of respondents currently providing residential services to victims of DMST operate under some other type of license.

**Expanded Responses to: *What type of licensing (if any) is required to operate your program or residence? If you are a non-residential facility and do not have any type of license, please put “not applicable.” If you are a residential facility and do not have a license please explain why licensing is not required. (Ex. School, rehabilitative treatment, mental health, etc.)***

1. **Courage House:** Residential Group Home: CCL compliant under state of California
2. **Emma’s Home:** Licensed as non-public homeschool with the Dept of Administration & we are in the process of getting licensed as a Residential Child Care Facility.
3. **Freedom Place:** Freedom Place is a licensed general residential operation (GRO), multiple services which includes treatment, emergency, and basic services through the Department of Family and Protective Services (DFPS).
4. **Hope House:** DFS – DSS: private residential group home; initially opened as a boarding school, but now licensed as a private residential group home. The DSS came in and did a licensing, question why they need a home that treated DMST in their state. Didn’t know it was a statewide problem. Had to get them up to speed, but there was not a license issued for what they wanted to do. Suggested that they opened up as a boarding school. Continued to work with DSS for the next two years and finally came up with being licensed as a residential group home. Took about 6 months. Getting started as a boarding school worked great though.
5. **Janus Youth Programs, Inc.:** All of our services serving minors are licensed by the State of Oregon Department of Human Services.
6. **Indiana Protection of Abused and Trafficked Humans Task Force:** The shelter we use currently is a DV shelter and is licensed as such. A new shelter for adult human trafficking and sexual exploitation victims is scheduled to open shortly.
7. **Restore Corps:** Residential child care agency
8. **Redemption Ridge:** State of Oregon Residential Care facility
9. **Youth For Tomorrow:** Virginia Department of Social Services, Virginia Department of Behavioral Health and Developmental Services, Virginia Association of Independent Special Education Facilities (VAISEF) and Virginia Department of Education.
10. **Youthcare Seattle** - We are licensed as a group care provider by the Department of Social and Health Services (DSHS) in the state of Washington



## 2.2 License issuing agency<sup>233</sup>

The majority of survey respondents had their licenses issued through a state health and human services agency or recovery agency.

- 82% of respondents currently providing shelter services to DMST victims have licenses issued through state Health and Human Services and Recovery Agencies.
- One respondent currently providing shelter services to DMST victims has a license issued through the state Department of Education.
- 24% of respondents did not specify the state agency issuing their operating license.
- All licenses were issued at the state level.
- One program was not issued a license, but instead operates a DMST-specific program within a state/county Juvenile Justice Center.

### Expanded Responses to: *What authority issues your license?*

1. **Bilateral Safety Corridor Coalition:** State of California and County of San Diego
2. **APECA:** Arizona Department of Economic Security
3. **Araminta Freedom Initiative:** Department of Human Resources
4. **Courage House:** Community Care Licensing
5. **Generate Hope:** Community Care Licensing
6. **Freedom Place:** Department of Family and Protective Services (DFPS)
7. **GEMS:** Office of Children and Family Services, NYS
8. **His House Inc. dba His House Children's Home:** Florida Department of Children and Families
9. **Home of Hope:** DFPS
10. **Indiana Protection of Abused and Trafficked Humans Task Force:** State of IN
11. **Janus Youth Programs, Inc.:** The State of Oregon Department of Human Services.
12. **Kristi House:** Department of Children and Families
13. **Mission 21:** Department of Human Services
14. **Multicultural Clinical Center:** Virginia Department of Behavioral Health and Developmental and Virginia and Virginia Board of Health Professionals
15. **Restore Corps:** Department of Children's Services

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<sup>233</sup> 17 organizations did not respond to this question, and only organizations that are currently providing residential services are included in percentage calculations. Percentage calculations are taken out of 17.

16. **Redemption Ridge:** Oregon's Department of Human Services DHS/Treatment Services & Licensing  
Street Light USA - Dept. of Economic Security
17. **The Salvation Army of Central Ohio:** OH SWMFT Board, Ohio Chemical Dependency Professionals Board
18. **Traffick911 :** The Texas Department of Family and Protective Services.
19. **The Genesis Project:** Washington Dept. of Licensing
20. **Youth For Tomorrow:** Virginia Department of Social Services, Virginia Department of Behavioral Health and Developmental Services, Virginia Association of Independent Special Education Facilities (VAISEF) and Virginia Department of Education.
21. **Youthcare Seattle:** The state of Washington DSHS, licensing division

## 2.3 Staff Structure

- Staff composition varied among organizations. Directors, case managers, clinicians and house managers or house parents made up many of the responses.
- Several organizations employed volunteers as part of their staff, although none exclusively.
- The importance of having 24/7 awake staff was noted by several organizations.

**Expanded Responses to:** *Please explain your staffing structure. Would you recommend it? If not, what staffing structure would you recommend?*

1. **Freedom Place:** We would recommend using “shift staff” rather than house parents solely or volunteer staff. Our program is heavily staffed which accounts for a majority of the budget. Major positions include: Executive Director, Residential Treatment Administrator, Clinical Director, Therapist (per 10 residents), and Residential Counselor. Ratio 1:5.
2. **Generate Hope:** 4 house mothers, 2 teachers, several volunteer tutors, mentors, drivers, case managers, etc.
3. **Georgia Care Connection Office:** Our team consists of 2 CSEC Service Coordinators, who provide the coordination of services and support needed; 2 Intervention Specialists, who mentor and support the youth; and a Family Support Specialist, who supports the guardian and family. Each referral is matched to one of the CSEC Service Coordinators. After a screening is completed, the youth is linked to specific CSEC services and if CSEC matched to an Intervention Specialist, and if applicable the Family Support Specialist. GCCO continues to monitor and mentor the CSEC youth in whatever other program or service they are linked to. Yes, this team effort works well for the work we do.
4. **His House Inc. dba His House Children's Home:** The residential staffing structure is family-style with live-in house parents/life coach and supporting care givers. The staff-to-child ratio is 1 to 6, however the DMST program will have a 1 to 4 ratio. I would recommend that the ratio be even

lower. Perhaps this can be done through live-in interns or volunteers. Currently, our girls adolescent cottage has a mom and adult daughter as leaders of the home. A Crisis Intervention Specialist also resides on campus for immediate support. A Behavioral Analyst is available to address behavioral issues. A Residential Services Director oversees the program who is a licensed clinical social worker.

5. **Hope House:** Live out Managing Director, Live in Resident Director, Live in Education Coordinator, Live in Weekend Supervisor, Live out Program Administrator, Live out Executive Director, Live in Interns on occasion.
6. **Kristi House-**Program Manager Shelter Coordinator (licensed therapist/case manager/shelter supervisor) Case Manager / Youth Advocates (2) Program Assistant (survivor). So far this has worked well. It is good for the CM's to do the intakes to develop the rapport and then continue relationship building over time. The only complaint is that the intensity of the work requires them to have a smaller case load to be very effective. I would ideally like all of these positions or many of them filled by survivors. Currently we are only able to fill the assistant role with a trafficking survivor.
7. **Mission 21:** Rotating Staff. Two staff per shift at all times. 2 live-in interns to offset staffing cost. Professionals are hired as private contractors.
8. **Multicultural Clinical Center:** The staffing structure for this outpatient mental health center includes specific Program Directors and Coordinators assigned to the specific population groups, which include Sex Offender Program, Gang Intervention Services (includes DMST Program), Substance Abuse Program, Anger Management Program, Home Based Services, and other Outpatient Mental Health Treatment. Within the specific programs, cases are assigned dependent upon to the need of the client(s). Program Coordinators and Program Directors assign specific cases to clinicians. I would recommend this structure for an outpatient mental health program as it specifically assigns cases to specifically meet the needs of the clients.
9. **The Salvation Army of Central Ohio-**We currently have two case managers, one clinical specialist, one education specialist and myself (coordinator) who all work collaboratively as a team.
10. **The Salvation Army STOP-IT Program:** We currently have 3 full time case managers, 3 part time case managers, and two MSW interns.
11. **Wellspring Living:** For all Clinical Staff (Therapist/social Workers) they must have a master's degree in counseling or social work and be licensed to practice in the state of GA. This is LPA/LAPC/LCSW/MSW (Licensed Professional Counselor, Licensed Associate Professional Counselor, Licensed Clinical Social Worker, or Master's in Social Work). For Clinical Supervisors they must be fully licensed with at least 5 years of Clinical Experience. The minimum requirement for all our teachers is that they have a Bachelor's Degree in an education related field, but all of our teachers at this point have had master's degrees. Our Volunteer Coordinator/Logistics Coordinators have a minimum of a Bachelor's Degree in a Human Services Field. Our Coaches have a minimum requirement of a Bachelor's degree or 4 years of experience working with similar populations. All of our staff go through thorough training related to CSEC, Trauma, Strength Based Approaches, Boundaries, Missional Approaches, Culture and Diversity etc. All our professional staff are supported in obtaining training as required

by their individual licensing boards and are encouraged to obtain ongoing training in the areas of CSEC, Trauma, Attachment, Evidence Based Approaches for adolescents, etc.

## 2.4 Staff licensing, educational or training requirements

- 78% of organizations employ more staff or staff with a higher educational level than required.
- 22% of organizations do not employ more staff or staff with higher educational level than required.

**Expanded Responses to: *What are your licensing, educational or training requirements for your staff? Are there any other staff requirements? (Please describe your requirements for both licensed and unlicensed staff.)***

1. **Clark County Juvenile Justice:** Bachelors to be a probation officer, Sexual assault advocate training, training on DMST
2. **Freedom Place:** This depends on the position each staff has. Therapists need to be licensed in the state of Texas and have a Masters Degree. Residential counselors are required to only have a high school diploma however, most of our employees have earned their bachelors. All staff is required to go through 40 hours of training and as well as supervision hours. Some of the training includes a trauma-based course, managing aggressive behavior, human trafficking 101, CPR, and policies and procedures. RCCL minimum standards set training topics.
3. **GEMS:** Have 30 hours of training for staff, fingerprinting and background checks for all staff, even more training for those working with children. Bachelor's is preferred but not required. License needed for Social Workers.
4. **Georgia Care Connection Office:**

Director – responsible for the implementation and coordination of GCCO, fostering strategic partnerships, securing and overseeing funding streams, and heightening awareness of Georgia's CSEC crisis. (Master's or JD in an applicable field)

CSEC Service Coordinator – receives referral, develops, implements, and monitors the unified comprehensive care plan. Also provides court room advocacy on behalf of the child. (Masters in Social Work or Counseling, licensed or licensed eligible)

Family Support Specialist – has primary responsibility for communicating with, supporting, and guiding the parent or guardian of the victims of CSEC. (College Degree, experience with CSEC is key)

Intervention Specialist – provides support and mentorship for victims of exploitation as they go through the assessment and treatment processes. (Survivor or CSEC is key)

Administrative Assistant – provides clerical and administrative support for the Georgia Care Connection Office.

5. **His House Inc. dba His House Children's Home:** Licensed Staff- The Residential Services Director is a Licensed Clinical Social Worker with over 20 years of experience. -Therapists are Masters level clinicians- some are licensed and some are working on licensure. Case Managers must pass Pre-service 10-week course at the CBC's Lead Agency Academy and pass test to complete a first phase of training and obtain State Certification within the first year. Unlicensed house parents receive the regular foster parent training (MAPP or PRIDE curriculum- both 40 hours) and the Therapeutic Foster Parent training (30 hours) as well as all the training that direct care givers receive. All direct care staff receive a minimum of 40 hours of training. The Core Classes are: CPI Non Violent Crisis Intervention (16 hours), CPR, First Aid, Incident Reporting, HIPAA, Infectious Diseases, Proper Supervision, Medication Management, Fire Safety, Safe Driving, Food Management. Cultural Diversity and Sensitivity, Normalcy Plans, De-escalation, Reporting Abuse and Maltreatment, Risk Management, Handling Medical Emergencies, and Storm Preparedness and Evacuation.
6. **Mission 21:** We utilize a network of professional service providers to come in/or to take children to. In house staff; most have 4 year degree in social services/sciences/psychology/counseling or 4 years of experience working with at-risk youth in similar organizations. All staff is required to complete in-house training on sex trafficking, youth work, trauma-focused cognitive behavioral therapy, motivational interviewing, problem solving, stages of change, etc. On-going training throughout the year on subjects pertaining to youth work.
7. **Multicultural Clinical Center:** Staff comprised of Qualified Mental Health Professionals (QMHP), Licensed Clinical Social Workers (LCSW), License Professional Counselors (LPC), Certified Sex Offender Treatment Practitioners (CSOTP), Licensed Psychologist, etc. Clinicians are required to maintain their licensure through the Virginia Board of Health Professionals. In addition, clinicians attend clinical supervision with specific program supervisors and attend regular training within the organization and outside the organization.
8. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** There are no specific requirements for staffing. We seek survivors of The Life first and foremost but any relevant personal/educational experience is ok as well. We conduct a three-part interview which includes some of the girls we serve so that they too can help choose the candidates.
9. **Safe House of Hope, Inc. (SHO Hope):** We train each facet of our staff with general and specific training. For Host families they must go through 10 hours of training then weekly counseling and for family and client when clients are in their homes. We believe that training is vitally important to the success of the host family program and that extensive support while clients are in the home is imperative. Host families must be trained in the specific challenges they will face with our clients and need 24/7 intervention help in case of a challenging situation or event.
10. **The Salvation Army of Central Ohio:** We require an LSW min requirement with preference for chemical dependency licensing as well. We also require staff to complete 40 hours of pre-service training, including, but not limited to, ethics, case management, motivational interviewing, crisis, de-escalation, etc.
11. **Veronica's Voice:** While we partner with outside agencies that have licensed professionals, our biggest asset at Veronica's Voice is the women survivors that have the expertise in dealing with the

issues our clients are dealing with currently in their lives. The survivors are passionate about the work they do, due to their experiences in the life.

**12. Wellspring Living:** For all Clinical Staff (Therapist/social Workers) they must have a master's degree in counseling or social work and be licensed to practice in the state of GA. This is PA/LAPC/LCSW/MSW (Licensed Professional Counselor, Licensed Associate Professional Counselor, Licensed Clinical Social Worker, or Master's in Social Work). For Clinical Supervisors they must have be fully licensed with at least 5 years of Clinical Experience. The minimum requirement for all our teachers is that they have a Bachelor's Degree in an education related field, but all of our teachers at this point have had master's degree. Our Volunteer Coordinator/Logistics Coordinators have a minimum of a Bachelor's Degree in a Human Services Field. Our Coaches have a minimum requirement of a Bachelor's degree or 4 years of experience working with similar populations. All of our staff go through thorough training related to CSEC, Trauma, Strength Based Approaches, Boundaries, Missional Approaches, Culture and Diversity etc. All our professional staff are supported in obtaining training as required by their individual licensing boards and are encouraged to obtain ongoing training in the areas of CSEC, Trauma, Attachment, Evidence Based Approaches for adolescents, etc.

**13. Women's Crisis Center & PATH:**

- a. Counselors - BA minimum + 40hr (sexual assault/domestic violence training)
  - I. HT Case Manager - BA minimum + 40hr (above training) 40hr train specific to HT
  - II. Social work/counseling preferred
  - III. All staff maintain 8-10 hours of training per year
  - IV. All volunteers/auxiliary - 40hr (sexual assault/domestic violence training)
  - V. All staff & volunteer application & background check process
- b. **PATH:** Trainers & Emergency Response & Victim Advocate [40hr sexual assault/domestic violence training + 40hr min train specific to HT]
- c. All staff & volunteer application & background check process

**14. Youthcare Seattle:** The Director of Residential Services holds a PhD, which is beyond licensing requirements (licensing does require a Master's degree or commensurate experience)

- a. All staff must be "cleared" (background checked) through DSHS prior to unsupervised contact with youth.
- b. Per state licensing: all staff must have current First Aid and CPR, a food handlers permit, the state approved Managing Aggressive Behaviors (MAB) training, and have training on HIV/ bloodborne pathogens

Additionally for staff at the Bridge Program they receive 40 hours of training on sexual exploitation. Staff must also receive 24 hours of continuing training per year (also per licensing). Additional training topics have included: verbal de-escalation, Motivational Interviewing, Trauma and the Brain, Secondary Trauma, crisis management

## 2.5 Staff and therapeutic foster care provider training

- 100% of organizations require ongoing staff training or training for therapeutic foster care providers.

**Expanded Responses to: *Does your program employ more staff or staff with a higher educational level than the licensing authority requires?***

1. **GEMS:** Yes, but less about requirements and more about good job. All of our staff gets 3 day intensive training when they start. Also do additional trauma training, youth development training, etc. for some of their employees. Various ongoing training. Yearly 30 hour requirement
2. **Mission 21:** Monthly optional training: leadership, health, team building skills. Quarterly mandatory training: Suicide, HIPPA, Emergency Intervention, TF-CBT, Effective Communication, Group Counseling, Program evaluation, De-escalating skills, Goal setting; Boundaries, Priorities, Aftercare, Relapse Prevention, etc.
3. **For the Sake of One:** Yes we do have rehabilitated and restored survivors on staff to assist in roles where they are best suited and to serve as advisory because they are committed and passionate about the work they do, they have empathy not sympathy, they present a picture of hope and healing and expedite the trust and bonding relationship between staff and client. Development of trust and bonding is essential in the healing process.
4. **Safe House of Hope, Inc.<sup>234</sup>(SHO Hope):** Host families MUST go through at least 10 hours of in person training and finish on-line training before being considered as available for a client in the home. At home reading is also required.
5. **Redemption Ridge:** Yes. Additionally, on-going bi-monthly trainings are required. Consists of required training for group home staff by State: for all group home policies reiteration; updates, restraint trainings, TFCBT training.

## 2.6 Policies regarding Survivors on Staff<sup>235</sup>

- Policies include mandatory survivor roles on board or staff, a certain numbers of years out of the life ranging from 1-5 and required counseling before working with victims.
- 28% of respondents specifically noted that they prioritized survivors on staff.<sup>236</sup>
- 14% of respondents specifically noted challenges in hiring survivors because of state licensing restrictions.
- 14% or respondents noted that survivors should be screened for potential triggers.

<sup>234</sup> This question was Safe Homes of Hope's response to: "Do you provide training to foster families- specifically for foster care providers. However because foster care providers was not clearly defined by the survey authors, it was determined Safe Homes of Hope was the only organization that program was specifically defined to provide treatment foster care by training host families.

<sup>235</sup> In response to question: Do you have requirements or policies related to survivors on staff? If so, please describe them.

<sup>236</sup> Many respondents indicated that have survivors on staff, but did not indicate that they prioritized it.



- 7% of respondents indicated hesitations around hiring survivors including concerns around their own healing including possible re-traumatization or triggering of a traumatic response, and adherence to intuition over policies and boundary setting.

**Expanded Responses to: *Do you have requirements or policies related to survivors on staff? If so, please describe them.***

1. **Araminta Freedom Initiative:**<sup>237</sup> We have written into our organization by-laws that a survivor will be on the board, and when available be on staff as well.
2. **Georgia Care Connection Office:** Yes, survivors are on staff at GCCO. Currently, 2 survivors are on staff in the positions of Intervention Specialists. There are policies related to these positions:
  - a. Out of the life for a minimum of 5 yrs
  - b. Has received counseling for past CSEC experiences
  - c. Willing to participate in ongoing counseling
  - d. Able to work effectively in a team approach utilizing the system of care philosophy  
(note: 1-3 above we learned from Roxbury Youth Works in Boston)
3. **Janus Youth Programs, Inc.:** We actively seek out survivors when filling open positions but have been unable to find very many due to restrictions of our license and criminal history checks.
4. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** We seek survivors of The Life first and foremost but any relevant personal/educational experience is ok as well. We conduct a three-part interview which includes some of the girls we serve so that they too can help choose the candidates...<sup>238</sup> We certainly look to hire survivors but they must be able to talk about the trauma work they have done and demonstrate that they are able to seek help/guidance when things may become triggering.

## 2.7 Shift vs. Live-in Staff model

- 55% of respondents providing residential services use a shift-based model only.
- 45% of organizations use a live-in model. 18% specifically indicated that they provided both shift and live-in model staffing.<sup>239</sup>

**Expanded Responses to: *If you provide residential services, does your residential care center follow a live-in or a shifts model? Why did you choose this model?***

1. **Courage House:** We follow both models. We have a house mom as live-in staff. But we also have supportive shift workers. We function as a family. We want to restore and nurture the girls in the idea of what a healthy family looks like.

<sup>237</sup> Araminta is not currently providing direct services (to open)

<sup>238</sup> Per direction of respondent, first half of answer taken in response to question regarding staffing model.

<sup>239</sup> It is unclear whether the remaining 36% of organizations also had additional shift model staffing.



2. **Freedom Place:** Utilizing a shift staffing model is ideal for this population. The burn out rate for live-in staff is too high and this population would be too stressful on a house-parent model. The victims require lots of individual attention which a high staff ratio provides. Since the victims are highly traumatized, the likelihood of them acting out is high which would require constant attention and energy from staff which we feel live-in staff would not be able to provide adequately.
3. **His House Inc. dba His House Children's Home:** The program includes both live-in leaders of the home as well as supporting shift work staff working 8 hour shifts. This model offers a family like setting with supportive staff being available to provide on-going support and ensure safety.
4. **Mission 21:** We are starting with both. 2 live-in interns and a rotating shift model. We chose this model based on other group homes where this model is working well. It prevents burnout for staff, and the 2 live-in interns are the consistent staff that are there all the time and it saves on cost.<sup>240</sup>
5. **Safe House of Hope, Inc. (SHO Hope):** We work on a Host Family Model. We believe that the best long term healthy change for our clients comes through an 'adoptive' family. A strong on-going life support from a family that is loving and supports healthy life choices first in the home and later as the client moves out of the home will help the client to have the support necessary to maintain a healthy life. We encourage our host families to stay in touch with their host people and to consider this a permanent placement like adoption of a teen or an adult would be. It is when our client fails and needs to call for support that these families will show their long term commitment.<sup>241</sup>
6. **Youth For Tomorrow** - House parent model. Girls are modeled good male/female roles and relationships/boundaries.

## 2.8 Attendance Requirements for Community Based Providers

- 65% of organizations have attendance requirements for their programs.
- 35% of organizations do not have requirements for their programs.

**Expanded Answers to: *Are there attendance requirements to being in the program? If so, please explain.***

1. **Georgia Care Connection Office:** Youth are referred to GCCO, and if they are CSEC they are linked to a CSEC Intervention Specialist, who will consistently be there for that child. There are no attendance requirements or a set schedule. Appointments are made to meet with the child on an as needed basis. Intervention Specialist are available to receive calls as need.
2. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** It is a voluntary program, however, by agreeing to the service the clients are required to meet with their Life Coaches 1-2x weekly.

<sup>240</sup> Because Mission 21 has not yet opened the residential component of their program, they were not included in percentage calculations.

<sup>241</sup> Because Safe House of Hope has host families rather than staff, they were not included in the percentage calculations.

## 2.9 Incentive for client participation in community based programs

- The following were listed as methods to incentivize participation in community programs by DMST victims.
  - Artistic programming
  - Bonuses/incentives/gifts/prizes/rewards/gift cards<sup>242</sup>
  - Constant support/attention/advocates/encouragement/words of affirmation/positive reinforcement<sup>243</sup>
  - Food<sup>244</sup>
  - Graduation
  - Mentorship
  - Outreach (juvenile detention, child welfare facilities)
  - Recreational Programming/Field trips<sup>245</sup>
  - Relationship with peers/Peer support<sup>246</sup>
  - Relationship with staff<sup>247</sup>
  - Survivor events
  - Therapeutic Programming<sup>248</sup>
  - Trust
- One organization responded that this was not an issue.

### Expanded responses to: *How do you motivate you to participate in your program?*

1. **Multicultural Clinical Center:** Youth are motivated through activities, providing support and guidance and focusing treatment to meet their individualistic needs.
2. **Restore Corps:** We believe in positive reinforcement, giving the client more and more freedom as she progresses through levels of care and demonstrates responsibility.
3. **Safe House of Hope, Inc. (SHO Hope):** Incentives - prizes, McDonalds coupons and gift card, special things they want they can earn with points, responsibility. Clients can grow in our program to helpers, client volunteers, stipend volunteers, and then paid staff. We are implementing a point system so that all volunteers can earn the same things to encourage all volunteers and participates to grow. We also have special food, Chik-fil-A, Papa John's pizza, and other partners that will provide special food for a series of classes. Often asking a client about what would motivate them, what she really wants, helps. This has included special field trips upon request.

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242 Five organizations listed this in their response.

243 Five organizations listed this in their response

244 Two organizations listed this in their response

245 Three organizations listed this in their response

246 Four organizations listed this in their response

247 Two organizations listed this in their response

248 Two organizations listed this in their response

4. **TurnAround, Inc.:** We engage youth by showing that we will both stand, advocate and fight for them and their well-being. We show up and continue to show up and this level of intensity and follow through helps to build trust and rapport. We also listen to the goals, dreams and needs of the survivor on a physical, mental, emotional and personal level and help connect them to these resources. For example, one 14 YO survivor really wanted to sing so we connected her with an advocate for free voice lessons. Another survivor liked horses so we connected her to equine therapy. Another survivor had never been to the beach so we planned a day beach trip. We also utilize incentives to encourage new and healthy habits. All of our groups are assigned a number of TurnAround points. When girls attend these groups they earn points. At the end of the month the points are calculated and they get a gift card equal to the number of points that they have earned.

## 2.10 Policy for Parents

- 72% of organizations have policies or requirements for parents of victims.
- 28% of organizations do not have policies or requirements for parents of victims or address parents on a case by case basis.

**Expanded Responses to: *Do you have policies or requirements for parents of victims? (Ex. Visiting hours, family therapy sessions, etc.)***

1. **Courage House:** All visits are handled off site. We are a confidential facility.
2. **For the Sake of One:** Yes the parent must be safe and have gone thru five counseling prior to visiting with their child under supervision with only 24- 48 hour weekend visits every quarter of the year.
3. **Freedom Place:** Family therapy is offered to parents/guardians of victims. All family sessions are scheduled and take place with the therapist present.
4. **His House Inc. dba His House Children's Home:** Visitation Sun-Sat (pre-scheduled) family therapy sessions are offered by our community resources.
5. **Mission 21:** Yes. Parents are required to be a part of the child's review meetings. We request and highly encourage and help support that parents attend suggested family therapy sessions and parenting workshops but it is not mandatory.
6. **Restore Corps:** Once staff has determined that the parents played no part in the exploitation of the victim, family therapy and parent visitation will be encouraged as soon as possible at the counselor's discretion. If it is discovered the parent played a part in the exploitation of the victim, there will be requirements of law enforcement interaction and pending parental visitation/group sessions.
7. **Polaris Project:** For clients living in our transitional housing clients may have only approved visitors, which may include family members.
8. **Redemption Ridge:** Visitations are scheduled and monitored by each young woman's social worker, according to the need and appropriateness of the visit.

9. **Safe House of Hope, Inc. (SHO Hope):** Host families and their host client must get regular counseling separately and together and must meet with a staff member for family meetings regularly. We start with daily meeting for the first three to five days, ten weekly meetings for the first three months, then bi-weekly, then monthly meeting.
10. **Wellspring Living:** Visiting hours and family therapy sessions.
11. **Youth For Tomorrow:** Yes. We have visiting hours and appointment for family therapy. We also work closely with parents as residents transition home, assisting with school enrollment and identifying support services in the community.
12. **Youthcare Seattle:** This varies case by case. For youth that have family still involved in their lives we encourage family therapy (which we provide).

## 2.11 Community-based operating hours

- Most community based programs have regular operating hours, and emergency on-call or individual case management.

### Expanded Responses to: *What are your hours?*

1. **Courtney's House:** M-F 9-6, Saturday during Support Group Times. Crisis on call 24hrs
2. **End Slavery Tennessee:** Theoretically 9-5 weekdays but case manager is available as needed 24/7 and irregular hours in nights and weekends are common.
3. **GEMS:** Program - 9.30 -7pm - on call 24 hrs
4. **The Genesis Project:** Currently – call out basis only – 8pm-8am 5 days a week mirroring the vice unit's working schedule
5. **Georgia Care Connection Office:** GCCO is available 24 hrs by phone. The GCCO team works flexible hours as needed.
6. **Indiana Protection of Abused and Trafficked Humans Task Force:** 24 hours
7. **Kristi House:** 9-5:30pm generally speaking. However, we work on flex time and usually the case workers keep later hours and are responding to crisis 24-hours.
8. **Mission 21:** 24-hours
9. **Multicultural Clinical Center:** Hours are dependent upon the client needs. Services can and are provided on weekends and/or evenings.
10. **Restore Corps:** 24h
11. **Polaris Project:** Our hours are 9am to 5pm Monday through Friday in Washington DC and Tuesday through Saturday in New Jersey

12. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** Office hours are 10-6, however, we provide 24-hour on call support. Each of the six Life Coaches takes a week-long on-call shift on a rotation and are able to be available by phone or in person when necessary.
13. **Safe House of Hope, Inc. (SHO Hope):** 901 Hollins open Drop-in - Wed and Thurs 9am-2pm; 901 Hollins classes and counseling, Mon 10am - 2pm; 901 Hollins Awareness and Choir Sat 10am to noon. Starting in late Nov 2012 - 4710 Curtis Ave, Open Drop-in Tues and Friday, 9am-3pm; Street Outreach Fridays 10pm - 3am, Sat midnight – 5
14. **San Diego Youth Services:** Group is Wed 5-8pm, group is on site of another program and clients can stop by or make appts for case management services
15. **Traffick911:** 24/7
16. **TurnAround, Inc.** M-F 9am-7pm. We also operate a Helpline and law enforcement can call this line 24/7 to reach a human trafficking advocate to provide emergency and community-based service.
17. **Women's Crisis Center & PATH:** 24hr (walk-in 8:30a-5pm)

## 2.12 Drop-in services

- 70% of organizations do have drop-in services.
- 23% of organizations do not have drop-in services.

### Expanded Responses to: *Do you have drop-in services? If so, please describe them.*

1. **Courtney's House:** Yes. We are a drop-in center. We offer food, crafts, attention from staff, practical resources (i.e. computer access, as needed)
2. **GEMS:** Yes for everything. Everything. Educational support (tutoring, getting back into school), employment training, food and clothes, computer use, case management, group counseling, activities, individual counseling, art therapy, yoga, etc. Lots of services. This is the core of the program. Some kids come in because court mandated, others because they have friends here.
3. **Georgia Care Connection Office:** There is not a Drop in Center. GCCO's team meets the youth and family where they are. GCCO is available to assist law enforcement 24hrs with youth found on the street. GCCO team members often work after hours, receiving phone calls from youth or partners.
4. **Janus Youth Programs, Inc.:** Yes. Youth can come in 24 hours and meet with staff. Food is available. If they need a safe place to stay overnight but do not want to enter shelter, they can stay in the office.
5. **Kristi House:** Yes. There will be someone to greet anyone that comes to the front desk at the main or program office and contact us to work with the client and open the case.
6. **Mission 21:** Advocacy Center opened for emergency intervention services. We provide food, clothing, medical, a place to feel safe, immediate case management.

7. **Polaris Project:** Yes we have a drop-in center during business hours where clients are able to access computers, participate in group, receive job and education counseling and obtain food and clothing through our food bank and donation closet
8. **Safe House of Hope, Inc. (SHO Hope):** Yes, we are open to all who gender identify as women for a family environment that includes free food, hygiene, clothes, sheets and blankets, house hold goods, computers, classes, referrals.
9. **The Salvation Army of Central Ohio:** Yes, We have a drop in center that is open one day of the week from 1-9pm.
10. **TurnAround, Inc.:** Yes, drop-in day center services are M/W noon - 7pm. We are working to determine if Saturday hours are necessary. Drop-in provides: safe daytime shelter, peer and therapeutic groups, basic needs/food shopping area, access to advocates, computers, case management, life skills.
11. **Women's Crisis Center & PATH:** Walk-in offices in various counties. Security systems. Private entrances. Front door staff.
12. **Youthcare Seattle:** YouthCare operates the Orion Center which is a drop-in program (M-F 3-6pm) but drop-in services are not DMST-specific.

## 2.13 Length of Care Variables

- 33% of organizations responded that time length, at least in part, determines how long each individual is served.
- 80% of organizations responded that a child's well-being or mental state, at least in part, determines how long each individual is served.
- 23% of organizations responded that funding, at least in part, determines how long each individual is served.
- 40% of organizations responded that the individual's age, at least in part, determines how long each individual is served.
- Several providers also listed there was no limit to the length of services or the length of services was determined by the desire the client to participate.

## 2.14 Services After Youth Reaches 18 Years of Age

- 38% Transition youth to other program
- 14% of programs continued to age 21 or 22

### Expanded Response to: *What happens when a child that you are serving turns 18?*

1. **Georgia Care Connection Office:** GCCO will connect them with other partners serving 18 and older. The CSEC Intervention Specialist will assist them through that transition and can be available if appropriate by phone.
2. **His House Inc. dba His House Children's Home:** The Independent Living Specialist assists the youth to transition to a program that serves this population or explores options with family members, or other sponsor.
3. **Janus Youth Programs, Inc.:** We can continue to serve them with a break in service. If they leave our program at 18, they will not be able to return. If they turn 18 in our program we can continue to serve them in our residential and crisis programs.
4. **Mission 21:** When child turns 16 they may be referred to other services (Breaking Free) or reintegrated back into bio-family or foster family.
5. **Multicultural Clinical Center:** Depending on the funding source and referring agency, clients can continue to receive treatment.
6. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** If she signs a voluntary placement agreement with DCF she can continue with us up until her 22nd birthday.
7. **StreetLight USA:** They can remain up to the age of 22 as long as they are enrolled in school or working
8. **The Salvation Army STOP-IT Program:** They can transfer from the DM program to the adult program and continue to receive case management services if they are working with law enforcement.
9. **Youthcare Seattle** We attempt to transit on them into one of YouthCare's over-18 Transitional living programs or those run by the YMCA. Sometimes the youth returns home. We start planning months before the 18th birthday if possible so the youth has as much control as possible over the process and can make informed decisions about their futures.

## 2.15 Relationships with law enforcement, taskforces, child protective services and other related organizations

- All respondent organizations currently providing services maintain relationships with local law enforcement, area taskforces or child protective services.
- Most organizations currently providing services report having very good and productive relationships with local law enforcement, task forces, child protective services, although some indicated that relationships could be improved.
- One organization currently providing services is run by law enforcement.



**Expanded Responses to: *Please describe your relationship with local law enforcement, area task forces, child protective services and other related organizations.***

1. **Bilateral Safety Corridor Coalition:** BSCC has an incredible relation with law enforcement both federal and domestic and throughout the State of California. BSCC has a memorandum of understanding with Child welfare service and our agency is held in high esteem. We respond to prostitution raids, curfew sweeps, johns details etc.
2. **End Slavery Tennessee:** We work closely with law enforcement on the local, state and federal levels. Most of our referrals come from them. We work with CPS and DCS primarily through LE though occasionally directly; we train foster parents with DCS.
3. **For the Sake of One:** We have connections with Texas law enforcement and FBI victims' specialist throughout Texas. One of our founding board members in the leader of the North Texas anti Human Task force and conducts training to area departments. We also work closely with other NGOs.
4. **Freedom Place:** Fostering strong relations and partnerships with local law enforcement and task forces in the community is critical. Having an educated law enforcement helps identify and provide services to victims and due to our relationship with law enforcement we are able to rely on them in the event of an incident. Area task forces are a great resource for local service providers to collaborate. Engaging in communication and building relationships with local organizations is key to an effective program.
5. **GEMS:** Relationships have gotten better but still not where they need to be. Law Enforcement: now there is a specialized trafficking unit – great relationship (but only 11 cops of many more officers). Child Welfare: 6,000 workers. There is training but that's a lot of people. Massive shift. Film has been a major part of that. Change needs to be systemic, not just one good cop or judge. Great relationships in some but not all boroughs.
6. **The Genesis Project:** We are one in the same with LE – our founder is a Police Officer and the board consists of 2 other police detectives.
7. **Georgia Care Connection Office:** The relationships that have been built with all of the partners listed above are the basis of the collaborative efforts in Georgia. The relationships that have been built with all of the above and other partners are the basis of the collaborative efforts in Georgia. This relationship building is a primary focus and role of GCCO. The goal from the beginning has been to bring everyone to the table, and it has taken the collaborative efforts of everyone to build the system of care approach to serving CSEC youth, develop the continuum of care options, change laws, strengthen apprehension and prosecution of perpetrators, and bring awareness to the issue that these CSEC victims are Georgia's children. Some of the key relationships developed are:
  - a. Governor's Office for Children and Families CSEC Task Force, a collaborative effort of all CSEC partners in Georgia, with workgroups focusing on various issues. Through the GOCF CSEC Task Force work, and funded through GOCF, curriculum and trainings were developed and continually presented for Law Enforcement, Prosecutors, community awareness, Mental Health Providers, and Medical Professionals.



- b. FBI Match Task Force, includes Metro Atlanta local law enforcement, refers youth to GCCO.
- c. GBI has a Human Trafficking Task Force, had a grant, which also provided monthly to GCCO's Safety Gap Fund. GBI also worked side by side with GCCO and other partners to develop the Emergency/Crisis Bed Protocol Process, which provides a process for when law enforcement in the metro area find a CSEC youth on the streets in the middle of the night. The protocol is a process by which the child can get immediate placement into an emergency bed. Children's Health Care of Atlanta's (CHOA) Emergency room and the Child advocacy Center connected with CHOA, the safe Home and GCCO, along with DFCS, and sometimes the Juvenile Courts, are all a part of developing this protocol and implementing it successfully.
- d. Local law enforcement in all of Georgia's Counties is ongoing relationship building, through awareness training, and meetings.
- e. The State level of DFCS has really been at the table in drafting a policy pertaining to CSEC, partnering on the emergency/crisis be protocol process, and working closely on individual cases.
- f. DJJ, individuals on the state and local level work collaboratively with DJJ in serving CSEC youth.
- g. Prosecutors on the federal level and local levels have had growing success in prosecution of the perpetrators and lengthy sentences, including life sentences.
- h. Emory University's Barton Clinic, created tools for prosecutors on the GA Laws,
- i. Well Springs and GA Baptist, the joint venture for the safe home and the emergency beds, have grown alongside GCCO in the journey to serve Georgia's CSEC youth. The consistent collaborative efforts of all three of these organizations in serving CSEC youth, in a safe home, has been an opportunity to learn a lot about serving CSEC.
- j. Well Springs leads the way in providing mental health services in the safe home and developing the CSEC specific ELP program, and working with GCCO to collaborate with others to build a continuum of care.
- k. View Point Health, previously GRN, a regional mental health provider, was one of the original partners in developing the system of care approach to serve CSEC youth. GOCF awarded them GCCO's from June 2009 to November 2011.
- l. Children's' Advocacy Centers, serves as the primary prevention partner. Some CACs provide forensic interview. Key CAC partners have worked on specific CSEC Forensic Interviewing protocol, a second level of Mental Health Provider training, and sit on many GOCF Task Force committees and meetings. In November 2011, Children Advocacy of Centers of Georgia, the umbrella membership body of Georgia's CACs was awarded GCCO's contract with the intent to assist GCCO to grow statewide.
- m. EMSTAR, collects data, provides evaluation, and research, on CSEC youth and GCCO's efforts and growth in serving CSEC youth.

- n. youthSpark, formerly the Juvenile Justice Fund, was a part of the beginning of CSEC efforts in Georgia in Fulton County. A Future Not a Past is a program under the Juvenile Justice Fund, is a strong advocate on CSEC Issues, and focuses on Demand issues,
  - o. Children's Health Care of Atlanta, CHOA, is the medical emergency provider partner, as described previously. A key partner in the emergency/ crisis bed protocol and training medical providers.
  - p. Many others could be added and more relationships are developed daily as we grow statewide and reach more people and organizations.
8. **His House Inc. dba His House Children's Home:** The Crisis Intervention Specialist knows regular responding officers. Officers are supportive. We participate in the S. FL Human Trafficking Task Force and CSEC Working Group of Miami. We've been licensed for 20 years with the Department of Children and Families so we work closely with Protective Services as we receive all clients through them.
  9. **Hope House:** It took time to build trust amongst governmental organization.
  10. **Mission 21:** Law Enforcement/Child Protection- only when mandated or requested by child. We do work together in overall policy planning for the county however. Active participants in Minnesota Human Trafficking Taskforce and Safe Harbor Working Group.
  11. **Multicultural Clinical Center:** Collaboration is a contributing factor to success and frequently utilized. The efforts made between law enforcement and clinicians are required as plays a pivotal role in the clients' life.
  12. **Redemption Ridge:** Oregon's DHS seems to be quite political. We trust that we will meet the right people when the time is right for us to open our doors. We will provide the program, offer it to DHS and we expect they will allow us to help them since we are the only provider for this population in the State of Oregon. Doors are opening slowly with relationships with law enforcement and the judicial system.
  13. **Restore Corps:** We have a strong legislative campaign and have strong relationships with law enforcement and the attorney's office resulting from this campaign. We have been invited to participate in numerous public speaking engagements as expert panelists alongside law enforcement. We have provided intel to law enforcement on criminal activity, and have been invited by federal law enforcement to respond to victim needs.
  14. **Polaris Project:** Our DC office works with local law enforcement and area tasks forces in the DMV areas in order to provide services to potential victims. This partnership often means that we respond to crisis calls referred by law enforcement. We assist client by providing criminal or court advocacy as needed during the length of an investigation. We also provide information on best practices as needed an request by other social services agencies
  15. **Redemption Ridge:** We trust that we will meet the right people when the time is right for us to open our doors. We will provide the program, offer it to DHS and we expect they will allow us to help them since we are the only provider for this population in the State of Oregon.

**16. Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** We work closely with the Human Trafficking Unit of the Boston Police Department as well as the two local BPD districts we are located near. We are contracted through the Department of Children and Families. I am a 5-year steering committee member of the SEEN (Support to End Exploitation Now) Coalition through the Suffolk County Children's Advocacy Center and the Suffolk County DA's Office.

**17. Safe House of Hope, Inc. (SHO Hope):** We are partnerships with local and federal law enforcement. I am the deputy chair of the victim services subcommittee of the MD HTTF and am trying to work with CPS.

**18. The Salvation Army STOP-IT Program:** We currently are on the Cook County Human Trafficking Task Force collaborating with key law enforcement individuals and community based agencies.

**19. Traffick911:** Traffick911 partners with the North Texas Anti-trafficking Task Force, headed by Dallas Homeland Security Investigations, and local law enforcement. That partnership has led to multiple felony arrests of traffickers, recruiters and buyers.

Traffick911 also partners with CPS, the Juvenile Justice System and other key governmental agencies to train first responders, identify and rescue victims and provide services.

**TurnAround, Inc.:** We work VERY closely with MD Human Trafficking Task Force, FBI Crimes Against Children Task Force, DSS, DJS and other community based services. We could not operate successfully without these partnerships. We have an official MOU with DJS to implement a screening tool for flagging detained youth with indicators of DMST. Our MOU provides us access to the youth once they have been flagged for follow-up HT assessment and ongoing services for youth confirmed as former or current survivors.

Additionally we are co-located with the Baltimore Child Abuse Center where they have a team of forensic interviewers who are trained and willing to provide this service 24/7. We have an informal agreement with law enforcement that allows them to access the BCAC to conduct interviews and then access services through TurnAround. While this protocol is not formalized through an MOU we've successfully facilitated this process on several occasions.

**20. Youth For Tomorrow:** Very good. Meet with local law enforcement quarterly, Program Director is chair of victims service committee

**21. Youthcare Seattle:** There has been a multi-system anti-trafficking task force in Seattle for over 8 years. However, it was mostly focused on international trafficking. In 2010 the City of Seattle formed a Steering Committee to develop a response protocol and 3-5 year strategic plan to respond to sexual exploitation.

YouthCare's Bridge Program has worked closely with police and juvenile justice since the inception. Most of the program's referrals stem from somewhere in the criminal justice system. The Seattle Police department transformed the Vice unit to the Vice/High Risk Victims Unit in 2010 and have specially trained detectives that are dedicated to recovering victims and investigation perpetrators (pimps, gangs and buyers).

## 2.16 Relationship with business, faith community and volunteers

- The majority of respondent organizations currently providing services have productive relationships with local businesses and/or religious communities. One program is a church.
- Organizations currently providing services listed the following volunteer roles:
  - Childcare
  - Daily operations
  - Fundraising/raising awareness<sup>249</sup>
  - Leading skill based classes: jewelry making, photography, yoga<sup>250</sup>
  - Material preparation
  - Mentoring<sup>251</sup>
  - Research team
  - Street outreach
  - Support group leaders
  - Translating
  - Transportation<sup>252</sup>
  - Tutoring<sup>253</sup>
  - Web maintenance

**Expanded Responses to:** *Please describe your relationships with the local business community and/or the local spiritual community, such as area churches, etc. Also, describe the role of volunteers from the community in your organization.*

1. **Araminta Freedom Initiative:** We were founded out of 5 local churches and currently engage with over 20 local churches. Our mission is to Awaken, Equip and Mobilize the local church and community to effectively stand against DMST in the Baltimore region. We have a 5 week training course that volunteers take to engage in our teams, which include education, community awareness, church mobilization, economic deterrence (working with local hospitality venues to become traffic free), and aftercare (currently working with TurnAround to assist their case management but are developing aftercare initiatives). We work with other local agencies, including the TurnAround anti-trafficking program.
2. **Bilateral Safety Corridor Coalition:** We are supported by the Eastlake Church Soroptimist clubs, Rotary International and foundations . We have community volunteers from schools for community service, community leaders and church individuals.

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249 Four organizations listed this response

250 Three organizations listed this response

251 Four organizations listed this response

252 Two organizations listed this response

253 Two organizations listed this response

3. **Courage House:** We love our community and our churches. Our volunteers primarily have come from the church at large. We have a training program to prepare the community at large to serve the girls.
4. **Courtney's House:** Volunteers play a vital role for CH. Mentors, Drivers, Support Group Leaders, Research Team, Street Outreach.
5. **End Slavery Tennessee:** We utilize many volunteers, and the vast majority are from area churches. We hold monthly volunteer groups in six areas geographically. Volunteers serve in many ways from support roles (web maintenance, training professional organizations and community groups etc. to direct work with survivors- transportation to appointments, childcare, tutoring, "Lifeline" (mentoring of minor survivors)
6. **For the Sake of One:** We have nationwide relationships with churches, NGO and social service providers and activists. We have FSO task force teams launching this year across America that volunteer and some strong business ties we are developing.
7. **Freedom Place:** Many of our services and amenities are possible from local businesses and spiritual communities. Almost all of our volunteers come from a church base and also support the program through community funds. If we did not have the support of community businesses and churches we would not be successful. All donated services have come from volunteers who became engaged from either their business environment or church.
8. **GEMS:** It really depends on the borough, each one has different relationships. Faith communities have actually been one of the slowest to step up. Business community also not massive. Volunteers – mentoring program. More like group mentoring. Mentee/BigSister/Sister Group facilitation – usually volunteers have a specific skill – jewelry making, photography, etc. Most volunteers are not taken because of capacity and managing that many people.
9. **The Genesis Project:** We have a very healthy relationship and support with many churches and local businesses. Many of our donations come via local churches, businesses, and community leaders. We also have established relationships with members of the state legislature and are in constant contact with many of them. Also, describe the role of volunteers from the community in your organization. We have 84+ volunteers that have been through our trainings and currently in our data base ready to serve in the center or other aspects of GP.
10. **Georgia Care Connection Office:** Many local churches reach out to GCCO for presentations and are interested in CSEC issues. One nearby church has collected gift cards and offered space in their church for GCCO to provide community support groups.
  - a. StreetGrace is faith based collective effort of churches, which focuses on advocacy, prayer, awareness, and volunteering.
  - b. Out of Darkness is a relatively new faith based organization focusing on outreach and linking 18 and over victims to services.

- c. Interfaith Children's Movement is a faith based organization which focuses on a variety of children's issues, including CSEC. ICM was funded by GOCHF to facilitate the Mental Health Providers' training throughout the state.

GCCO in of itself does not really have a place for volunteers other than those interested in fundraising for the Safety Gap Fund. However, the skills of a volunteer can often be matched with one of our Partners within the GOCHF CSEC Task Force.

- 11. His House Inc. dba His House Children's Home:** Large companies such as Comcast, Royal Caribbean, Publix, FedEx sponsor major fund-raising events and service project. Smaller business partner with the agency for various drives i.e., food, school supplies, holiday gifts, etc. Partners in the construction industry continuously participate in home renovation. A bilingual (Sp/Eng) Church Liaison on staff performs numerous visits to churches every week as well as participates in Pastors Association meetings. This Liaison coordinates speaking opportunities for the Executive Director as well as invites the same to visit the campus. Community awareness displays are presented at concerts, churches and other venues. Hundreds of volunteer hours are given in service to the agency on a monthly basis. Volunteers assist with fund raising as well as direct care and enrichment activities and professional services. We currently have matched volunteer mentors for children residing on campus.
- 12. Home of Hope:** Local business and churches are excited that someone is trying to help. Volunteers are mainly donation bases including clothes, supplies, funds. They understand that due to the nature of what we are doing, that no access to this property is available.
- 13. Hope House:** Found it somewhat difficult at the beginning as a faith-based organization to break the stigma. But the business community has been very giving.
- 14. Mission 21:** All of our financial support comes from each one of the entities described above. Businesses and Faith Communities are active in supporting, sponsoring or hosting awareness and fundraising events. Some serve on our board of directors and provide us with resources within their own networks. Community volunteers help out with awareness events by hosting or organizing. Others help our outreach team put together care packets, meals, transportation, etc. Most community volunteers help in community education, teaching our trafficking awareness classes throughout the state.
- 15. Multicultural Clinical Center:** The relationship is very positive. Often times resources within churches or religious organizations assist in deterring negative influences
- 16. Restore Corps:** Local businesses and churches have asked staff to educate and empower their staff and congregations on how to take part in fighting DMST. Volunteers from businesses and churches have provided many services ranging from printing to covering medical costs for victims, and/or translating for staff.
- 17. Polaris Project:** Through the expansion of our job training program we are attempting to engage local businesses by providing training and advocating for potential employment opportunities for our clients. We work with faith-based groups to provide training and to request donation drives

in order to fulfill additional needs of our clients. Additionally, we staff fellows in our office whom provide support to our clients in the form of job coaching, tutoring, drop-in center management

- 18. Redemption Ridge:** Once we purchase the land, we have the Architect and Contractor from the Medford's Extreme Home Makeover project who have procured building supplies and services to build the school and 1st home. Churches have started to support us, local businesses are on board, and several large donors have given. We hope to begin building in 2013.
- 19. Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** I attend a neighborhood stakeholders meeting monthly. We have developed strong relationships/partnerships with community providers, churches etc. We don't often have volunteers come in due to confidentiality issues as well as the youth being in state custody; but if so, they need to undergo a criminal background check and we must get approval from our referring agency.
- 20. Safe House of Hope, Inc. (SHO Hope):** We are continually building more relationships with local businesses and churches. We need them and have had many in-kind donations and financial support from both as well as a many volunteers from churches. Until Nov 5th we were completely volunteer since our beginning in Nov 2010. We just hired one survivor of DV and SA to work as our drop-in coordinator to ensure safe drop-in services in our two locations. We cannot run without volunteers and interns. They are imperative to our daily operations. We also have started a client volunteer initiative that has really helped our client to move forward.
- 21. The Salvation Army of Central Ohio:** We are a church and have a good reputation in the community. We utilize many volunteers for various aspects of our programs
- 22. The Salvation Army STOP-IT Program:** We are currently working to educate churches and train volunteers to provide services to our clients.
- 23. Traffick911:** Traffick911 partners closely with businesses, the faith-based community and volunteers. The majority of our programs, including those that result in identifying victims, are led by volunteers. Traffick911 volunteers are trained for the specific area they work in and execute their programs with excellence, professionalism and integrity.

Businesses and the faith-based community open doors for us to raise awareness, preventing victims; hold trainings for first responders; host fundraisers and provide other donor sources; and recruit volunteers.

**TurnAround, Inc.:** We also have an MOU with Araminta Freedom Initiative which is a faith-based group that provides support, direct service funding and advocates for our programs. Araminta has developed a 6 week training course that is aimed at providing an in-depth education to individuals who are interested in using their time and energy to combat sex trafficking.

Following the 6 week training individuals are provided with several engagement opportunities, one of which is volunteering as an advocate or mentor with TurnAround. This is a great partnership because it provides us with highly qualified volunteers who have already been trained. Additionally, Araminta conducts the background checks on these individuals.



The advocates are a crucial extension of our direct services and support team. Advocates sign-up online for monthly shifts. Advocates assist with a variety of activities including: transportation for survivors to appointments, assistance with appointments such as signing up for school or social services, tutoring, activities, making food for the drop-in center, and court advocacy. After a volunteer has actively engaged in the advocacy program for 3 months they can apply to be a mentor. Mentors are assigned to one survivor based on a variety of availability and compatibility needs. Mentors are required to make a one year commitment to the survivor they are paired with.

All of our volunteers have a fingerprint background check conducted along with a sex offender registry, and Maryland case search review.

**24. Youth For Tomorrow:** Very strong. Our volunteers make our organization successful and run programs for us in prevention, rescue and restoration.

**25. Youthcare Seattle:** YouthCare has a Volunteer Coordinator that manages volunteering across the agency. Individuals that actually want to volunteer the Bridge Program must also go through the 40 hour Sexual Exploitation Training that staff go through and there are very limited volunteer opportunities in that program. Mostly volunteers at the Bridge serve as tutors in the school component, make or deliver meals to the program, teach life skills classes or physical activity (such as Street Yoga with whom we have a partnership).

- a. The Bridge Program Training and Policy Coordinator has done many, many talks and outreach events coordinated by faith based groups and churches. These groups also do drives and donate money to the program.

### 3. Funding

#### 3.1 Initial capital raised

- Residential tended to be much more expensive than community based programs, with capital costs ranging from \$250,000 for a 1-year pilot to \$4 million.
- Community responses ranged from \$2,100-\$350,000
- Several organizations noted donations or rented facilities over capital costs.

**Expanded Response to:** *How much capital did you initially raise to create your program/facility?*

1. **Bilateral Safety Corridor Coalition:** \$8,000.00
2. **Courage House:** \$1 million. This was used to secure the property and create the necessary program.
3. **End Slavery Tennessee:** Our office and its furnishings and many services were donated by a university; we received a grant for computer – our only cost was for a printer and office supplies.



4. **Freedom Place:** We initially raised \$1.6 million before opening.
5. **GEMS:** No capital campaign. The house is rented, not owned.
6. **The Genesis Project:** \$2,100
7. **Georgia Care Connection Office:** GCCO is an initiative of the Governor's Office for Children and Families and has been funded by GOCF since it began in June 2009.
8. **His House Inc. dba His House Children's Home:** \$300,000
9. **Home of Hope:** \$200,000
10. **Indiana Protection of Abused and Trafficked Humans Task Force:** No new capital was raised to create the facility which was created for DV but grant funding has been available for HT services through the task force.
11. **Janus Youth Programs, Inc.:** Nothing. Our agency had a vacant residential facility already. We received about \$75,000 in donations to help do some remodel of the building.
12. **Kristi House:** \$500,000
13. **Mission 21:** We are currently trying to raise \$500,000
14. **Polaris Project:** We started our housing program in 2007 with a 3-year grant of \$255,000
15. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** Our primary funder is the Boston Region of the Massachusetts Department of Children and Families. We have been fortunate to receive private donations and grant monies to help sustain our program over the years. We are always looking for grant opportunities.
16. **Safe House of Hope, Inc. (SHO Hope):** none, we decided to start with Host families because it would bridge the gap for housing. We desire to open a therapeutic group home with an enormous cost to start and maintain. We have clients now so I decided to try Host families.
17. **San Diego Youth Services:** all donation at first
18. **Street Light USA:** \$2.5 Million Dollars
19. **TurnAround, Inc.:** \$200,000 for a 1 year pilot that includes 9 staff (34 program staff, 5 adult residential), drop-in center, and transitional housing for adults.
20. **Wellspring Living:** \$350K
21. **Youth For Tomorrow:** At first, none. YFT initially created the program within existing resources. Later, through a large donation from the Bowles Family Foundation, we hired additional staff and provided training for the purposes of sustainability. We also receive considerable private donations for continued support.

22. **Youthcare Seattle:** 1.4 million for a 3 year pilot. This was combined with \$480,000 that was blended from other contracts already held by the agency. The annual operating budget is basically 1 million dollars per year.

### 3.2 Cost per individuals served

- It was difficult to determine the cost of a child served because lengths of survey varied. Annual costs listed per child in a residential facility ranged from \$24,000-\$50,000.

#### Expanded Responses to: *What is your ongoing cost per individual served?*

1. **Bilateral Safety Corridor Coalition:** \$2,500.a month for the emergency response and \$5,000.00 for the transitional shelters
2. **Generate Hope:** \$1500/month
3. **The Genesis Project:**(undetermined)\$325,000 per year to operate a 24/7 drop in center - \$207,000 for personnel, \$125,000 operating costs (including rental, utilities, food, educational and vocational needs) – Safe house budget has yet to be determined.
4. **Georgia Care Connection Office:** No answer, as there are too many variables and individualized options to know. GCCO collaborates with other agencies to blend funding streams to serve CSEC youth.
5. **Hope House:** \$34,000 per girl per year
6. **Janus Youth Programs, Inc.:** That's a tough question to answer. Some youth are with us for 4 months or longer. Others are with us for a couple of nights. If you simply divided all the DMST funds (roughly \$650,000) into the total number of youth served (in residence, case management and advocacy services 250) that per cost per client would be about \$2,600.
7. **Safe House of Hope, Inc. (SHO Hope):** None - We are all volunteer, including the executive director so the training and all the development of materials has been free. Printing has also been donated by private corporations and families volunteer their lives and homes for our clients. So far our counseling has also been donated. Our 24/7 Talkline is also manned by volunteers. The background check costs are paid by the host family and have not been included in our costs.
8. **Wellspring Living:** \$15K for therapy and education; residentially- \$35K

### 3.3 Government Funding

- 64% of organizations receive government funding.
- Government funding sources include: Child welfare agencies, state funding through county juvenile probation, DFPS contracts, city runaway and homeless youth funding, governor's office, OVC, VOCA, ORR.
- 36% of organizations do not receive government funding.

**Expanded Responses to: *Do you receive government funding? If so, how do you receive that funding and what agencies do you receive funding from?***

1. **Courage House:** Yes, we do receive CPS funds as appropriate if a girl comes from foster care or probation.
2. **Freedom Place:** We receive limited state government funding which is from county juvenile probation contracts and child specific DFPS contracts.
3. **GEMS:** City funding- Runaway and homeless youth funding- dept of homeless youth in NYC Office of Violence Against Women.-
4. **Georgia Care Connection Office:** GCCO is an initiative of the Governor's Office for Children and Families and have been funded by that office since it began in June 2009.
5. **Indiana Protection of Abused and Trafficked Humans Task Force:** Yes, we receive a grant from OVC through the HT task force IPATH although that funding has not been renewed at this time.
6. **San Diego Youth Services:** Group- no, it is grants and donation from the community; Shelter - yes, FYSB and OES; Counseling - county funded.

### 3.4 Referral Funding

- 93% of organizations said they do have the capacity to receive a child who doesn't have a government funding stream attached.
- 7% of organizations said they do not have the capacity to receive a child who doesn't have a government funding stream attached.

### 3.5 Private Sources

- 93% of organizations do seek funding from private sources. Sources include:
  - Churches<sup>254</sup>
  - Businesses/Corporations<sup>255</sup>
  - Donations<sup>256</sup>
  - Events<sup>257</sup>
  - Foundations<sup>258</sup>
  - In-Kind
  - Private donors/ Individuals <sup>259</sup>
  - Non-profits<sup>260</sup>
  - Retail store
  - Schools
  - Will bequeaths
- 7% of organizations do not seek funding from private sources.

**Expanded Responses to: *Did you fundraise from private funding sources? How did you fundraise? (Ex. donations, corporate funding, funding from area churches, etc.)***

1. **Emma's Home:** Get a lot of funding from churches, and businesses. Churches: funding/volunteers/ awareness. Business: services/goods/event funding
2. **Freedom Place:** We used a variety of fundraising tactics. Majority of donations came from individuals through small home parties, about 44% is from corporations and grants and the remainder comes from churches.
3. **Generate Hope:** Education, fundraising events, grant writing
4. **The Genesis Project:** Yes- private donors, churches, businesses, annual auction, annual Freedom Walk fund raiser – online donations – other trafficking organizations – smaller scale fundraisers (all private)
5. **Georgia Care Connection Office:** No fundraising, but created the Safety Gap Fund, for those private individuals and groups wanting to help. They can contribute to the Safety Gap Fund and assist in the residential care for CSEC victims.
6. **Mission 21:** Donations from corporate and private parties, churches, fundraising events, benefit banquets, public concerts, auctions, grants.

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<sup>254</sup> Fourteen organizations provided this response.

<sup>255</sup> Twelve organizations provided this response.

<sup>256</sup> Eight organizations provided this response.

<sup>257</sup> Seven organizations provided this response.

<sup>258</sup> Eight organizations provided this response.

<sup>259</sup> Six organizations provided this response.

<sup>260</sup> Two organizations provided this response.

7. **Street Light USA:** Yes. Our fundraising strategy is a diverse portfolio of income, in-kind, corporate, foundation, churches, individual giving, special events, major donors
8. **Youthcare Seattle:** Yes, the city of Seattle established a “Prostituted Children Recovery Fund” that raised almost 1 million dollars with some smaller foundation donating. YouthCare has a full development team (that supports the whole agency not just the DMST program) that includes grant writing and major gifts cultivation and an annual luncheon.

## 4. Programmatic and Therapeutic Care

### 4.1 Importance of Therapy

- 100% of organizations said that therapy is a critical component of providing restorative services.

*Expanded Responses to: Do you feel that therapy is a critical component of providing restorative services? What are the core components of providing therapeutic care to a DMST victim?*

1. **Courage House:** Therapy is absolutely critical to the restoration process. But trust is absolutely paramount for this to work. We help our girls through their trauma working through their core narratives often finding that early childhood trauma played a huge part in their later victimization.
2. **Georgia Care Connection Office:** Yes, and the timing of therapy is critical. It is important for mental health providers to understand CSEC youth, to know when youth is ready for that step and which therapy is best for each individual’s needs
3. **GEMS:** Yes. Traditional 1 on 1 therapy is needed but it’s not always the most important. The girls need to be in a stable healthy place before they can begin this type of therapy. It should be less trauma focused, at least at the beginning, and more on providing a safe environment where you can approach the child about the trauma later. You need a Trauma-Informed Model that incorporates therapeutic elements throughout. Also it’s important for workers to be good because they often do as much therapy as an actual counselor. For example, Night shift often doesn’t have Social Work degree but they really are doing more therapeutic work so make sure they are good staff – it’s a different type of therapy. Young people don’t care about your degree. Other therapeutic activities besides traditional: artistry, physical activity, tattoo removal.
4. **Kristi House-** Yes and no. Therapy is critical to the healing process once the survivor is ready for it. Forced therapy when they are not ready could cause more harm and build resistance toward healing in the long run. It’s important to view all steps from stabilization and education to therapeutic processing as part of the “therapeutic care” of the survivor. Much of what we do is the front end stabilization, case management, advocacy and education / insight building, all of which will lead to successful engagement and consistency in therapy. Kristi House does TF-CBT specializing in sexual abuse and exploitation. We are also trained in Motivational Interviewing which is a key technique

used to engage clients for services and help them to build insight and make better choices. The main components of therapeutic care include: stabilization, psycho-education and finally therapeutic processing.

5. **Multicultural Clinical Center:** Yes, the core components for treatment of DMST victims/survivors are based upon the individual needs. This can include gender specific group therapy, individual therapy and family therapy. The components of treatment can be a combination of art therapy, Eye Movement Desensitization and Reprocessing (EMDR), Psychophysiological Trauma Treatment, trauma specific treatment and Cognitive Behavioral Treatment.
6. **Safe House of Hope, Inc. (SHO Hope):** I think that therapy is important although clients do not usually keep going to it. We are piloting therapy through life coaches to see if this will help our clients to consider their future; not keep reliving their past. We need to work in therapy to help our clients see a possibility of a future and a good future for them. If we work to help our clients to in vision a healthy future and also only work on past issues that are directly impeding that future I believe we may be more successful in keeping clients in their needed therapy.
7. **San Diego Youth Services:** Yes, therapist must be open and non-judgmental. Depends on youth for which therapy is most effective - narrative therapy, CBT, EMDR, Seeking Safety, survivor based support groups,
8. **The Salvation Army of Central Ohio:** Yes. Core components: Trauma sensitive, self-worth, self-esteem, love, healthy relationships, identifying triggers and safe coping habits.
9. **Traffick911:** Absolutely. Victims of domestic minor sex trafficking have experienced unique trauma that they can only heal from with professional, license counseling that follows a strength-based and trauma-informed model. Trauma for these victims often begins before the trafficking, so it is important for counselors to understand they are exposed to chronic interpersonal trauma that began at an early age in many cases.

Traffick911 trauma counselors stay on top of the latest research and methods.

10. **TurnAround, Inc.:** Yes therapy is a core component but basic stabilization (physical, mental, emotional) must occur first. A survivor must be stabilized and moderately consistent for therapy to be safe and effective. Additionally, many girls in our program are not ready to put their experience into words....so we have started offering alternative therapeutic outlets such as yoga, relaxation skills and equine therapy.

We have found that therapeutic groups are a better first introduction to therapeutic intervention. Additionally it provides them with the peer support and relationships that can help them understand their victimization.

11. **Wellspring Living:** ABSOLUTELY. Personalized therapeutic plan based on girl's needs and responses
12. **Youthcare Seattle:** We believe that harm and trauma are inherent in the experience of being sexually exploited/trafficked. We also see that most youth in "the life" have prior abuse/neglect/trauma

histories. Therefore, yes, we believe that trauma recovery or therapy are critical components to a program serving this population.

## 4.2 Types of Therapy

- Many respondents reinforced that types of therapy approaches should be guided by the victims individual needs or progress.
- Many types of therapy models were listed including:
  - Art-based Therapy
  - Cognitive Behavioral Therapy<sup>261</sup>
  - Cognitive Therapy
  - DBT
  - Egala/Equine Therapy<sup>262</sup>
  - Eye Movement Desensitization and Reprocessing<sup>263</sup>
  - Family Therapy
  - Life coach
  - Multi-cultural/Feminist Theory
  - Narrative and Existential Therapy
  - Psycho-educational
  - Psychophysiological Trauma Treatment
  - Seeking Safety<sup>264</sup>
  - Survivor based support groups
  - Tattoo removal
  - TBRI from Dr. Karen Purvis out of Texas Christian University (TCU).
  - Trauma Specific/Informed Treatment<sup>265</sup>
  - Trauma Recovery Empowerment Model
  - Trauma Focused/Informed Cognitive Behavioral Therapy<sup>266</sup>
  - Touching
  - Twelve step model
  - Yoga and Relaxation

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261 Four organizations listed this method.

262 Two organizations listed this method.

263 Four organizations listed this method.

264 Two organizations listed this method.

265 Two organizations listed this method.

266 Nine organizations listed this method.

**Expanded response: *Do you use a specific therapy model? Please describe the model you use. Have you tried any other therapy models? If so, what were the strengths and weaknesses of the models you used?***36

1. **Georgia Care Connection Office:** Not applicable to GCCO, except as to considerations in linkage for mental health services in the community, and participation in the committee which developed a six hour basic CSEC mental health awareness training for mental health providers. A second level of SCES specific training is a project of a GOCG Task Force workgroup and will hopefully be developed in the near future. GCCO links to community mental health providers who have staff trained in trauma focused therapy and who have experience working with CSEC youth. The safe home, through Wellspring, has a full array of mental health counseling available, developed through their experience in working with our CSEC youth. They are able to utilize the therapy which is most appropriate at the time for each child.

### 4.3 Therapy On-site vs. Offsite

- 71% of organizations use staff resources for therapy, although 50% of these also noted they provide external sources.
- 29% of organizations use external resources.

**Expanded Responses to *Do you use a staff resource or external resource for therapy/counseling? Why do you use this approach?***

1. **Courage House:** We have staff on-site to provide counseling. We find it beneficial that this relationship is fostered here so all of our treatment team can provide insight to a resident's progress and behavior.
2. **Kristi House** Yes. We do not provide therapy in the home or substance abuse counseling, so if the family requires that, we will refer to another trusted agency. Also, many of the foster children come into our program already attending therapy through their foster care agency. We do not disrupt relationships if they are currently benefiting from their outside therapist.
3. **TurnAround, Inc.:** We use internal therapists and I think this is important for the treatment team approach. Survivors are great at reading people and knowing how to change the context of the conversation to get their needs met. Having a treatment team approach ensure that all conversations are centered around a shared goal and dialogue set by the survivor.

Additionally for most of our DJS youth, they are placed in locations and provided with therapy in-house. In these situations we play a critical role in helping the therapist understand some of the trafficking dynamics.

4. **Redemption Ridge:** Staff resources: We plan to have lead therapist and all staff who've been trained in TF-CBT. Therapy starts in the therapist's office and continues with staff knowledge of the components of TF-CBT. This proves to be a great reinforcement.



5. **Mission 21:** External resources for therapy and staff for life skills and group counseling. Less cost.
6. **His House Inc. dba His House Children's Home:** Yes . We should say we use both staff resources and external for therapy. Agencies in the community have the specialization.

#### 4.4 Services for Parents and Guardians

- 84% of organizations that responded provide some form of support or training for parents or guardians of victims.
- 16% of organizations that responded do not provide support.

**Expanded Responses to: *Do you have services, support or training specifically geared toward parents or guardians of victims? Please explain the benefits or importance of this component.***

1. **Clark County Juvenile Justice:** It is critical for me to educate the parent that this is not a choice the child is making and they need to continue to provide the safety net.
2. **Courage House:** Yes, we do offer family therapy as appropriate and available. We can skype the parent as appropriate as well. This is integral if reunification is anticipated to happen
3. **Courtney's House:** Yes. We offer Parent Support Groups. When you are working with youth, you are working with the entire family structure. Parents have experienced their own level of trauma as a result of their child's trafficking situation. Services Provided: Education, Spiritual Care
4. **For the Sake of One:** If family is safe to re integrate then a parent will need to attend 5 therapy sessions before they can see their child at the site. The reason it is important is because a majority of these children have been abused or neglected at home by parent and or family members that resulted in them being on the streets.
5. **Georgia Care Connection Office:** GCCO has a Family Support Specialist on staff, who has previous experience raising a niece who was CSEC, and understand the role of a guardian with a CSEC youth, as well as prior work experience in Social Services. The Family Support Specialist is part of GCCO's Team approach in serving the CSEC youth and family. Experience shows that, except when the family is the perpetrator, the family needs to be an intricate part of the recovery process, even when the youth is placed in a safe home or group home. Experience shows a CSEC youth can successfully complete a safe home program, but if the family dynamics has not changed the child will not continue on the right path. GCCO, in partnership with the safe home and a counseling program, developed a pilot program for parents. We hope do more work in this area and develop a program for community families as well. Family counseling is an integral part of the recovery process, however, too often the child is seen as the one with the issues and it is difficult for family members to recognize or take responsibility for their issues which are often contributing to what is going on with their child.
6. **Mission 21:** Yes. Parents/guardians are encouraged to be a part of every step of the child's decision making and services. We provide parents and families with support through therapy as well, workshops,

support in day to day life. We believe that helping the parents get to a healthier place themselves will help the child reintegrate into their home and society better with little chance of relapse. We believe that it takes a village to raise a child and that village should be on the same page so that the child's positive behavior can be reinforced and the child can feel and be supported.

7. **Polaris Project:** Yes, we do have training specifically geared for parents and/or guardians. We believe that these training components help parents/guardians better understand the dynamics of human trafficking. The trainings and individualized support services that we provide help clients identify potential red flags, addressing behavioral change, and any and other behavior that may prevent the development of a healthy relationship with parents/guardians
8. **Safe House of Hope, Inc. (SHO Hope):** We have extensive training for Host families and I believe training of a similar nature for families of children that are now in DMST that have run away from home would be really helpful IF the parents are willing to work through retraining and then be accountable. Parents will need on- going counseling to be successful with clear goals and 24/7 support for parent/guardian and client.
9. **Traffick911:** Traffick911 will open its safe home for victims of domestic minor sex trafficking in the next few months. Once Triumph House opens, we will provide services for the family geared to reintegrating the survivor back into the family when possible. We believe healing of the family is critical to the overall health of the survivor.
10. **TurnAround, Inc.:** We provide services and support to parents and foster parents of survivors. Parents/foster parents can access individual therapy which can bridge into family therapy for the full home team. Additionally, we do quite a bit of work providing education to parents/foster parents on their youth's experience to inform a more accepting and trauma informed home environment. The dynamic of the home environment is one of the primary factors in a youth's healing process. Additionally, we do a lot of advocacy on behalf of the survivor to DJS/DSS to investigate the home environment prior to placement since many times these are driven factors in the youths run history or victimization.
11. **Women's Crisis Center & PATH:** Services for family or guardians: individual counseling, group counseling (after individual counseling). Benefits - we are supporting the family unit, assessing for safety, and increasing access to community services to decrease vulnerability.

#### 4.5 Counseling for DMST Foster Care Support

- 100% of organizations providing foster care support offer some form of counseling outside the home.
- 100% of organizations providing foster care support offer support groups for foster families/children.

## 4.6 Education On-site

- 67% of organizations provide education on-site
- 37% of organizations, individuals attend public school
- 22% of organizations, individuals attend charter schools
- 11% of organizations do not provide educational services

**Expanded Responses to: *How do you meet the educational needs of individuals you serve? What are the challenges and positives of this approach?***

1. **APECA:** In-home distance learning is recommended to assure privacy and security while meeting educational standards and individualized education plans.
2. **Clark County Juvenile Justice:** In detention the teachers do not have the time (short stays less than 30 days) to evaluate and teach each child at their level.
3. **Courage House:** We have an on-site teacher that works in conjunction with a teacher from a charter school who provides the curriculum. The girls respond well to the continuity and structure. But, it is difficult as they often come in at levels much lower than their chronological ages.
4. **End Slavery Tennessee:** We use volunteers who are trained with local literacy council and with us in working with this population. We also use a “big sister” type mentoring program (we call Lifeline) and within that trusting relationship, specialized opportunities are arranged. This works well for us.
5. **Freedom Place:** The girls at Freedom Place are on each end of the spectrum of education level. Due to varying competency levels we chose a self-paced online private school curriculum so each girl is able to bring herself up to the appropriate level. We have residential counselors help the girls through their course work as well as teachers who volunteer days to come in and work with the girls. Choosing to offer school on site was carefully evaluated however, since most of the girls are significantly behind in grade level and have experienced extensive trauma, it is not easy for them to matriculate into a public school. Another pro is the residents’ ability to move around and use unconventional tactics to self-regulate. Due to the trauma the girls have experienced they are unable to self-regulate. If the girls are having difficulty concentrating we allow them to get up and walk around, chew gum, bounce a ball etc. to refocus their concentration.
6. **Georgia Care Connection Office:** There are many challenges in finding the educational support services in the community for our youth, especially since the youth are generally a year and a half behind in school due to long periods of time they are not in school or inconsistent attendance. GCCO CSEC Intervention Specialists on occasion will tutor or assist a youth with their work. Mostly, the GCCO team tries to link the youth to community services for support and there are many options available.

Another challenge is when a child has missed a lot of school and when they return to school they are put in a class where they are much older than their peers. They feel embarrassed and do not engage in school. For example when a 17 year old is placed as a freshman in High school class.

The safe home works on an individual basis, home school computer type learning with a supportive staff. Having such a program in the community setting would be ideal for these girls on many levels. Well Springs Living has been working on creating a community school program like this for our girls.

**7. His House Inc. dba His House Children's Home:** Challenges- truancy, lack of motivation to succeed in education. Positives- on campus children allows more immediate enrollment and will maintain positive influence. DMST program will include on site school. Positives- on campus children allows more immediate enrollment and will maintain positive influence. DMST program will include on site school.

**8. TurnAround, Inc.:** Educational goals can include: onsite individualized GED or tutoring, community based GED program, enrolling in high school, enrolling in Job Corp. Each youth has an idea of where they believe they will be most effective. For example many of our older youth have not been in school since 9th grade. They are vocal that they will not be successful being placed in 9th grade at their current age. So we work on an individual basis through our in-house educational advocates to rebuild some skills and then work to connect them with GED or Job Corp programs that are more specialized. On the other hand some girls really want the "high school experience" with prom and dances.....in those cases we will work to enroll them in public or charter schools.

We have had several challenges getting youth re-enrolled in school when they are under the guardianship of an inactive or ineffective parent. Several of our youth WANT to be back in school however this requires the parent who they are living with to go up to the Office of Admission in Baltimore city and bring the proper documentation. After educating the school on some of our current challenges with inactive parents they have begun accepting these youth as technically homeless and getting them back into school more quickly.

**9. Youthcare Seattle:** We did not have a school program when we first opened and it was VERY difficult to maintain the youth in multiple mainstream or alternative school settings. The logistics of getting youth to different schools was tricky since we provide transport for at least the first several weeks to month of a youth's placement. Furthermore, youth in this program had a very hard time regulating in these settings. There was too much stimulus, they ran into people from their "old life", they relapsed on drugs/alcohol or had sex while they were supposed to be at school. Adding a small school site element to the program was highly beneficial to the overall functioning of the program, though finding the right teaching staff was also a challenge.

## 4.7 Provision of Life Skills or Vocational Skills

- 94% of organizations do provide life skills and/or vocational skills education.
- 6% of organizations do not provide life skills and/or vocational skills education.

**Expanded Responses to: *Do you provide life skills or vocational skills education? Do you feel that teaching these skills is a critical component of restorative care?***

1. **Courage House:** Our girls are provided opportunities for life skills education daily. It helps them gain confidence in a new way. Many girls are choosing to continue their education in beauty school or college after spending time with us.
2. **Courtney's House:** Yes. We offer support groups, which cover a wide variety of life skills. Survivors comment that no matter how many times they repeat the same course, they come away with more knowledge and tools to better handle life.
3. **End Slavery Tennessee:** Yes- We work on a case by case basis, matching volunteers with survivors to teach job skills, filling out forms, taking citizenship tests etc. Yes, this is critical. Most survivors have big gaps in life skills; some did not receive schooling while being trafficked, some lacked parenting, and often the only "job skills" and worth they've known is related to commercial sex.
4. **Freedom Place:** Life and vocational skills are provided to the girls. We allow the girls to learn life skills day to day and schedule vocational education similar to extra-curricular courses so the girls are able to choose what they would like to learn.
5. **The Genesis Project:** Absolutely – these skills are desperately needed and most of the time these girls lack common life skill sets. The more they are trained and educated the more confidence they will have to begin the process of being independent in the future.
6. **Janus Youth Programs, Inc.:** Yes. We work with a vocational program to provide bi monthly vocational/experiential training to our youth.
7. **Mission 21:** Yes. It is a requirement through licensing and a critical component. It teaches children responsibility, the value of money, self-efficacy, self-esteem, etc. Positive reinforcement motivates children to change behavior and builds skills necessary to be a well-rounded, healthy adult. For some, these life and vocational skills will break a cycle of poverty.
8. **Polaris Project:** Yes we do provide life skills classes such as financial/budgeting classes, computer workshop classes, creative writing, resume building, job readiness programs. We believe that providing these life skills classes allow clients to prepare themselves to enter a more intensive vocational skills curriculum at a community based school and to succeed. We provide 1-1 tutoring as needed and often pair clients with outside volunteers to continue honing their skills.
9. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** Yes and Yes! Our name, GIFT, stands for Gaining Independence for Tomorrow....Independence from abuse/trauma, from a pimp, as an adult in this world, etc...

10. **Safe House of Hope, Inc. (SHO Hope):** In-home life skills taught as part of parenting is really important. We teach life skills as part of drop in and find it is helpful in preparing our clients to live successfully on their own.
11. **TurnAround, Inc.:** Life skills are a crucial part of the rebuilding process. Our girls have missed out on core life lessons and experiences that provide them with everyday skills. Providing both experiential and training opportunities are key. We have job advocates that provide one on one professional development and vocational skills. We have a partnership with a local kitchen/culinary program that our mentors take the youth to participate in.
12. **Youthcare Seattle:** Yes, we focus heavily on both Life Skills and vocational training and paid community service learning. YouthCare operates 4 paid employment training programs and there are several others in the community that we access for our youth. All youth are assessed by the Life Skills Coordinator using the Ansel Casey Life skills assessment upon placement and have an individualized life skills plan developed.

## 4.8 Faith Based vs. Secular

- 47% of organizations are faith-based.
- 53% of organizations are not faith-based.

## 4.9 Spiritual Care Provided

- 46% of organizations provide spiritual care as part of their curriculum, however the majority of these respondents suggested that participation is optional.
- 14% of organizations offer availability to attend worship services as part of their programming (on or off site).
- 21% of organizations provide referrals to spiritual care upon request.
- The remaining organizations have no specific policy around spiritual care or their responses were unclear.

### Expanded Responses to: *Do provide spiritual care? If so, what is your approach?*

1. **APECA:** Recommend spiritual needs be assessed upon admission, with client rights being respected, and all services being provided on a voluntary basis, free of coercion, manipulation, trickery, or any suggestions that one will be approved of or treated better by staff based on decisions made. Avoid any “pimp and perpetrator” techniques.
2. **Clark County Juvenile Justice:** No, child may ask and their pastor could visit. Staff are allowed to talk to youth about faith if the youth asks.

3. **Freedom Place:** As mandated by the state, part of intake procedures is to determine if the client has a spiritual preference. If the client practices a certain faith it is our responsibility to provide a form of worship for them. Since we are a faith-based organization we offer bible study as an optional activity and provide an alternate activity for girls who prefer to not participate.
4. **GEMS:** Yes. Girls have opportunity to go to church, pray but it is not pushed on children. It's also important to understand that many of our children have been hurt by traditional church institutions. People define "spiritual" differently; it's critical to develop some type of spiritual connection however that looks to them.
5. **The Genesis Project:** Yes – we have a Prayer Team Leader that meets regularly with our 91 +\_ prayer team members providing prayer for GP and especially the girls and their recovery. We offer spiritual counseling to the girls when they are in the center and provide prayer for them if they desire it when offered. We do not force this on anyone, but to date, all have been very open to being prayed for.
6. **Mission 21:** You do not have to agree with our faith statement to receive services. Every child will be offered an opportunity to attend a church of their choosing through our approved list. If a child chooses not to attend church, they will be given an alternative option that would be equivalent to the activities done at church. Never will a child be punished for not participating in faith discussions or activities. Child has the right to request going to any faith service as long as Mission 21 staff has approved it in regards to the child's physical and emotional safety.
7. **TurnAround, Inc.:** Spiritual assessments/goals are a part of the intake process. Survivors are connected with spiritual mentors/opportunities based on their interests. Additionally, we work with faith-based and spiritual communities to ensure they are trained and prepared to engage with survivors.

#### 4.10 Community Base Curriculums

- 19% of community based organizations are not currently facilitating a curriculum, although 58% of these reported that they intend to.
- 81% of community based organizations do facilitate a curriculum.
- 31% of community based organizations facilitating a curriculum with a set start date.
- 54% of community based organizations facilitating allow individuals to begin the curriculum at any time.

**Expanded Responses to:** *Do you operate a curriculum? If so, please explain. (Ex. Can a minor enter at any time in the curriculum or are there set stages of entry? Is there a graduation?)*

1. **Courtney's House:** Yes. We have a curriculum for our Support Groups and our positive hustle plan (survivor and parent/guardian support groups) all curriculums were created by founder.
2. **His House Inc. dba His House Children's Home:** We are considering Hands that Heal by FAST.



3. **Kristi House:** Yes. We have a Youth Leadership Program that is a set curriculum of 21 weeks with a graduation. We also run an open ongoing support group when we get critical mass.
4. **Multicultural Clinical Center:** There are a number of different curriculums utilized through the various outpatient programs. This includes Substance Abuse Treatment, Sex Offender Treatment and Gang Intervention Services. The curriculum is developed after conducting a comprehensive assessment and the implementation of the treatment plan. Each program varies in terms of clients entering at various times. Specifically within the group setting, these are typically open groups and include a graduation upon successful completion.
5. **TurnAround, Inc.:** For our groups we utilize several curriculums - My Life My Choice, Unhooked and a curriculum that was developed by our Survivor Advisory Board.

## 4.11 Activities and Privileges

- The following were listed as activities or privileges provided:
  - Allowance
  - Art<sup>267</sup>
  - Art therapy
  - Case management
  - Classes: art, music, leadership, home economics, nature, computer, financial<sup>268</sup>
  - Dance
  - Designating smoking areas
  - Empowerment based activities (photo and poetry projects)
  - Equestrian/equine therapy<sup>269</sup>
  - Exercise: gym, canoeing, karate, mountain-climbing, rope climbing, snow-skiing, swimming, yoga, rock climbing, roller skating<sup>270</sup>
  - Free days
  - Gardening
  - Horse arena
  - Individual Service Planning
  - Karate
  - Job training
  - Legal services
  - Legislative work
  - Life skills training
  - Movie nights

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267 Three organizations listed this response

268 Four organizations listed this response

269 Four organizations listed this response

270 Seven organizations listed this program



- Music/Choir<sup>271</sup>
- Outings/Field trips: barbecues, beach, circus, libraries, national parks, entertainment centers, plays, restaurants, museums, salon trips, shopping, birthday outings, theme parks, shows, concerts, national youth events, women of faith, sporting events<sup>272</sup>
- Parties: birthdays, graduation, Christmas/Holiday<sup>273</sup>
- Peer groups
- Pet therapy
- Picking group activities/facilitation groups<sup>274</sup>
- Television
- School
- Service projects and outreach opportunities<sup>275</sup>
- Speaking engagements
- Sports: soccer, softball, basket ball<sup>276</sup>
- Staying up late
- Vacation/Summer camp/road trips<sup>277</sup>
- Worship
- Youth clubs

**Expanded Responses to: *What activities or privileges do program participants or residents take part in?***

1. **Freedom Place:** Freedom Place has a level system and the girls earn additional privileges based upon the level. We offer a variety of activities for the girls.
2. **Janus Youth Programs, Inc.:** Lots of activities ... dinners out, sports events, movies, short road trips. All of our residents have single rooms. We also allow the youth to smoke (in designated areas) if they come in to the program already smoking.
3. **Safe House of Hope, Inc. (SHO Hope):** All family activities and whatever the Host family and the client decides with help from their advocate.

## 4.12 Off-site Management by Community Based Providers

- 84% of community based organizations have staff that conduct home visits.
- 16% of community organizations only operate out of their facility and do not conduct home visits.

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271 Two organizations listed this response  
 272 Twelve organizations listed this response  
 273 Three organizations listed this response  
 274 Two organizations listed this response  
 275 Three organizations listed this response  
 276 Four organizations listed this response  
 277 Two organizations listed this response

**Expanded Answers: *Do case managers or staff do home visits or do you only operate out of your facility?***

1. **Bilateral Safety Corridor Coalition:** We operate out of our facility , in extreme cases we do house visits
2. **Georgia Care Connection Office:** GCCO meets youth in their homes, detention centers, group home placements, PRTFs, and in court.
3. **Multicultural Clinical Center:** Yes, we operate within the community the client resides in.
4. **Safe House of Hope, Inc. (SHO Hope):** Host family do home visitors. Advocates may meet with approved clients and go to any appointment they need and transport clients with approval of the executive director. We have a supervisor case manager that only works in house.
5. **TurnAround, Inc.:** Our case managers, advocates and mentors work both in the office and in the field. Our entire HT program staff is expected to be mobile. We provide transportation and will connect with girls in community placements, foster homes, on the street, anywhere we can have access to provide support and engagement.
6. **Youthcare Seattle:** Case managers operate in the community, in detention and can go to homes if indicated. Basically they go where the youth needs them to.

#### **4.13 Length of Direct Service Provision**

- Maximum average length of stay varied from five days in emergency service to indefinitely.
- The maximum average length of stay for residential programs was 4 years.

**Expanded Responses to: *What is the average length of time that you serve each individual that participates in your program or lives in your residence?***

1. **Courage House:** 1 year
2. **End Slavery Tennessee:** Varies...we work with survivors for as long as it takes. Still have contact with first girl from four years ago.
3. **Freedom Place:** Estimated 9-18 months
4. **GEMS:** Average about 1-2 years. Often it's the second or third time, they can stay up to 24 months or until 21 birthday
5. **Generate Hope:** 2 yrs
6. **The Genesis Project:** As long as it takes
7. **Georgia Care Connection Office:** GCCO can serve each child until they are 18 or no longer needs GCCO services. The safe home stay is approximately 8-10 months depending on the needs of the youth. Other group homes, community services have different lengths of time. GCCO Intervention

Specialists stay connected with the CSEC youth wherever they are linked to services and often hear from the youth when they are on the run

8. **His House Inc. dba His House Children's Home:** 6-8 months
9. **Hope House:** Set up the program to be a long-term option. Asks girl to commit to a year up front, but don't force it. At any time, a girl is free to go
10. **Indiana Protection of Abused and Trafficked Humans Task Force:** Few have stayed in the shelter but we have provided social services for HT victims for more than a year. We do not have an average length of time.
11. **Janus Youth Programs, Inc.:** Residential Services - 2 months Crisis Services - 5 days
12. **Multicultural Clinical Center:** Six Months
13. **Restore Corps:** 9-12 months.
14. **Polaris Project:** The average length of time for services provide is dependent on whether or not a client's needs have been met this can range from 1-2 days to 3-4 years. Our transitional housing program allows clients to participate in the program for up to two years which a reassessment done every 6 months.
15. **Redemption Ridge:** We anticipate the average length of time to be from 18 months to however long it takes for recovery. At 18 years of age, our plan is for the young woman to either return to her family (if it is a healthy family) or relocate to a family with whom she has connected while a resident.
16. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** 9 months to a year.
17. **Safe House of Hope, Inc. (SHO Hope):** Shortest 2 days, longest 9 months, average 5-6 months.
18. **San Diego Youth Services:** Group-12 weeks Shelter-14 days Counseling-26 sessions.
19. **Street Light USA** - Our program is three Phases, each phase is 6 months.
20. **The Salvation Army of Central Ohio:** 6 months-1 year.
21. **TurnAround, Inc.:** Undefined - long term.
22. **Wellspring Living:** One year.
23. **Women's Crisis Center & PATH:** 1 month - 3 years.
24. **Youth For Tomorrow:** 9 months.
25. **Youthcare Seattle:** The average length of time is about 4 months but we recommend 6-9 months.

## 4.14 Components for Successful Transition to Independence

- The following were listed as components of successful transition to independence<sup>278</sup>
  - Transition plan begun at start of program
  - Community collaboration
  - Client fulfillment all steps of his or her program goals/ individual action plan<sup>279</sup>
  - Client fulfillment of life skills/leadership program/vocational program<sup>280</sup>
  - Development of a relapse prevention plan
  - Maintained connection to client after transition
  - Mentorship program<sup>281</sup>
  - Support and communication
  - Trauma therapy<sup>282</sup>
- The following were listed as indicators that the client is prepared to transition to program independence.
  - Connected to the community support systems<sup>283</sup>
  - Crime free
  - Developed positive coping mechanisms<sup>284</sup>
  - Displaying self-efficacy/self-motivation<sup>285</sup>
  - Displaying self-care/ healthy boundaries
  - Emotional/mental health stability achieved<sup>286</sup>
  - Family stability achieved<sup>287</sup>
  - Feels ready for transition<sup>288</sup>
  - Financially independent
  - Healthy self-esteem
  - Housing secured<sup>289</sup>
  - No longer attempting to run or contact trafficker
  - Operating successfully in all facets of life
  - Program/personal goals met<sup>290</sup>
  - Physically healthy
  - Spiritually healthy
  - Stable in school or employment<sup>291</sup>

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278 Wording changed from reintegration based upon respondent feedback.

279 Three organizations listed this response.

280 Four organizations provided this response.

281 Two organizations provided this response.

282 Two organizations listed this response.

283 Three organization listed this response.

284 Three organizations listed this response.

285 Three organizations provided this response.

286 Five respondents provided this response.

287 Three organizations listed this response.

288 Two organizations listed this response.

289 Three organizations listed this response.

290 Four organizations listed this response.

291 Five organizations provided this response.

**Expanded response for: *What are key program components of successful reintegration? What are indicators that a child is prepared for reintegration?***

1. **Courage House:** Successful reintegration means that she has a healthy body, mind, spirit, and emotions. She has the support of her community and family.
2. **Courtney's House:** Needing CH client services less and less. They are operating successfully in all facets of life.
3. **GEMS:** I take issue with that word. "Reintegration" into what? Most of them were never integrated to begin with but were marginalized. Primary outcomes: mental health, emotional stability, housing, education, and employment. Intake and follow-up assessments (by staff and self-report) along the way to track progress.
4. **Generate Hope:** Crime free, CHSPE passed, job training complete or in college, stable mental health
5. **The Genesis Project:** Trauma therapy shows positive results / up to or surpassing educational standards for their age. / life skill and vocational trainings completed / individual action plan completed / case manager and child in common agreement to engage in reintegration /
6. **Georgia Care Connection Office:** GCCO relies on a System of Care team approach, with all involved with the youth's care, to assess whether a child is prepared for reintegration and what those next steps will be.
7. **His House Inc. dba His House Children's Home:** Youth has made positive family connection Youth has gained positive connection with community services and support system Youth has a plan of action to complete education and/or employment. Youth if possible has relocated and not returned to prior community where victimization occurred. If guardians are involved in the victimization, youth is placed in out of home care.
8. **Mission 21:** Child is confident in effectively using tools learned to cope with trauma. Child is displaying self-efficacy, self-motivation, healthy self-esteem/image, a positive outlook to the outside world. They are displaying healthy communication skills and making healthy choices for themselves. Child has identified and is developing a strong support group including, family, friends and community. They are able to identify and work to achieving goals set. They have a relapse prevention and intervention plan and are confident in how to implement plan.
9. **Polaris Project:** Key components for successful reintegration depend on a case-by-case basis and on the successful achievement and completion of goals by the client. We evaluate whether the clients' needs have been met whether that is financial independence, housing independence, and educational/vocational achievements
10. **Safe House of Hope, Inc. (SHO Hope):** Support and communication are key components. Reintegration has to do with mental health and having and meeting goals. A person ready to reintegrate has learned how to control their emotions and impulses, has proven to use good coping skills and asked for help when needed. Host families help client to look at the future, make and reach goals, get their next place, and keep in contact with client.

11. **Street Light USA:** This is a case by case response. It depends on the goal of the placement.
12. **TurnAround, Inc.:** Reintegration starts immediately as we engage survivors with members of their treatment team. Our goal is to safely re-engage them with the world through intentional and guided interactions that provide opportunities for skill building and positive life experiences. This is another reason that I think the drop-in center and the volunteer advocacy team is very important. The drop-in center allows for safe interaction with people who care and this assist in rebuilding trust.
13. **Youthcare Seattle:** This varies case by case but we consider benchmarks to include: Successfully completing an internship or vocational program; obtaining a H.S diploma or GED or be on track with credits for their age. Have completed some trauma counseling and emotional skill building in order to avoid future victimization and continue to cope with effects of stress and trauma. Develop a positive social network and aftercare plan. Map their “maintenance/relapse cycle” in order to avoid relapse to relapse to drug or the sex trade.
14. **Redemption Ridge:** Each young woman has a Needs/Services/Life Skills plan in which she works & progresses during her time at Redemption Ridge. When she shows readiness to emerge to independence she can choose to live with her “adopted family” or return to her biological family if it is deemed healthy.

#### 4.15 Aftercare/transitional housing

- 96% of organizations provide or refer to aftercare or transitional housing.
- Only one program did not refer to aftercare or transitional housing listing that none are available.

**Expanded response:** *Do you provide or refer to aftercare or transitional housing? What do these programs look like?*

1. **Bilateral Safety Corridor Coalition:** Yes they all depend on a child’s needs, foster care , group home or out of state programs when needed
2. **Freedom Place:** Yes, we are opening transitional living apartments on site and have formed partnerships with transitional living facilities who serve victims age 18-24. The programs are structured so the victims are able to live there and have access to services as long as they hold a job or are enrolled in school.
3. **The Genesis Project:** We will soon have our own aftercare (long term housing) currently partner with others that have it – some programs have 6month programs up to 2 years(Hope Place) 1 year Dream Center – during that time similar programs are offered such as job skill trainings and educational opportunities as well as trauma counseling.
4. **Georgia Care Connection Office:** Yes, GCCO continues to monitor and link the youth to services for aftercare. Presently, there is one newly started CSEC specific ELP program for those youth not in DFCS custody. Other options are non-specific CSEC ILP programs with partners for those in

DFCS custody. There are also two other partners who serve 18 and older youth who we can link to if appropriate. GCCO continues to build relationships with those serving 18 and older youth, to continue building services for our CSEC youth. GCCO also views aftercare services as “step-down” services into the community. If a youth transitions from a safe home back home, the youth will still receive wrap around services, just in the community to aid during the transition.

5. **His House Inc. dba His House Children’s Home:** Yes Casa Valentina- 4 apt complex- 2 bedroom/2 bath apartments, shared common areas with a Program Manager who resides on site. Transitional Housing program - Small cottages 2 bed/2 bath. Support services are available.
6. **Mission 21:** We would provide child with an aftercare plan and help implement that plan throughout a 5 year period. Aftercare plan includes; continuing education, job training, emotional support, community, legal and social services resources and relapse plan. Transitional housing referrals are made to Breaking Free in St. Paul.
7. **Multicultural Clinical Center:** Yes, upon discharge the client and clinician assess the additional services recommended. This can include housing, food, vocational/employment education, etc.
8. **Polaris Project:** Yes, we may provide clients referrals to transitional housing programs. These programs usually have case management integrated into their residential program therefore our role changes to being a secondary support system for the client
9. **Redemption Ridge:** Yes. Our transitional housing will be families who are recruited and trained to reinforce healing and restoration while encouraging the young woman in healthy, independent living.
10. **Wellspring Living:** Yes. Efficiency apartments with focus on life skills and therapeutic and educational support
11. **Youth For Tomorrow:** Yes, we have an After Care Coordinator, who follows-up with former residents to assist them with rent, finding housing, finding employment, educational scholarships, etc.
12. **Youthcare Seattle:** YouthCare operates 4 over-18 transitional living programs that we encourage youth to transition to. They are much less structured than the long –term recovery program so we try to prepare the youth and the program for the unique needs of these clients.

#### 4.16 Length of Service and Aftercare

- 73% of organizations have a formal process monitor a child’s progress after leaving the program.
- 27% of organizations do not have a formal process for monitoring process, but indicated that the clients stay in touch.

**Expanded Responses to: *Do you monitor a child's progress after leaving the program? How do you monitor that progress?***

1. **For the Sake of One:** Yes we will continue to follow up and provide support as needed. We will have a aftercare case worker do a weekly call once a week for the first six months and then monthly thereafter for the first two years.
2. **GEMS:**Case managers reaching out. Girls tend to stay in touch. Facebook actually made it easier to track. There is no set period of how long to monitor.
3. **The Genesis Project:** Yes – each child is assigned a case manager that will monitor for as long as the child desires – we are committed to complete physical, mental, and spiritual restoration to include help the child realize their God Given right to pursue their dreams and destiny in life.
4. **Georgia Care Connection Office:** GCCO is involved in connecting the youth to aftercare programs and services, and monitors them in the programs they are linked to. The youth is still connected with GCCO and especially with an Intervention Specialist. Aftercare is part of building the continuum of care and services for our CSEC youth. GCCO Service Coordinators are responsible for monitoring the youth's progress. GCCO build relationships with those providing aftercare services. In aftercare programs there may be phone calls with the partner agency serving the youth, updated reports, or team meetings if necessary. The CSEC Intervention Specialist specific to that youth is likely still involved with the youth and provides information in the monitoring of their progress.
5. **His House Inc. dba His House Children's Home:** After reunification, a child's progress is monitored for six months. Progress is monitored by monthly visits to the home and follow up communication as needs arise.
6. **Redemption Ridge:** As with a family, we will stay in touch with our young women, offering support and encouragement to her and her adopted or biological family.
7. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** We are looking to implement a tracking system but do not have anything formal as of yet. We are fortunate that most clients we have served stay in touch via phone, social media (GIFT Facebook accounts), and often visit the program. They tend to reach out when they need support even after their case has closed.
8. **Safe House of Hope, Inc. (SHO Hope):** For client that stay and are not here for only emergency care we follow up through the host family and the executive director. Progress is monitored by mental health and communication. We want to know if the client is still going to church, has a job, is maintaining healthy boundaries, is asking for help when needed, and is not back in the life So far any non-emergency client has gone to church with the host family and has chosen to receive Christ as her personal Savior. This is not a requirement AT ALL but has happened so far.
9. **San Diego Youth Services:** Group and shelter - aftercare phone call checks Counseling - no monitoring
10. **Street Light USA:** Yes, six months thus far with a goal of one year.



**11. TurnAround, Inc.:** We stay in contact as long as they would like to stay in contact. For many survivors we continue to provide emotional support and advocacy where ever they end up. This is a core component of our philosophy as we believe that the inconsistent of other systems such as DSS and DJS does not allow for solid relationships to be built and within this inconsistency the goals and interests of the youth fall through the cracks.

**12. Wellspring Living:** Yes. By talking with girls, family members, and mentor.

**13. Youthcare Seattle:** The youth ideally maintains contact and services with the community case manager and (sometimes) the therapist/CDP. The program case manager tracks aftercare using a form and tries to contact the youth at least every 90 days. Often youth continue to call the program and check in with staff even after they leave the program.

## 4.17 Length of monitoring after client has transitioned out of the program

*Expanded responses to: How long to you monitor a child's progress after leaving the program?*

- 1. Freedom Place:** We hope to do it at regular intervals 3,6, 9, 12, 24, 36 months etc.
- 2. Georgia Care Connection Office:** Until they turn 18 or are no longer in need of GCCO's services.
- 3. Street Light USA -** Yes, six months thus far with a goal of one year.
- 4. Wellspring Living:** One year minimum

## 4.18 Measurements of Success

- Respondents currently providing services listed the following as a definition of success
  - A life changed
  - Clients participating in program<sup>292</sup>
  - DMST victims out of detention
  - DMST victims treated as victims not criminals
  - Small incremental changes in survivors behavior<sup>293</sup>
  - Survivors abilities to meet goals
  - Survivors breaking gang ties
  - Survivors excelling/ gaining independence/leading more productive lives: finishing school, becoming a parent, working, making competitive salaries<sup>294</sup>
  - Survivors not running away/ stable home<sup>295</sup>

292 Four organizations listed this response.

293 Three organizations listed this response.

294 Six organizations listed this response.

295 Two organizations listed this response.

- Survivors not returning to the life
  - Survivors overcoming trauma<sup>296</sup>
- Respondents currently providing services listed the following quantitative methods to measure success
- Assessments as intake, midway point of program, and end of program to evaluate things such as stress, anxiety, PTSD, etc.
  - Recording number of identified DMST victims
  - Recording number of partners
  - Recording number of referrals
  - Recording number of survivors reached through outreach
  - Recording number survivors that graduate or achieve program goals<sup>297</sup>
  - Third party evaluator to assess program

**Expanded response to: *How do you define success and how do you measure this? Please share available data.***

1. **Araminta Freedom Initiative:** Reduction in the number of minors who coerced into trafficking (looking at how to quantify with lack of existing research in our area). More reports being made to intervene from the school system and other programs that work with youth.
2. **End Slavery Tennessee:** Survivors have such a wide array of issues and start in what I picture as negative numbers on a number line. Any movement towards zero is success!
3. **For the Sake of One:** Success would be to have children victims out of, juvenile receiving care and treated as a survivor not as a criminal, that we would have curriculum offered in every school, that we would continue to stiffen up penalties and take better records as to the number of victims, have a data base of referrals offered, more city task force in Texas. There is a lot to be done!!
4. **GEMS:** Variety types of success and levels – finishing school, becoming a parent, working. Seeing alums making competitive salaries, that's a form of success Girls just showing up each week even with their problems, that's still success. [Expanded response to Stages of change – understanding that returning to pimp might not be a total loss but just part of the overall process of change – they aren't really back at square 1. There was still change that can be built upon. You're in it for the long haul, pain didn't happen overnight and neither will healing.
5. **The Genesis Project:** Success to us is getting girls into our center and seeing them restored – in the 10 months that we've been open on a very limited and part time basis, we've had 36 girls come through our center – 5 are now confirmed out of the life because of their experience at GP –All 5 have stayed in contact with our counselors on some level. We have at least 3 more in long term abuse recovery programs – we believe that there are more but as of now we cannot verify due to our limited resources.

<sup>296</sup> Two organizations listed this response.

<sup>297</sup> Six organizations listed this response.

6. **Georgia Care Connection Office:** GCCO is only beginning its fourth year. Success pertaining to the youth we serve, is mostly measured in small successes by individual girls, such as graduating from the safe home: staying at home and not running; or calling their Intervention Specialist when they do run and saying that they want to come back home, or back to the program. Some of the other ways we can measure success are in the number of identified CSEC youth, the increasing number of referrals from a wider variety of sources, the increasing number of services and providers to link to, the emergency/crisis bed protocol has been used, and the number of partners at the table
7. **His House Inc. dba His House Children's Home:** Success for our program will be measured by completion of phases. Successful graduation from the program includes substance abuse recovery and renouncing /not returning to the life. We will measure success by movement through phases of the program and ability to assist others and form healthy relationships.
8. **Hope House:** Therapists do assessments at intake, midway point of program, and end of program to evaluate things such as stress, anxiety, PTSD, etc. The staff is trained to be trauma sensitive. The therapist uses Trauma Focused Cognitive Behavior Therapy and we have seen tremendous success with this model of therapy.
9. **Mission 21:** I define success by assessing how society and survivors define sexual exploitation. We measure this by observing the policies that are being changed in our state and community and by the shift from victim to survivor in the children and family's we serve. We have seen a difference in police response to prostitution in our city and by an increase in community awareness and support in the last 2 years.
10. **Multicultural Clinical Center:** Success within the context of gang controlled DMST is defined as an individual that can break away from gang ties and lead a more productive healthy life. Specifically, the gang controlled DMST victims. These victims are typically different than pimp/family controlled. The cultural aspects associated with the gang have to be addressed in order to intervene and prevent further gang controlled DMST.
11. **Polaris Project:** Success is measured and determined by the clients' ability to meet all of their goals. Their achievement and completion of goals may not occur for many years therefore short term goals may take 1-6 months while long term goals may take 6 months- 2 years. If we determine that a client may need additional assistance in order to meet their goals and achieve success then we would work in partnership with other service providers in order to help the clients achieve their goals
12. **Redemption Ridge:** When a young woman understands her worth, is able to verbalize her value and giftings, recognizes her right to redeem what was stolen, is able to emerge into life with her dreams intact, we consider this success. We will have tools in place (Needs and Services type) to show her growth.
13. **Safe House of Hope, Inc. (SHO Hope):** Any forward motion! Anything that help my client with their mental, physical, or spiritual health. This may include regular teeth brushing, showering, using coping skills, controlling impulses, not participating in the life, seeking help with addictions, seeking help with codependency, going to classes, school, work, therapy, church, or participation

in any group that positively supports client. Also any admission of relapse that includes help to get back on track. Client that starts to desire to set goals and wants a future.

14. **San Diego Youth Services:** We define it with baby steps - come to group, don't call a regular back right away, get an ID, go to the doctor etc.
15. **Street Light USA:** Success is measured on a case by case basis and based on the plan of care developed at the time of entry into our program. Additionally, we have recently hired a third party to evaluate our program every six months for the next two years.
16. **TurnAround, Inc.:** Success is both qualitative and quantitative. Normal "measures" for engagement are not necessarily appropriate for this population due to the extensive nature of their trauma. Quantitative is the willingness for survivors to stay connected to the program and to staff. Another level is the steps that survivors take towards their goal plans and mental/physical/psychological well-being. Qualitative are the stories of success that highlight significant achievements and also changes in behavior that establish paths for longer term success.
17. **Youth For Tomorrow:** Six months following placement: 85% of our former residents are in school or in college; living with a relative or parent; have not had additional legal charges; and 60% are employed.
18. **Youthcare Seattle:** Formal indicators of success include: educational attainments (HS Diploma, credits or GED or secondary education placement), vocational attainments (completion of internships, vocational programs or acquisition of paid employment), housing stability and improvement of quality of life (decreased pre/post scores of mental health or trauma indicators, increased self-esteem or self-efficacy). Informal indicators are conceptualized as strengthened relationships and access to community resources.

## 5. Safety and Security

### 5.1 Phone and Internet Access

- 92% of organizations allow youth to use the phone and/or the internet.
  - 91% of organizations that responded "yes" allow youth to use phones, though most only allow youth to call people on a pre-approved list.
  - 82% of organizations that responded "yes" allow youth to access the internet, though in most instances internet use is monitored and certain website (or types of websites) are blocked.
- 8% of organizations do not allow youth to use the phone and/or the Internet.

**Expanded Responses:** *Do youth have access to the phone or internet? If so, how is this access monitored?*

1. **APECA:** Recommend they are only allowed access with staff supervision, and that they are allowed to contact individuals on their approved contact list only

2. **Courage House:** They are allowed phone access (2 phone calls a day) as approved by their social worker. It must be in sight of a staff. No internet access is given.
3. **For the Sake of One:** They will be allowed with staff supervision to make phone calls to those who have been approved by their case workers and internet usage is for school room only with precautionary measure to grant very limited access to sites we have approved for research studies.
4. **Freedom Place:** The youth have limited and monitored access to phones and internet. The internet is only used during school and their searching capabilities are limited and continuously monitored by staff. Phone use is restricted to family calls and a therapist or staff must be present.
5. **His House Inc. dba His House Children's Home:** Yes, internet is limited by [a filtering program called] Barracuda. DMST program will not allow cell phones.
6. **Home of Hope:** Phone on a limited basis, depending on each child and this is with appropriate family member. All Calls are monitored.
7. **Hope House:** Girls are not allowed cell phones or electronic devices. They can have mp3 players so long as they can't get online. Get supervised internet time, but no Facebook or email. They are allowed to call from an approved call list (which won't have more than 3 or 4 approved people). These calls are all supervised.
8. **Indiana Protection of Abused and Trafficked Humans Task Force:** There are 2 resident telephones that are not monitored and a computer center that is monitored.
9. **Janus Youth Programs, Inc.:** If a youth has a cell phone, they can still have access to it outside of the residence. Once back in the residence they must turn it in to staff.
10. **Mission 21:** Yes. Scheduled in the evenings after dinner and chores are finished. Approved phone list, staff dials and stays in room the whole time. 1 call for 20 minutes each day. Not including parents. More time as reward. Internet access monitored by security program and staff being in the room. Can only get online for school or job related activity, unless granted permission.
11. **Restore Corps:** They will be permitted to phone use on a time limit and only to specific people that have been allowed by senior staff. Internet will be used for homeschooling, and monitored by staff. Internet time given as incentive will also be monitored by residential staff. Computers will also be monitored through parental control software.
12. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** Yes, provided it is ok with families/foster families/DCF Social Workers/ residential program staff. Facebook and other social media websites can be entered ONLY in the presence of a Life Coach when at our site. We monitor this as closely as possible
13. **Safe House of Hope, Inc. (SHO Hope):** Earned access usually after a black out period, but it depends on the Host family rules. We train and discuss the options and the final decision and implementation is up to the Host family with our support.

14. **Street Light USA:** Yes, access is monitored through staff and call list. Internet is monitored for computer surveillance and staff as well as site restrictions.
15. **TurnAround, Inc.** Yes and yes. The drop-in center has internet access for job hunting and resources. We have blocked social networking sites. We provide girls with phones when they exit the life to help create a safer and more successful break from their exploitation.
16. **Youth For Tomorrow:** Yes, but only under staff supervision. They are allowed to contact individuals on their approved contact list only and only under staff supervision. YFT also has a level system. Once a resident reaches level five, they are able to have unsupervised time in the community and with phone and the internet.
17. **Youthcare Seattle:** - Phone access in the program is logged and staff monitored. Youth may have cell phones that must be checked in by staff to the staff office while in the program; youth are not permitted to have phones in their bedrooms or common spaces but may check them out while on passes, walks or out in the community (while at internships, for instance).

## 5.2 Visitors

- 68% allow visitors although 31% of these indicated that the visits tend to or must take place off site and 69% indicated the visitors must be screened and approved.
- 32% of organizations do not allow residents or participants to have visitors, although it is unclear if this percentage includes offsite visitors.

### Expanded Responses: *Are residents or program participants allowed to have visitors, if relevant?*

1. **APECA:** Recommend they only be allowed visitors from an approved contact list.
2. **For the Sake of One:** They can have visitors who have been thru counseling prior to visits and only visitors who are safe under staff supervision.
3. **Freedom Place:** The girls accept scheduled visitors however the visitors are limited to family or guardian visits/therapy and their case worker, juvenile probation or attorney.
4. **The Genesis Project:** No for drop in center; safe houses will have a different policy.
5. **His House Inc. dba His House Children's Home:** Yes, participants are allowed to have visitors, if legally permitted, after phase 1.
6. **Janus Youth Programs, Inc.:** Not at the residential site. We have a publicized office site where they can meet visitors or other providers.
7. **Mission 21:** Depends on resident. Visitors must be approved and a request must be made in advance. Visits must be done off-site with staff supervision or if permission has been granted.

8. **Restore Corps:** Residents will be allowed to have visitors and eventually leave for short term visits as they progress through the program. These visits will be some of the incentives/privileges participants work towards.
9. **Polaris Project:** Both our office and transitional housing program are in confidential locations. Transitional housing clients are allowed to have pre-approved visitors previously screened by staff.
10. **Redemption Ridge:** No - the safe house doesn't offer visitation. All visitations occur off-site.
11. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** Nobody outside of GIFT is allowed at the site unless it is an immediate family member or program staff. Girls are not allowed to bring friends given the confidential nature of the work we do.
12. **Safe House of Hope, Inc. (SHO Hope):** It is up to the Host family. We do not allow visitors in the beginning and if the client makes healthy friends at school or while in the family the host family may choose to allow them to visit. Also client's family may visit with supervision and approval of our staff. The Host family and the client, with help from their SHO Hope support person and their counselors, have the final decision.
13. **TurnAround, Inc.:** Our drop-in space can be used to connect with family and friends who have been cleared as safe and supportive.  
  
We do not allow males in our drop-in center however, we have a separate space where families including fathers and brothers can meet with girls to re-establish these relationships.
14. **Wellspring Living:** Yes, if approved and on the phone in their plan care.
15. **Women's Crisis Center & PATH:** If in shelter - not at shelter - clients must meet out of shelter.
16. **Youth For Tomorrow:** Yes, but only from an approved contact list.
17. **Youthcare Seattle:** - We discourage visitors at the program location generally speaking. If family wants to visit we attempt to have the youth meet family in the community somewhere and will supervise the visit if indicated. Meetings with social workers, probation officers, law enforcement and legal representative can take place at the house in the group/meeting room or in the staff office.

### 5.3 Geographic Separation from Place of Exploitation

- 47% of organizations feel victims do need to be separated from the geographic environment of victimization.
- 42% of organizations said separation of victims should be determined on a case-by-case basis.
- 11% of organizations do not feel it is necessary to separate DMST victims from the geographic environment of victimization.



**Expanded Responses: *Do you feel that a DMST victim needs to be separated from the geographic environment of victimization? Why or why not?***

1. **Courage House:** Yes. For the girl to begin to have a “new life”, a geographical location change is essential. She needs to be able to break away from old reminders.
2. **For the Sake of One:** Yes I strongly feel that a child needs to be removed from the area where their trauma occurred due to a myriad of issues such as safety, triggers and for a fresh start.
3. **Freedom Place:** We feel it is beneficial for DMST victims to be separated from the geographic environment in order to naturally make the separation from trauma to healing. If the victims are removed from the harmful environment they will have minimal inhibitions during their treatment.
4. **The Genesis Project:** Drop in center needs to be right in the thick of it for easy access and quick and immediate help for the girls – long term and residential needs to be away from the “life and lifestyle” - recovery and restoration (long term) need to be away from the life that has enslaved them so the healing can occur unhindered – they need to be away for the healing and restoration to occur, not to mention away from temptation and others who would try and lure them back into the life
5. **GEMS:** There’s no one answer. It’s different for each individual. Survivors are not a monolithic group. People think there is one model but that’s not true. Some girls need different things. Some girls can live with the same family while some cannot. It really depends on the girl. The goal is to make girls able to survive in the real world so it makes sense to do therapy there. No men or drugs within 50 miles would be great but that’s not the real world. Lock down facilities in the middle of nowhere can still feel like juvenile detention because of the isolation. You’re not a good program just because you’re not a jail.
6. **His House Inc. dba His House Children’s Home:** Yes. Gives a sense of a new beginning.
7. **Indiana Protection of Abused and Trafficked Humans Task Force:** Yes. We are aware that many victims continue to be pursued by their previous pimps and may be in danger.
8. **Kristi House:** It depends on the situation. Most clients want to stay close to their family and people they know. They also would benefit from learning how to manage triggers in their natural home environment. However, there are some cases where a change of environment or getting away from the perpetrator would make more sense for the clients’ safety. It should completely depend upon each case individually
9. **Redemption Ridge:** Yes. The tendency of these young women is to RUN away from (1) uncomfortable situations (2) unfamiliar situations (safe, loving) (3) keeping them from their myth of “the dream” provided by their pimp. Not until the lies are dispelled, the reality of safety, love and vision has set in and the truth is seen will a young woman desire to stay in a safe house. Rural settings help motivate her to stay.
10. **Roxbury Youthworks’ GIFT Program (Gaining Independence for Tomorrow):** Very well. We were previously located in a very “hot” location in the city where the girls were finally able to articulate they were not comfortable coming to. This was two years in to the program. We immediately started



looking for a new site and have been at our current location since (no signage, on a side street, more private).<sup>298</sup>

11. **Youth For Tomorrow:** Depends on victim. If a victim wants to run, geographic location does not matter. Geographic environment does matter when it comes to safety and getting a victim away from an unsafe community due to retaliation and/or threats.
12. **Youthcare Seattle:** There are undoubtedly a few cases where this would be beneficial but I believe they are the exception, not the norm. Examples are cases where the youth is being actively sought by a trafficker or gang or where the youth's impulse control is very poor. However, at some point youth must re-integrate into their community and we feel that keeping them close to that helps build resiliency and allows them to build a pro-social and positive support network while they are in the program that can follow them after discharge.

## 5.4 Urban vs. Rural

- 35% of organizations are located in rural settings, 83% of which were residential.
- 65% of organizations are located in urban settings, 54% of which were residential.

**Expanded Responses:** *Are you located in a rural or urban environment? What are the advantages or disadvantages of your location?*

1. **APECA:** Rural. Setting itself is naturally therapeutic, providing support for the overall mission of recovery.
2. **Bilateral Safety Corridor Coalition:** Urban. the biggest advantage is accessibility to the office transportation and schooling
3. **Emma's Home:** In a more urban area now. Were out in the middle of nowhere, and felt unsafe. Location is undisclosed.
4. **For the Sake of One:** Rural area for the safety of a child who might run. We need to have a home where the child is separated from the street life.
5. **Freedom Place:** Being located in a rural environment is ideal. The advantages are the wildlife, serene environment, natural barriers and protection. A disadvantage of being in a rural area is an inconvenient proximity to volunteers and services.
6. **Generate Hope:** Rural, [positives] less triggers, [negatives] more difficult to connect with referral services.
7. **The Genesis Project:** Our drop in center is in the middle of the worst area of trafficking (urban) in our region. This is where the police work and where we have rescued over 36 girls from the life and brought them into the center for immediate shelter and care. This is only a temporary shelter/safe

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298 This was the only expanded response to the question, "how is your location working?" so it was instead highlighted in this section.

place for the girls. It is more important to be located where access is easiest for the girls as opposed to being somewhere where they are unable to find us when they need us most.

8. **His House Inc. dba His House Children's Home:** Urban. Advantages- Nearby community resources; disadvantages- client may perceive Miami as exciting, new territory to explore. Increased recruitment in a very active sex entertainment industry.
9. **Kristi House:** Urban. We get a lot of business and it's easier to come and go. That's both a positive and a negative. Pro - We have a multi-disciplinary team that is very experienced and comprehensive because we are an urban area with a thriving sex industry. There are more resources available for the clients.
10. **Indiana Protection of Abused and Trafficked Humans Task Force:** Urban. We are accessible to referral by law enforcement and referral for victim services.
11. **Redemption Ridge:** Rural. It is hard to run away when the road to freedom is acres away, public transportation is non-existent, and there are no street lights. Keeping a young woman safe until she becomes healthy enough to see the truth of her situation, is important. Rural settings provide this motivation.
12. **Youth For Tomorrow:** - Urban - Advantages are numerous – qualification of workforce, access to medical/mental health services, etc. Opportunities for employment of victims when they are ready and transportation, service agencies and housing.

## 5.5 Methods to maintain safety and security

- The following methods were listed to maintain safety and security within programs:
  - Security Cameras<sup>299</sup>
  - Secure entrance: commercial grade locks/key card/call box/secure windows<sup>300</sup>
  - Confidential location<sup>301</sup>
  - Confidentiality of survivor<sup>302</sup>
  - Do not accept local survivors
  - Emergency response button
  - Fence<sup>303</sup>
  - Individual Clearance: finger printing, background checks, FBI Clearance, ID checks<sup>304</sup>
  - Location where survivor feels comfortable
  - Relationship with law enforcement<sup>305</sup>

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299 Six organizations listed this response.

300 Five organizations listed this response.

301 Twenty-five organizations listed this response.

302 Ten organizations listed this response.

303 Two organizations listed this response.

304 Four organizations listed this response.

305 Five organizations listed this response.

- No secrets
- Release of information
- Review online safety with survivors
- Safety and psych assessment of client
- Security alarm system
- Security guard or surveillance<sup>306</sup>
- Training<sup>307</sup>
- Twenty-four hour staffing

**Expanded Responses:** *What are your policies to maintain safety for victims? (Ex. Secrecy of location, secrecy of identity, privacy of the facility, etc.)*

1. **Courage House:** We are a confidential location. No one comes to the property without fingerprinting, background check, FBI clearance, etc. To come on site, you have to be cleared through our training processes. Everyone signs a confidentiality form.
2. **Emma's Home:** In an undisclosed location. Check IDs and have a security system. Parents and guardians are not allowed to know the location. All visits must be off-site.
3. **End Slavery Tennessee:** We are located in a private wing (counseling area) on a university campus.
4. **For the Sake of One:** The facility will be private and anyone coming to the facility must first pass a full back ground screening. We will also have a secure location with cameras and security alarms inside and outside of windows and all exit doors. No pictures will be allowed and when referring to victims in public names will be changed.
5. **Freedom Place:** The location of the facility is kept confidential and each visitor is required to sign a non-disclosure agreement. No information about clients is shared. We also have an extensive security system in place and extensive training for staff.
6. **The Genesis Project:** Location is undisclosed – building has a false name on the front – commercial grade doors and locks – for safety – local police all know where the center is and are constantly watching over it as well as the girls and staff inside. We are currently accepting bids for bulletproof lexan panels which are tinted out
7. **Kristi House:** Location is secret, house is on a lot that is secured with video surveillance and an external buzz in fully alarmed system. The fence surrounding the premises is 8 feet tall and lined with hedges that are taller. GPS will be disabled on phones entering the safe house.
8. **Mission 21:** All staff is HIPPA trained and we follow all data privacy laws. Location is hidden in plain sight. Location is only disclosed as advocacy center on a need to know basis. Facility is secured with cameras, alarms, motion sensors and emergency response buttons.

<sup>306</sup> Three organizations listed this response.

<sup>307</sup> Three organizations listed this response.

9. **Multicultural Clinical Center:** Safety of the victims is centered towards meeting the client within an area they are comfortable in (i.e. office, community, home, public place). The identity of the victim is never disclosed without prior consent.
10. **Redemption Ridge:** Our safe house is a secret location. Deliveries will be made to the main house maintained by the grounds keeper/security guard at the road. Any services provided to the safe house facilities will be done by trained volunteers or a required Confidentiality and Liability Waiver will be signed by non-trained service people.
11. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** No signage, no address on any of our literature, partnerships with the local districts of the Boston Police Department who provide street patrolling in our area.
12. **San Diego Youth Services:** Secrecy of location and at group- interior front door is locked with need to be buzzed in,
13. **Street Light USA:** Secrecy of identity, individuals communicating with girls must be on call/visitation list, bag check out/in system, facility has infra-red cameras, fully gated, employ security guards, and camera in cottages and throughout the property.
14. **TurnAround, Inc.:** We are constantly assessing safety. Both of our offices have a call box for visitors so individuals are screened before gaining access. On every intake we are assessing emotional, geographic, physical, and online safety and conducting safety planning with victims. Our drop-in center is not advertized with a sign. This becomes a continuous conversation with all of our girls as they work to develop the skills necessary to assess safety and engage in their own safety planning as well.
15. **Traffick911:** Triumph House is in a secluded, undisclosed location. All information is confidential. A former secret service agent oversees our security.
16. **Youth For Tomorrow:** Quarterly meetings with local police, security cameras, confidentiality/ secrecy of resident (name change)
17. **Youthcare Seattle:** Undisclosed location; internal and external cameras; secure room with provision and panic button linked to Seattle Police Department; crisis management protocol; security system

## 5.6 Response to internal security issues: violence, self-harm

- The following were listed as methods to prevent/respond to violence and self-harm:
  - Adequate staff/volunteer to client ratio.<sup>308</sup>
  - Crisis Response Team (CRT)
  - Call police when necessary<sup>309</sup>

<sup>308</sup> Six organizations listed this response.

<sup>309</sup> Five organizations listed this response.

- Ensuring client wants to participate in program
- File incident report
- Follow-up with the appropriate people: parents, social workers, etc.
- Meetings to review and address potential dangerous situations.<sup>310</sup>
- No weapons of hazardous materials allowed<sup>311</sup>
- Open communications with clients.
- Removal from program<sup>312</sup>
- Refer client to anger management program
- Safety plan conducted with client and family
- Screening of personal belongings before entering facility
- Security equipment: alarm system/secure gate/camera/double entry<sup>313</sup>
- Separate clients if necessary
- Staff training: Managing Aggressive Behavior (MAB)/ trauma informed/ Crisis Prevention Institute- Non-Violent Crisis Intervention/ de-escalation, verbal and physical responses<sup>314</sup>
- Standard harm reduction

**Expanded answers to: *What methods/policies do you have in place to prevent internal security issues such as violence or harm against other staff or individuals served? What is your response plan or policy?***

1. **End Slavery Tennessee:** We require volunteers/staff to go out in pairs when driving domestic victims; volunteers check in every two hours with staff; everyone uses company rather than personal e-mail.
2. **For the Sake of One:** There will be a cool down area where a child can be monitored by staff at all times and children are not allowed at any time to be unsupervised except at bedtime, children only go into their room for a limited time period with doors open and cameras are in place for all corridors and main areas. We will also call police when need be and should a fight break out we will remove the other children to safety.
3. **Freedom Place:** All staff undergo extensive training including MAB (managing aggressive behavior) an evidenced based approach through university of Oklahoma. We also require all staff to be training in our trauma model (TBRI). Additionally, all staff are required to train in reporting and identifying abuse and neglect; boundaries, and sexual safety.
4. **GEMS:** If you physically fight with another resident, both will be kicked out. Luckily fighting with staff has only happened maybe twice in 15 years.
5. **Generate Hope:** Response plan: violence not tolerated, consequence imposed, final consequence = 3 strikes invited to take 2 weeks away.

310 Two organizations listed this response.

311 Three organizations listed this response.

312 Three organizations listed this response.

313 Five organizations listed this response.

314 Six organizations listed this response.

6. **The Genesis Project:** Every girl is “qualified” before she comes to the center – sometimes as long as 3 hours of interviewing is done by Law Enforcement to ensure that this victim is not only ready but desires GP’s help. This has been our single most effective measure to ensure no violent incidents have occurred inside after 36 girls have come into the center. Girl’s personal belongings have all been checked before entering the center – knives or other simple weapons that the girls use for protection while on the streets, are locked away while they are at the center. They are returned only when they leave. The girls can leave at any time which deflates any situation that may become hostile or violent. If a girls decides at any time that she is not ready for our help she can simply walk out. That however, rarely happens. [In response to the question] what is your response plan or policy? Staff and volunteers out number girls and will defend themselves if the need should arise. Volunteers have been instructed in accordance with state law that they may use any and all means necessary to remove a troublemaker from the premises.
7. **His House Inc. dba His House Children’s Home:** CPI- Crisis Prevention Institute- Non-Violent Crisis Intervention training and Conflict resolution training is provided to staff. Grievance procedure includes mediation by supervisors. Two staff members handle all escalating conflict. Law Enforcement is called when violence occurs.
8. **Indiana Protection of Abused and Trafficked Humans Task Force:** We have emergency buttons that would notify police and we have a police office in the building
9. **Kristi House:** Non-violent conflict resolution training will be conducted for all staff. If violence escalates to the point of causing harm to self or other clients, law enforcement will be called. Disciplinary model used will be based on restorative justice principles in which the household will sit in a circle to discuss the disruptive actions and decide consequences collaboratively.
10. **Mission 21:** Double Entry in front of building. Unsecure area has cameras and alarms. Lockers are provided to lock up personal belongings before entering secure areas. This is in place to prevent weapons and/or drug paraphernalia from entering the rest of the building. Staff is trained in de-escalating methods to help with altercations. Emergency response buttons are on each staff person in case law enforcement needs to respond to a violent or dangerous threat.
11. **Polaris Project:** One of our core values is the practice of non-violence. We discuss this value with clients and make it clear that in the event of violence amongst clients or violence directed against staff would terminate the client’s case with our program. In the event that the client exhibits violent tendencies we would refer the client to an anger management program before continuing to provide case management services. However, if violence does occur in the office we would immediately call 911 and move other clients out of harm’s way.
12. **Redemption Ridge:** Staff is to be trained in techniques of behavioral management, methods of handling aggressive and assaultive behavior & restraint measures. Every incident (mandated by the license) will be reported to DHS.
13. **Safe House of Hope, Inc. (SHO Hope):** We train staff in de-escalation tactics and have monthly meeting to debrief and go over any problems. We maintain order and separate people if there is any problem. We may ban a client for a short period of time if it is in her best interest. We have a

doorbell and always locked front door. We have separate women days and plan on having separate men days. Call in other staff and 911 if necessary.

**14. Street Light USA:** No sharp objects, heating elements, toxic chemicals are left within reach of survivors. Staff is not to enter the rooms of the survivor without another staff/volunteer present.

**15. TurnAround, Inc.:** We have weekly case management meetings to discuss any safety issues or threats. Immediate safety issues are communicated to the Program Director and plans are made. Additionally, we have monthly all team meetings with the clinical staff to determine and discuss any potential safety threats.. Additionally, should a high level safety issue arise we have good relationships with law enforcement who have responded to provide assistance and protection. For example, two trafficking victims who were being released to the care of TurnAround were simultaneously bailed out by someone connected to the trafficker. Law enforcement responded to the jail in minutes to provide protection and safe passage to the survivors and victim advocates to get them to the emergency shelter.

Should a safety issue arise in the office we would restrict anyone from entering or leaving the building until LE arrived.

**16. Youth For Tomorrow** - Crisis Response Team (CRT), staff training in verbal and physical responses. Staff calls a code red for CRT, CRT available 24 hours to response to crisis on campus.

**17. Youthcare Seattle:** All staff is background checked prior to hire and then fully “cleared” through DSHS. Staffing ratios have been adjusted during the pilot phase so that youth are not alone with one staff most of the time (exceptions being staff taking one youth to a meeting or appointment). Response to an allegation or evidence of misconduct would include a report to CPS, notification of agency leadership and board of directors who would determine the next steps depending on the circumstances.

## 5.7 Response to internal recruitment

- The following were listed as responses to internal recruitment
  - Adequate staff or volunteer to client ratio<sup>315</sup>
  - Call law enforcement
  - Cameras/audio recording<sup>316</sup>
  - Changing room assignments for unhealthy relationships
  - Confiscation and review of notes
  - Clients are not allowed to use phones
  - Clients are not allowed to speak openly about the life
  - Clients are not allowed to “glorify” the life<sup>317</sup>

315 Two organizations listed this response.

316 Two organizations listed this response.

317 Two organizations listed this response.

- Client made aware of policies against recruitment<sup>318</sup>
- Client must want to participate in program
- Client removed from program<sup>319</sup>
- Client separated from group programs
- Highly structured schedule
- Open communication with clients
- Prescreening
- Pre-screening at intake of clients: client not accepted.
- Pre-screening at intake: client heavily monitored and supervised.
- Pro-active intervention
- Staff monitoring<sup>320</sup>
- Staff training<sup>321</sup>

**Expanded Responses to: *What are your response plans or policies to combat internal recruitment?***

1. **Bilateral Safety Corridor Coalition:** Screening will weed out this issue. In 12 years we had one and never made it to a safe location with other victims.
2. **Freedom Place:** We try and get as much information upon intake as possible. If we learn after admission that we have a recruiter then we monitor conversations and provide extensive supervision. If an elopement occurs then the recruited will not be accepted back on campus.
3. **For the Sake of One:** We will train staff how to monitor catchers who are trying to recruit other children and they will be asked to leave and go to another facility. We will also not work with gang children as this often will be difficult on the other children.
4. **GEMS:** Only when a girl comes in to intentionally recruit will we shut it down immediately- you get services but can't live with us. Most of the time though it's not intentional recruitment. There is a difference between malicious recruitment and 2 girls struggling and running away together - it can be hard to know who "recruited" who. Proactive intervention: teaching how to care for yourself and be a good friend (girls don't see it as recruitment) what to do if you don't feel safe.
5. **The Genesis Project:** Close monitoring of the girls that come into the center. If more than one girl comes into the center she is assigned a volunteer or staff person to assist her. The girls are not left alone together. However this has yet to happen due mostly to law enforcements very thorough qualifying procedures.
6. **Georgia Care Connection Office:** GCCO abides by the safe home joint venture plans and policies, and discuss those issues during our monthly CSEC Case Assessment meetings with our safe home joint venture partners, if applicable.

318 Four organizations listed this response.

319 Seven organizations listed this response.

320 Five organizations listed this response.

321 Two organizations listed this response.



7. **His House Inc. dba His House Children's Home:** Training for staff on early warning signs and detection of recruitment activity. Multidisciplinary staffing. Re-placement of verified recruiter to alternative placement.
8. **Indiana Protection of Abused and Trafficked Humans Task Force:** Anyone admitted as a resident must pass screening for DV or human trafficking. Staff are trained to beware of external risk, particularly with respect to DV.
9. **Janus Youth Programs, Inc.:** When exit from our crisis shelter, our policy was not to call the police. We simply call the guardian to inform them the youth has exited the program. In the past two years, if a youth leaves and the staff suspect they are recruiting we immediately call the police and they quickly show up and detain the youth. The youth are brought to our office where they are separated. The youth suspected of recruitment will be taken to our juvenile detention facility (if even just for a short time) and the case manager/therapist works with the other youth.
10. **Kristi House:** Active recruitment will not be tolerated and recruiters will be removed from the home and worked with separately from other clients. However, questionable activity will be dealt with in the circle.
11. **Mission 21:** There is zero tolerance for recruitment. All participants must agree that recruitment is a violation of our safety policy and will not be tolerated. Staff is trained to always be available to participants and they are all aware that there are cameras in place to keep them safe and protected within the facility. Recruiters will not be allowed to participate in program and an exception may be to meet with participant on an individual basis off-site.
12. **Multicultural Clinical Center:** Clients are often met individually. In terms of a group setting where there could be potential for recruitment, clients are monitored from the time they enter and leave the facility.
13. **Polaris Project:** Every client is briefed on Polaris Project's policy against internal recruitment. Each client must acknowledge their understanding and agree to abide by the policy. Any violation would be a cause for termination of services.
14. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** If we sense any recruitment, the client in question will be removed from any group activities but will continue to work with her life coach on an individual basis. We discuss this openly with our clients and encourage them to let us know if they are seeing anything we are not. We are very up front and honest with the young women we serve.
15. **Safe House of Hope, Inc. (SHO Hope):** Supervision and separation. We sit with clients in drop in and have only one client in a host family at a time.
16. **San Diego Youth Services:** No phone use and no "glorifying." Discuss the importance of not recruiting and define it for them.
17. **Street Light USA:** This is an area that we are working on. Currently, the survivors are not allowed to talk openly about their sex trafficking life and careful monitoring and communication of team

has been our key. Also, survivors exiting the plan are not allowed to communicate with survivors still residing at StreetLightUSA.

**18. Women's Crisis Center & PATH:** Individual sessions, client confidentiality

**19. Youthcare Seattle:** This is something we address concretely, seriously, and frequently. The very first item on the "rules and expectations" document that youth review, sign and receive a copy of address the recruitment and grooming policies (which include personal and physical boundaries and "glorifying"). There are signs posted in the common space that reinforce these policies. Youth exhibiting any grooming or glorifying behaviors are re-directed and can be addressed through 1:1 conversations, addressing behaviors in therapy or groups, behavior contracts or, potentially termination from the program (only if actual, proven recruitment occurs).

## 5.8 Restraint

- 44% of organizations have policies regarding physical restraint. Most organizations' policy is to only use restraint as a last resort.
- 56% of organizations do not use physical restraints on clients.

**Expanded Responses to: *Do you have policies for discipline/restraint? What are they? What is maximum level of restraint that you use?***

1. **Freedom Place:** Yes. We utilize a program called MAB. We do not restrain unless child is hurting themselves or someone else.
2. **His House Inc. dba His House Children's Home:** CPI procedures. Team control positions for physically aggressive individuals. Manual restraints performed by two or more staff members - No mechanical or chemical restraints are used.
3. **Janus Youth Programs, Inc.:** We do not allow staff to touch youth unless they are being physically attacked. I don't think in my 15 years we have had more than a small handful (3 or fewer) of incidents of staff having to touch another youth. It is a rare occurrence.
4. **Roxbury Youthworks' GIFT Program (Gaining Independence for Tomorrow):** We do not restrain. We will dial 911 if necessary. As far as discipline, if a young woman is disruptive in our space, she will be removed until she can properly process her behavior.
5. **Traffick911:** Traffick911 is finalizing policies and procedures, working with an organization with 75 years experience running facilities for children in the state of Texas. We also have completed state-mandated training on restraint. Our goal is to always talk down the situation, but will use approved state-mandated methods when necessary for the safety of other clients and staff.
6. **TurnAround, Inc.:** No restraint. We use non-invasive mediation methods based off the survivor's Well Being Safety plan.

7. **Wellspring Living:** We have very specific policies around restraints. We will never use chemical or mechanical restraints. All our residential staff are trained in an approach called Mindset. This approach is strength based and educates our staff to deescalate- a situation without physical contact. Mindset does teach manual holds and our policy states that we only use manual holds when a participant is an immediate threat to harm herself or someone else.
8. **Youthcare Seattle: Seattle:** We are a motivation and incentive based program and attempt to use positive reinforcement to a far greater degree than consequences. We are a hands-off facility, although staff is trained in physical intervention per state licensing guidelines. Youth becoming assaultive or engaging in substantial property damage would be handled by law enforcement/probation depending on the legal circumstance.

## 5.9 Minimizing flight-risk

- 38% of respondents have other, non-lockdown policy to reduce elopement. Only one respondent is currently operating a lock-down facility, however that program plans to change this policy.
- 56% of respondents do not have any formal responses or do not attempt to deter elopement.
- Policies to prevent elopement include
  - Clients must indicate they want to participate upon intake
  - Highly structured schedule
  - Positive atmosphere, support youth in meeting their goals<sup>322</sup>
  - Staff interview techniques
  - Staff involvement: levels system, support, check-ins<sup>323</sup>
  - Security system: cameras, alarms on window and doors, alarm system, gates<sup>324</sup>
  - Separation of short-term and long-term programs

**Expanded Responses to: *How do you minimize the ability to run away? Is your facility a locked facility? Are there any legislative restrictions for locking your facility?***

1. **APECA:** Recommend measures that promote bonding as soon as possible post admission, keeping clients busy with outings and other activities, and promotion of healthy personal goals that will keep them focused.
2. **For the Sake of One:** We will not be a locked down facility. We will have the children run back and forth to their room to try and distract them and give them time to cool down and if they will not we will give them a stern reminder of the harsh street life and see how we can better assist them. Perhaps all they need is to be moved to another room, or need extra one on attention.

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322 Two organizations listed this response.

323 Four organizations listed this response.

324 Two organizations provided this response.

3. **Freedom Place:** We have internal cameras in the main living areas, chimes on the windows and doors, an alarm system and an electric gate which is only accessible to staff of Freedom Place when entering and exiting the facility. We also have tried to create an environment that the girls would not want to run and staff that are caring and supportive
4. **GEMS:** We are not a locked facility. We do an assessment to identify triggers for girls who are chronic runaways. Because it's an adaptive strategy for girls, we treat running away through therapy. Helping find other adaptive strategies and see that consequences of running are worse. You want to allow runaways to be able to still keep in touch with staff. It's more about relationships than a real "policy" regarding runaways
5. **His House Inc. dba His House Children's Home:** Level system to motivate participant. Supervision Staff trained in motivational interviewing techniques. Door and window alarms. Remote location with tall fence. The facility is not a locked.
6. **Hope House:** They are free to leave at any time. We tell them that. Giving them that freedom helps them not to feel trapped and like they need to run. We are a voluntary program. We turn down many applicants who do not want the help. We have to have buy-in from them. There is a lengthy application process but because of this, we are seeing tremendous success with our clients because we are picky about who we take.
7. **Janus Youth Programs, Inc.:** We operate a voluntarily placement for youth and if they decide to leave we will hopefully have time to talk with them to process what's going on but if they want to leave they will. Since youth "voluntarily" come to us they also have the ability to "voluntarily" leave so we don't usually refer to them as "running."
8. **Kristi House:** We will be 24-hour staff secure, meaning there will be awake staff ready to intervene in an elopement situation. Clients are encouraged to stay through the creation of an accepting family like environment that is nonjudgmental and supportive. We are not a locked facility, but an attempt to exit will be noticed by staff who will be trained to counsel clients and talk to them as they are leaving to try to mitigate triggers.
9. **Mission 21:** The facility is not on lock down and participants can walk out at any time. Our staff is trained in identifying participants at risk of running and will use set skills to prevent or intervene. It is our expectation that staff would be able to encourage the child to make a better choice.
10. **Redemption Ridge:** The safe house is not a locked facility. Young women who live at Redemption Ridge will do so by a signed agreement, understanding the policy that running away is equivalent to giving up their bed to someone else. If she returns before the bed is taken, she will interview with staff, state her reason(s) for running, make restitution to all in the home, and start fresh. If she returns after her spot is filled, she has relinquished her place.
11. **Safe House of Hope, Inc. (SHO Hope):** It is a continual choice of both the client and host family to stay in the home. From the very beginning of talking about placement both are made aware that a call to the executive director at anytime can end the client's' placement. We have never had anyone runaway. We have had calls to work out and both client and Host families that want to run out of

their placements. We have been able to sit down and work out all these difficulties and have been able to work through issues as they arise.

- 12. Street Light:** We cannot lock down the girls. Law states that they can leave on their own free will. This has been very difficult.
- 13. Wellspring Living:** The main thing we do to prevent runaways is to help a participant get buy-in to the program. Because we believe in individualized care buy-in can look different for each participant. If school is important to them we will identify a school credit that they can earn in less than a month to help them see the possibilities they have for the future. For other girls we may have her create a Vision board for her future and ID one way we can practically help her achieve a part of her vision in the first month. Currently we are in a locked facility however this will not be true in the future since we believe a more strength based approach and invitational approach is more effective.
- 14. Youth For Tomorrow:** Highly structure schedule, intensive (active) supervision, if suspect child is planning to run, noted as a Flight Risk and provided one-on-one supervision. YFT has an abscondence plan which includes preventive method as well as responding to a runaway such as searching for the resident and contacting local police within a specific time frame.
- 15. Youthcare Seattle:** We are not a locked facility. Youth verbalizing or otherwise exhibiting a desire to leave the program are met with verbal and motivation based interventions. We use frequent interventions. For instance, we ask a high-run risk youth every hour what is their “run scale” which is between 1 and 10 (1 is not planning to run and 10 is walking out the door) and respond accordingly using motivation or small incentives. Over time the “run scale” decreases as they bond and form supportive relationships in the program. This has worked well and we have had a surprisingly high retention rate for the first 2 years. The other major retention factor is the assessment process. Ideally, youth work with our community case managers for some time prior to being “ready” to try a program. The more we know about a youth and the more bonded they are to case management staff they more stable they are in placement. We use the Stages of Change approach and really wait until the youth is in the Action phase. Youth that are Pre-contemplative and refusing to acknowledge involvement are not seen as ready for placement. This creates a more stable milieu and ideally youth are in a place to support each other. Youth are “staged” for a 1-2 weeks in our Emergency Shelter program which is physically separated from the long term recovery program. This gives us time to assess the youth’s peer to peer and staff relations. What we have seen is that if a youth is going to run she will run while at Shelter but if she can stabilize there we have a high chance of working successfully with her in the long term program.

## 5.10 Elopement

**Expanded Responses to:** *How many runaway attempts do you typically see? Do you think there is a correlation between this and the types of referrals you accept?*

1. **Freedom Place:** Freedom Place has been in operation for 2 ½ months now and we have had two successful runaway attempts. Yes, most definitely. The referrals we accept are of girls who have been trafficked for sexual exploitation as children. Many of these girls have only known one lifestyle and that is to use their bodies to get their needs met or appease their pimp. They may know realistically that this lifestyle isn't safe or desired but that is what they know and feel comfortable with so they run.
2. **GEMS:** The number of attempted runaways is low because really the doors are not locked so there are not really "runaways." People often do much better the second or third time they are at the home.
3. **Janus Youth Programs, Inc.:** Probably 50% of the youth we serve have an unplanned exit. Most (if not all) of these youth will return to us again so we maintain our relationship with them.
4. **Kristi House:** 99% of the clients we have had in Project GOLD, our non-residential program, have a history of chronic running. Much of that behavior subsides or at least minimizes once the client fully engages in Project GOLD. There is absolutely a correlation between runaway behavior and victims of exploitation.
5. **Wellspring Living:** 1 runaway per 10 girls on average usually are runaways have minimal family support and a lot of DFCS/DJJ involvement. Yes there is a correlation. We believe in the stages of change model in relation to CSEC and that many girls that are court ordered to treatment are still in a pre-contemplation phase... Sometimes when they buy in to the program they move into the contemplation and preparation phase of the stages of change model.

## 5.11 Reporting Elopement

- 64% of responding organizations immediately report elopements.

**Expanded Responses to:** *What types of requirements exist for reporting runaways (or other infractions)? Does this in any way affect your licensing?*

1. **Freedom Place:** We must adhere to the Residential Child Care Licensing standards, which indicate that a child under 12 years of age who runs from your facility must be reported to the police and licensing within 2 hours. A child who runs from a facility who is 13 or older must be reported to the police and licensing within 24 hours. Because the referrals we accept are susceptible to abuse and exploitation we report to the police and their guardians immediately but wait to report to licensing according to the appropriate time frame. Does this in any way affect your licensing? This can impact our license if we do not adhere to our policies and procedures, or if it appears we have failed to supervise the residents who we have reported as runaways.

2. **His House Inc. dba His House Children's Home:** Elopements must be reported within 1 hour and a Critical Incident Report must be submitted to the Lead Agency for CBC within 24 hours. This affects our funding if the requirement is not met.
3. **Janus Youth Programs, Inc.:** When exit from our crisis shelter, our policy was not to call the police. We simply call the guardian to inform them the youth has exited the program. In the past two years, if a youth leaves and the staff suspect they are recruiting we immediately call the police and they quickly show up and detain the youth. The youth are brought to our office where they are separated. The youth suspected of recruitment will be taken to our juvenile detention facility (if even just for a short time) and the case manager/therapist works with the other youth.
4. **Kristi House:** We need to write incident reports and submit them internally and to Our Kids, our oversight agency for foster care. Also, we will make referrals to NCMEC and report to law enforcement and the DCF hotline.
5. **Wellspring Living:** The National Center for Mission Children must be informed of all runaways, we also report to whoever the custody hold is Parent, DFCS, DJJ, GA Care Connection and other agencies involved. Child Care Licensing does require that you report runaways and they will do an investigation to make sure that the staff did their part to keep the child safe.
6. **Youthcare Seattle:** The State of Washington mandates the run report procedure. If a youth is just late coming home we give it a few hours but if we know a youth has run and plans to stay gone we make the report immediately. We are required to call the police, file a report and notify the guardians and court (if on probation).

## 5.12 Self-harm/suicide reduction

- The following methods were listed to reduce self-harm/suicide:
  - Adequate supervision/case management<sup>325</sup>
  - Appropriate prescriptions
  - Contracts with clients to confirm they understand program policies<sup>326</sup>
  - Dialectical Behavior Therapy workbooks
  - Explore alternate coping mechanisms
  - Half bedroom door
  - Medicine locked up
  - No access to sharp objects, razors, knives or other dangerous utensils<sup>327</sup>
  - No access to healing elements
  - No solitary free time alone in rooms
  - Onsite therapists/clinical staff<sup>328</sup>

325 Seven organizations provided this response.

326 Three organizations listed this response

327 Five organizations provided this response.

328 Four organizations listed this response



- Room searches<sup>329</sup>
  - Place child on suicide watch, only clinician can lift
  - Safety plan<sup>330</sup>
  - Training<sup>331</sup>
- Several organizations indicated that severe cases should be taken to the hospital<sup>332</sup>

**Expanded response: *What methods/policies do you have in place to prevent self-harm/suicide? What is your response plan?***

1. **GEMS:** Self harm is about coping mechanisms. Cutting is an adaptive mechanism just like running. We want to find other mechanisms – one girl was an extreme cutter so we tried various interventions and skateboarding turned out to be a big stress reliever that replaced her cutting. Staff are also trained on recognizing suicidal behavior and knowing clear questions to ask the girls. If there is an affirmative suicide plan, an ambulance is called. We also do room checks for things like knives and try to restrict access to possible suicide tools. Medication is locked up. Really it's about knowing your kids and knowing the signs – they rarely come out of the blue. Some girls may also need low grade antidepressants to even participate.
2. **His House Inc. dba His House Children's Home:** The client is supervised at all times. Visual checks at night every 15 minutes and every 5 for clients who are at risk of suicide or self-harm. Licensed clinician will assess client for involuntary hospitalization. Safety plans are developed for high-risk individuals.
3. **Mission 21:** Prevention training is mandatory and on-going. Staff is trained to identify red flags and implement prevention/intervention plans. Cameras are also placed throughout the facility to prevent/intervene/deter self-harm/suicide. Our response plan is outlined in our procedure handbook in regards to notifying emergency services, law enforcement, family, other participants, staff, etc.
4. **Polaris Project:** Upon entry into the program we require that the client sign a contract, which clearly delineates the rules and regulations of living in the transitional housing program. We provide clients with the NHTRC hotline number in the event that they need to reach their case manager during off-hours and provide them with the suicide crisis hotline number as needed. Case managers perform a self-harm/suicide assessment with clients to determine that plausibility of severe harm in the event that the client is seriously considering harm and has a plan, appropriate individuals are contacted, including the director of the client services department and 911 if harm to self and others is imminent
5. **Redemption Ridge:** Items that pose a threat to the safety of the girls are not allowed. Sharp objects are used under supervision during life skills practices and locked up afterward. Generally, self-harm isn't a problem after the young woman is removed from the harmful effects of trafficking.

<sup>329</sup> Two organizations listed this response.

<sup>330</sup> Two organizations listed this response.

<sup>331</sup> Four organizations listed this response.

<sup>332</sup> Seven organizations provided this response.



6. **Safe House of Hope, Inc. (SHO Hope):** Training and DBT workbooks if necessary. Workbooks based in dialectical behavior therapy (DBT), a type of therapy designed to help people who have a hard time handling their intense emotions; for self-harm specifically we use Stopping the Pain: A Workbook for Teens Who Cut and Self Injure, by Lawrence Shapiro PhD.
7. **Wellspring Living :** Therapist work on site 5 days a week and we have a rotating on-call schedule so staff have access to therapist if needed. When a participant is high risk, we work with them and the staff to create a safety plan to protect the child. All clinical staff are trained to do risk assessments in the event a child may be at risk. We also have a policy around safety precaution when a participant becomes elevated but this helps to provide more oversight and positive attention to the participant. If a participant ever elevates past a point in which we cannot guarantee their safety we will work with a local Crisis line to get the participant transported to a hospital.
8. **Youth For Tomorrow:** Training and on-site clinical staff. If child threatens or attempt self-harm/suicide, they are transported to local Community Services for an evaluation
9. **Youthcare Seattle:** Having an internal therapist and chemical dependency professional and sub-contracted psychiatrist is very helpful in this issue. The therapist (primarily) screens and coordinates treatment activities when self-harming behaviors are present. The program may use “no-harm” contracts, conduct room searches (for blades or signs of disordered eating), set up motivation plans or engage outside consultation as needed. All program staff are made aware of issues at the weekly staff meeting/case consultation and work as a team to track significant behaviors. The psychiatrist is also available for psych evals, medication (as indicated) or crisis hospitalization (if needed).
10. **For the Sake of One:** Room checks every fifteen minutes, educated staff on what to look for and if staff is concerned to take precaution and monitor child heavily for twenty four hours. Should they have a plan to carry out harm to themselves we will call the Mobil psychiatric unit to see if a 72-hour hold is needed.

### 5.13 Staff secure<sup>333</sup>

- 65% of responding organizations are staff secure.
- 35% of responding organizations are not staff secure.

<sup>333</sup> The term “staff secure” is used here to mean that a facility is not physically locked from the outside and children can exit, but doors are secured from the inside and supervised by staff to deter residents from running away.

## 6. Comments, Advice, Lessons learned

*Note: advice listed is not vetted or endorsed by National Colloquium Partners*

- Assess community needs and carefully consider committing to providing residential services.
- Address the core issues of clients over behaviors.
- Be realistic about the complexities and challenges in providing shelter and services.
- Be committed and able to maintain services.<sup>334</sup>
- Be prepared for traffickers attempts to contact their victims and regain control of them.
- Build relationships with community stakeholders, including police, paramedics, community service providers, media, and hospitals.<sup>335</sup>
- Conduct regular meetings with all involved individual, staff and agencies to avoid miscommunications.<sup>336</sup>
- Do not reinvent the wheel.
- Do not force a victim to exit the life or enter a program.
- Expect the unexpected.
- Provide education on site.
- Have knowledge and understanding of licensing processes.
- Have knowledge and understanding of the legal process for clients.
- Include a self-care component for staff and volunteers.<sup>337</sup>
- Male staff should not be alone with clients.
- Partnerships are critical.<sup>338</sup>
- Promote vocational and employment programs including opportunities for clients to earn money.
- Programs must be adequately funded.<sup>339</sup>
- Programs must be adequately staffed.<sup>340</sup>
- Research other programs and methods before and during programs.<sup>341</sup>
- Take adequate security measures.
- Take it slow, begin small.
- Strive for empowerment mentality over rescue mentality.<sup>342</sup>

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334 Two organizations listed this response.

335 Four organizations listed this response.

336 Two organizations listed this response.

337 Two organizations listed this response.

338 Three organizations listed this response.

339 Two organizations listed this response.

340 Four organizations listed this response.

341 Four organizations listed this response.

342 Two organizations listed this response.

## 6.1 Challenges listed

- Obtaining and licensing a facility is complex.<sup>343</sup>
- There is competition and lack of trust or understanding with other NGOs and service providers.<sup>344</sup>
- Finding appropriate, qualified staff is difficult.<sup>345</sup>
- There is a lack of funding and resources.<sup>346</sup>
- The community misunderstands or is not aware of the issues.
- Miscommunications between involved providers make delivery of services difficult.
- Law enforcement need continuing training.

**Expanded Responses to:** *Please share any challenges or lessons you've faced in starting or operating your program or organization. Do you have any advice for other organizations that are just starting to serve DMST victims?*

1. **End Slavery Tennessee:** Educate yourself—talk to people who have been doing this work already—take time developing good working relationships with law enforcement and community service providers. Be sure you have a realistic, and not a Pollyanna, view of what you are getting into. Just “loving on those kids” is not enough.
2. **For the Sake of One:** Some of the hardest obstacles have been challenges in changing people minds sets who believed this was only happening overseas, getting them to go from knowing the facts to becoming a part of the solution from speaking out to raising funds even volunteering their time. I feel since there is such a flood of NGOs those who are actually working with children have to share donors resources and thus funding is very low. I have also seen many who are territorial and will not collaborate. I also strongly believe in others joining forces with another NGO thus not to reinvent the wheel but lend support to existing NGOs. Also every organization should work with survivors.
3. **Freedom Place:** It is very important to have someone on staff or contract with someone that has a thorough understanding of state licensing regulations. Develop a business plan and budget and secure one year's worth of funding before you start.
4. **GEMS:** Take your time in committing to residential. May not be your community's only need. What happens to the girls who aren't quite ready to leave pimp but they can't get housing? Where can they get their services? Girls being mandated into house, they won't last. We don't like the “rescue” mentality but prefer “empowerment” mentality; it's much more complex than keeping girls away from the bad men. Know distinction in race/class/gender – girls need to come into program where somebody looks like them. People worry about recruitment but the friendship and interactions between girls is important.

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343 Four organizations listed this response.

344 Two organizations listed this response.

345 Two organizations listed this response.

346 Two organizations listed this response.

5. **The Genesis Project:** Partnerships are key – at the same time other NGOs that state common goals can be a hindrance. Although partnerships are desperately needed, be sure you partner with very like-minded individuals and organizations. Allies in the media are essential to raise awareness and funds for your organization. We have noticed an abundance of awareness groups cropping up who claim to be on the front lines (Rescuing girls). They garner media attention on false claims, when in fact they do nothing for victims of DMST in terms of direct services.
6. **Georgia Care Connection Office:** This experience in being a part of developing GCCO as a statewide initiative to identify and serve CSEC youth; the CSEC system of care; the collaborative efforts of building a continuum of care and services; involvement in the GOCF CSEC Task Force; and all of the relationship building, education, and awareness, is a journey which we could not even imagined when we started.

Briefly, we have met so many amazing people, long time advocates; amazing smart beautiful CSEC youth; people ready to work hard side by side to build an effective program, and those ready to step up and do whatever is needed once they are aware of this crime against our children. In the process, we have also learned the value of discernment in what is offered as help; that not everyone really understands our CSEC youth; there are those who work with our youth who still want to focus on the behaviors, rather than the core issues; and that sometimes personal agendas often get in the way of what is best for our youth. However, the effort is much bigger than any of us individually, and experience shows focusing on the best interest of the youth will eventually bring everyone back to the same page.

7. **His House Inc. dba His House Children's Home:** Challenges- Securing a government owned building is extremely complex. It can take over a year. Assisting victims of human trafficking is the “trendy” thing to do these days- many parties want involvement. Finding dedicated and committed staff is of utmost importance.
8. **Hope House:** Since 2009, none of the girls taken in have come from a two-parent home. Saying no to applicants that do not want the help is always hard. Sometimes their parents want them to come but they want nothing to do with the program. We have learned too many lessons to list! Expect the unexpected. For example, we had hand sanitizer for the girls. They later used them to make alcoholic cocktails. Also, we used to have glass mugs, until one of the girls threw one through the window.
9. **Mission 21:** Challenges: We are the first/only anti-trafficking service provider for youth 15 and younger in our state looking to provide residential services exclusively for this demographic. Licensors not being assigned during application process. Zoning requirements/challenges regarding children group homes. It was helpful to have a fiscal agent and parent org in beginning stages to provide leadership skills and accountability and credibility. Don't forget to include self-care training as part of the mandatory training for staff and volunteers.
10. **Multicultural Clinical Center:** The biggest challenge is implementing a more collaborative approach. As clinicians, we try to communicate with all providers involved in the clients' life (i.e. school, law enforcement, probation, etc.). This can be challenging as often times individuals struggle to

understand the importance of this. Another challenge includes the financial aspect and limiting services due to budgets, etc.

**11. Polaris Project:** One of the challenges includes working in tandem with child protective services. When a minor is receiving services from different organizations, confusion may arise as to which organization provides which service. It is helpful to conduct regular meetings between the organizations to ensure the minor is receiving the best services

**12. Redemption Ridge:** Challenges to opening our Redemption Ridge safe house have been in obtaining licensing & use permits for the facility.

Our facility is still not open. Challenges to procure enough funding, obtaining necessary permits, etc. continue to cause delays.

**13. Safe House of Hope, Inc. (SHO Hope):** Please make sure you can maintain a service you start and never promise anything you can't deliver. Remember clients are smarter than you are and prayer needs to be the foundation of all decisions. It may seem hard to start something but it is even harder to maintain so get as much education and train staff as much as possible. You must have regular staff debriefing meetings and whenever possible bring in others to all talk with clients about services and future goals.

**14. Traffick911:** Professionalism and excellence are key to continued strong partnerships with law enforcement, child placing agencies, child protection agencies, etc. Please do due diligence and thorough research before launching any programs. We have seen organizations with good hearts and a desire to help re-traumatize victims and damage relationships with key governmental agencies for everyone by acting from their heart rather than a solid, professional, methodical model. Professional training and skills, along with a sustainable program, are key to success for both the client and the organization.

**15. Youth For Tomorrow:** Financing victims who do not have sponsors/agencies for placement. There is a hesitancy to accept these girls, not because of funding, but because if they become a danger to self or others it becomes difficult to discharge them without support.

**16. Youthcare Seattle: Seattle:** Program Structure- "keep them busy, keep them motivated"

- a. Try to have double staffing at all times; do not ever have male staff alone with youth (for the staff's protection as much as the youth)
- b. Have education in-house (or all residents attending the same program and train the school staff if doing it in-house)
- c. Understand the legal considerations that these youth face. How will a program respond when wedged between the youth and the juvenile justice system? For instance, the youth has a no-contact order with her pimp and the program finds out she has violated that order, or another term of probation or a bond order, what does the program do? Will you take youth on an ankle monitor (as sometimes happens with a federal material witness order)? Is the program really

voluntary in that case? Programs need to think about these issues BEFORE they accept a case like this because the program can, in effect, become part of the justice system.

- d. “Re-frame the economic strategy” - youth that have been in the sex trade have to choose not to go back for the rest of their lives. Therefore the program should focus heavily on vocation, education, money management, internships, paid community service, etc. Also, it’s a hook for a youth who may be ambivalent about leaving the life to say “we will get you into a paid internship and YOU get to decide what to do with YOUR money”.
- e. Don’t push a youth who is not ready to leave... it will likely prolong the process. Planting the seeds, consistency, unconditional compassion and an open door when they’re ready.
- f. Have really, really good staff support and supervision. This is incredibly draining and traumatizing work and staff needs a lot of support, conflict resolution, team building and a consistent knowledge that the agency leadership will support them.
- g. Build Art and Empowerment activities into the program regularly. This is culturally competent and, especially for traumatized adolescents, there are feeling and thoughts that can be expressed through art, dance, poetry and other forms of expression that are beyond traditional therapy. Some of the most profound healing work I have seen has been in the context of slam poetry, collage, or making documentaries about their lives and experiences.

# ➤ Appendix D

## National Colloquium Survivor Survey

### Survivor Survey: Shelter and services Response to Commercial Sexual Exploitation of Children

## 1. Survey Respondent Demographics

### 1.1 Participant Names

- Total number of Participants: 33
  - 1. Anna Beard
  - 2. Antonia “Neet” Childs
  - 3. Ashley Cacho
  - 4. Barbara Amaya
  - 5. Beth Jacobs
  - 6. Brooke
  - 7. El
  - 8. Holly Austin Smith
  - 9. Jessica
  - 10. Jessica McFalls
  - 11. Kate Price
  - 12. Keisha Head
  - 13. Leah Albright-Byrd
  - 14. Margaret Howard
  - 15. Melissa Woodward
  - 16. Normilita Ranara
  - 17. Rebecca Bender
  - 18. Sarita
  - 19. Shamere Mckenzie
  - 20. Shandra Woworuntu
  - 21. Shannon Kindler
  - 22. Stacy Jewell Lewis
  - 23. Tina Frundt
  - 24. Wanda Williams
- *Nine survivors requested to be listed as anonymous.*

### 1.2 Gender

- 32 of the respondents are female
- 1 respondent is male.

### 1.3 Racial composition

- 29% of the respondents identified themselves as Black/African-American.
- 52% of the respondents identified themselves as White/Caucasian
  - One of the respondents further specified herself to be white, but with strong Cherokee lineage on the father’s side.

- 3% of the respondents identified themselves as Hispanic/ Latino
- 10% of the respondents identified themselves as Asian
  - One of the respondents further identified herself as Vietnamese-American
- 10% of the respondents identified themselves as Multiracial
- 3% of the respondents identified themselves as other and further specified “East Indian” as their response.

## 2. Age when trafficked

- 55% of respondents were under 18 when they were first trafficked
  - 15% of the respondents were less than 10 years old when they were trafficked.
  - 3% of the respondents were 11 years old when they were trafficked.
  - 6% of the respondents were 12 years old when they were trafficked.
  - 6% of the respondents were 13 years old when they were trafficked.
  - 6% of the respondents were 14 years old when they were trafficked.
  - 0% of the respondents were 15 years old when they were trafficked.
  - 12% of the respondents were 16 years old when they were trafficked.
  - 6% of the respondents were 17 years old when they were trafficked.
- 45% of respondents were over 18 when they were first trafficked
  - 33% of the respondents were between 18-25 years old when they were trafficked.
  - 12% of the respondents were older than 25 years old when they were trafficked.

## 3. Source of Trafficking

- 35% of the respondents were trafficked by a family member or foster family.
- 10% of the respondents were trafficked by a family friend.
- 13% of the respondents were trafficked by a friend or acquaintance.
- 23% of the respondents were trafficked by a stranger.
- 70% of the respondents were trafficked by a pimp.
- 7% of the respondents were trafficked by a madame.
- 7% of the respondents were trafficked by a gang member.

## 4. Length of being trafficked

- 0% of the respondents were trafficked for less than one day.
- 7% of the respondents were trafficked for less than one week.



- 7% of the respondents were trafficked for 3-6 months.
- 10% of the respondents were trafficked for 6-12 months.
- 27% of the respondents were trafficked for more than one year.
- 23% of the respondents were trafficked for more than five years.
- 27% of the respondents were trafficked for more than ten years.

## 5. Initial Exposure to Trafficking

- 43% of the respondents reported physical force/rape as an initial exposure to trafficking.
- 47% of the respondents reported fraud as an initial exposure to trafficking.
- 70% of the respondents reported coercion as an initial exposure to trafficking.

**Expanded answers to: *Check all that applies to initial exposure to trafficking.***

1. **Anna Beard:** I was brainwashed, so I didn't realize what was going on. He was 40; I was 16 when he started grooming me. I got kicked out of my house and didn't have anywhere to go, since he was my boyfriend he said I should live with him. I was told that I was beautiful and he "needed" me. He loved me (so I thought) and I didn't want to do anything to lose that. He asked me to be a part of his "art project" and I could be his model. I never had a solid relationship role model in my life so I didn't know this was unhealthy nor wrong. I also didn't know what human trafficking was either. If I had known what either of these were, I wouldn't have fallen into it. I am not at fault for what I do not know.
2. **Beth Jacobs:** I was tricked. I was told I was going to a party.
3. **Brooke:** Explicit threats of harm to me and my family if I told.
4. **El:** Survival
5. **Holly Austin Smith:** I was told lies about modeling or acting jobs in order to convince me to run away. Once I realized they intended for me to prostitute, I reluctantly complied.
6. **Jessica McFalls:** Initially, at the age of 21, I was so curious about this "lifestyle" of the pimps and Ho's that when I randomly met a pimp one day, I was intrigued and decided to give him a "trial run." Little did I know what I was getting myself into and when I realized I was in over my head, the physical force and abuse began. After that, my prison was primarily physical abuse and psychological manipulation.
7. **Jessica:** I was "groomed" by a girl I thought was my friend and became accepted into a group of friends and I so badly wanted friends and acceptance. Then they wanted me to allow people to use me at parties and I thought it was all about of being accepted so I went along with it.
8. **Kate Price:** I was too young to even barely speak - my father prostituted and trafficked me to support his drug addiction.

9. **Margaret Howard:** It's complicated. I was a runaway. I got in the car willingly, thinking the boys/men looked like my peer group. I went into the house they took me to willingly, expecting community as was the dominant ethos of my peer group at that time. I would call all those things fraud -- they represented themselves to be something they weren't, and then turned me over to a pimp. Although I had no idea what a pimp was, then. Over five days I gradually came to understand that I wasn't allowed to leave, that if I tried to leave I would be drugged and physically forced back into the room where the men came in to have sex with me.
10. **Melissa Woodward:** My trafficker was a family member who then forced me into a trafficking ring. However, I was groomed through molestation, beating and shown pornography.
11. **Rebecca Bender:** He pretended to be my boyfriend for months, promising to marry me and give me the family I always wanted. Once secluded, he told me that if I wanted to help our family, I would need to sell my body to make extra money so WE could reach our dreams.
12. **Shamere Mckenzie:** My trafficker told me he would help me go back to school. He then threatened me and my family when I told him this is not what I wanted to do.
13. **Shandra Woworuntu:** Intimidation, isolation, use privilege, economic abuse, sexual abuse.
14. **Stacy Jewell Lewis:** Held at gunpoint and threatened with rape and physical violence to self and child if did not comply.
15. **Anonymous:** My trafficker was my biological father. When younger, I trusted him and feared (was threatened harm) disobeying him.
16. **Anonymous:** I was approached and coerced by other girls that were in the life.

## 6. Forms of abuse while trafficked

- 81% of the respondents mentioned they were physically assaulted while trafficked.
- 84% of the respondents mentioned they were sexually assaulted or raped while trafficked.
- 91% of the respondents mentioned usage of force/coercion while trafficked.
- 81% of the respondents mentioned they were verbally abused while trafficked.

**Expanded answers to:** *Check all that apply to the entire time of being trafficked: [This can apply to any time during your exploitation.]*

1. **Anna Beard:** I was watched 24-7. Every time I tried to go anywhere, he would make me feel like he couldn't live without me. I was drugged. I would wake up not knowing where I was. I faced extreme amounts of sexual violation. I was chained. I was exploited by photography. He took the pictures with a Polaroid camera which is another reason I didn't think anything of it.
2. **Holly Austin Smith:** Manipulation, intimidation due to age difference and insistence.

3. **Kate Price:** Neglect, child sexual abuse by multiple members of my family, emotional abuse
4. **Rebecca Beard:** The Power of Coercion: Why She doesn't just leave can be found on our website which describes some actual incidents: [www.redemptionridge.com](http://www.redemptionridge.com).
5. **Sarita:** Physical threats were also made to my children who were held somewhere I couldn't get to so I'd behave.
6. **Shandra Woworuntu:** Intimidation/weapons; isolation; economic abuse.
7. **Anonymous:** Manipulation and my father's power of parental authority.
8. **Anonymous:** Falsified threats of legal system and losing custody of child; threats regarding child and family.
9. **Anonymous:** I was constantly abused in some form so he could keep control of me. I remember crying while he raped me one time.
10. **Anonymous:** Forced (illegal) abortion.

## 7. Opinions on Provision of Services based on trafficking experience

- Although respondents varied in basic “yes” and “no” responses to this question, their elaboration of reasoning for either response indicated that all survivors deserve and benefit from services tailored to their experience.

**Expanded Responses:** *Some survivors and advocates believe that an individual's experience with trafficking determines which services he/she should receive. For example, some say that the type of services offered to a client should depend on how the individual was exposed to trafficking (e.g. gang-controlled, pimp-controlled, family-controlled, etc.) and what occurred during the time trafficked (e.g. drug use, physical/sexual assault, pregnancy, etc.). Do you agree with this? Please explain.*

1. **Anna Beard:** I disagree. Everyone deserves the same opportunity to succeed. What should determine services is what they NEED help with. I graduated a free-of-charge Christian based program that deals with girls ranging from eating disorders to sex trafficking. At Mercy, the staff targeted my areas that I personally needed help in. If we limit the services, we limit their healing process. They've been imprisoned enough! It's time to set them free!
2. **Ashley Cacho:** I agree, I personally think people have to change in the own way and some people need a little extra help then others.
3. **Barbara Amaya:** Every victim and survivor of trafficking has their own unique experience so of course services would and should be tailored to fit each different scenario.

4. **Beth Jacobs:** I think that anyone who is or has been trafficked should be afforded the same resources. We all have gone through emotional trauma as a result. Women in a group I facilitated stated that they should be eligible for veterans' benefits. If you think about it that is a true statement. Maybe one victim might need more therapy, but a victim is a victim. No one should limit the therapy. I think we could offer MORE therapy, or resources. If we do an assessment when a victim first comes for help, we should be able to come up with an individual plan. No two people are the same and we will have different needs. My answer is we will all be different and have different needs. Each survivor should be offered available services and help create their own case plan.
5. **Brooke:** All services should be client-centered and take into consideration the individual's history, but it is important to recognize what survivors have in common and encourage a collective response to this issue.
6. **El:** No, it doesn't matter what happened to get the person exploited; everyone deserves a second chance
7. **Holly Austin Smith:** I believe there should be a core program designed for victims of child sex trafficking. Then, there should be additional services available and accessible to those who need them. For example: parenting classes for teen mothers, foster care options for victims without a healthy home, Big Brother Big Sister mentors for those at home without siblings, etc.
8. **Jessica McFalls:** I do not completely agree. The underlying issues are the same no matter the circumstance. The results of having been trafficked are mostly the same no matter the circumstance. It is only the surface issues that differ based on individual experiences. If we only address those more surface type issues, the survivor will never experience complete healing.
9. **Jessica:** I think everyone's care should be treated individually not based on what happened to them but how it affected them.
10. **Kate Price:** Absolutely. The context in which a child is exploited informs her or his path to healing. Mine was very tied to my father and family, whereas, a child who has experienced poverty will have had a very different experience than mine. One size does not fit all, although, I would anticipate a lot of overlapping services since exploitation, in my experience, is about power and control.
11. **Keisha Head:** Yes, I believe in order for the services to be effective then they must be specific. It would have been helpful for me to receive services that addressed my sexual abuse. Services that dealt with drug abuse would not have been relatable.
12. **Leah Albright-Byrd:** Yes, I believe that every victim's treatment should always include individualized services commensurate with his or her experiences, needs, and requests.
13. **Margaret Howard:** All trafficking victims should have access to all services. At the same time, programs and treatment should be individually tailored, and all providers need to be versed in the differences in presentation and needs particular forms of trafficking produce.
14. **Melissa Woodward:** I believe that as long as children are in a safe and loving environment providing the tools they need recovery (regardless of their trafficker) is possible.

- 15. Normilita Ranara:** Yes. Because the effects are all coming out intensely not just emotionally but mentally as well.
- 16. Rebecca Bender:** I suppose each type of TREATMENT should be specified depending on the type of abuse/control that the victim has been exposed to. However, measuring each person's amount of trauma to determine their need of service is unfair. We cannot judge whose trauma was more or less.
- 17. Sarita:** I don't think you can pigeon-hole survivors in that way. There are so many ways and means and experiences every survivor should have a personal package. From questions asked and comments made during case management, therapy, doctor's visits etc., to see what each individual needs to restore their life. Most shelters have a time limit for their clients which is nowhere near long enough for many survivors to get their lives back together, find sustainable work, an apartment and so on when we are fighting every day to keep our heads together and get through one more day. For those of us who were trafficked from another country to deal with the whole T-Visa application and have paperwork chasing us round the country as we get moved from program to program and shelter to shelter just makes thing take even longer.
- 18. Shamere Mckenzie:** No I do not agree with this statement. I believe all sex trafficking survivors should receive the kind of services and these services should not be based in how they were exposed to trafficking.
- 19. Shandra Woworuntu:** No, I do not agree. As a victim, We should get services not only depending how individual exposed to trafficking or what occurred during the time trafficked, BUT we have to see what is the best and maximal help and service for the victim ( probably use the list) and moving victim with all the service as much as victim can get.
- 20. Shannon Kindler:** Yes, because every situation is different
- 21. Stacy Jewell Lewis:** No. This would suggest that the survivor will be open or even remember and understand all things experienced within the time of trafficking.
- 22. Wanda Williams:** yes, I was kidnapped and tortured multiple times and suffer from PTSD and terrible anxiety and there just were no counselors in our small town area that could even relate.... specialized help is so needed and people that have special training not just regular counseling...
- 23. Anonymous:** I feel that is just depends on the person. When it comes down to it the feelings of sexual trafficking are the same. I believe we learn from each other. I really believe that it takes a very strong person to run the services and have a great understanding of the different ways of trafficking.
- 24. Anonymous:** Yes, I agree. Trafficking is not a cookie-cutter experience and therefore, I feel the recovery and healing services do not need to be as well.
- 25. Anonymous:** No, all services should be centered around everyone. We don't always talk about everything that we we're involved in, but we all have experienced all or most of those things that are listed and things that are not listed.

- 26. Anonymous:** Yes. In order to provide proper and necessary services it is important to address the immediate effects of their experience. From there, providers must understand the survivor's core issue and create wrap around services based upon those issues.
- 27. Anonymous:** Partially. I do think there will be specific elements to each individual's victimization that needs specialized attention. I think a lot of the emotional or trauma effects cross over (sleep problems, PTSD, low self-worth issues, etc.) and then there are there are other services which need to be individualized (ex. victim with a child vs. victim without a child)
- 28. Anonymous:** I do believe some of it should be geared specifically towards each individual's experience. However, we need to see each other as well, hear each other's stories, see others that are healing from these traumas too.
- 29. Anonymous:** Yes, I agree with this statement. Survivors need services that meet their needs and it may be a long period of time that they will need services.
- 30. Anonymous:** No, although trafficking was manifested in different ways it is still similar.
- 31. Anonymous:** I think it should in the sense that survivors should have individually tailored services. Services should NOT depend on what they went through if it means limiting services or saying that one group is less worthy.

## 8. Arrest and Criminal Charges for Prostitution

- 55% of the respondents were arrested for prostitution or related charge.
- 45% of the respondents were arrested for charges other than prostitution.
- 50% of the DMST victims were arrested for prostitution.
- Several respondents noted the importance of being able to expunge these charges.

### Expanded answers to: *Were you arrested for prostitution or a related charge?*

- 1. Ashley Cacho:** When I was younger I got arrested for being a runaway child. I was placed back in the home where I was being trafficked.
- 2. Barbara Amaya:** I was trafficked in New York. I am in the process of vacating my criminal record. If I would have been trafficked here in VA where I live I would not be able to vacate, I am in the process of working with legislators to make sure that each and every state not just 7 allow survivors of trafficking to do what I am.
- 3. Beth Jacobs:** Yes I have been arrested probably 150-200 times. It was a game with the police. I got my money, and they got their arrest.
- 4. El:** They should treat people with respect and offer services to help.

5. **Jessica McFalls:** I ran into some police who were really great and others who were NOT. The best I can say is that these women and young girls need you to be their defense. You may well be the only defense they ever have.
6. **Kate Price:** My exploitation was hidden by the proprietary nature of the private family structure - I was my father's property, so his power (and bystanders' collusion) "shielded" this from the public eye.
7. **Keisha Head:** I was never asked questions pertaining to my victimization.
8. **Margaret Howard:** I was, however, picked up as a runaway within hours of escaping the pimp's house, and held overnight in a cell at a juvenile facility with no food, blanket, or access to toilet. What to say about this? It was inhumane.
9. **Melissa Woodward:** I feel that these children should be treated with compassion as if they were your own family member. I believe that they should first try to establish a relationship, before being questioned and that a female should always be present and above all when possible that survivors should be advocates that are called in when a child is discovered to have been trafficked or believed to have been.
10. **Shamere Mckenzie:** I was also arrested for solicitation and conspiracy to the Mann Act.
11. **Stacy Jewell Lewis:** Trafficker arrested, was subpoenaed.
12. **Anonymous:** Degrading and humiliating
13. **Anonymous:** It is more indirectly related to my victimization than a prostitution charge, but it was false report to a LEO [law enforcement officer] because I tried to report guys who had taken me on the interstate and I was beat up and bleeding. Because the officer was dirty, and I was looked at as a stripper on drugs, I was arrested instead of them even looking into whether what I was reporting was true. I think one point to make is that some arrests may be related to HT victimization but in a less direct manner.
14. **Anonymous:** I can't even count the times I've been arrested. Mostly for solicitation. I was arrested for federal crimes as well, for my trafficker, which is what began the process of me leaving.
15. **Anonymous:** I believe that when these girls and women are being arrested, that they should have survivors on standby who are willing to be there to help the victims. When girls are arrested, they are not talking to the police, because the police are their enemy.
16. **Anonymous:** I was very afraid of it though and I was taught about how/where to hide and how to speak with officers.

## 8.1 The charges made if arrested

- 63% of the respondents were charged/ prosecuted for prostitution if they were arrested.
- 37% of the respondents were not charged for prostitution if they were arrested.
- 58% of the DMST victims were charged with prostitution

**Expanded answers to:** *If yes, were you charged /prosecuted for prostitution or a related charge?*

1. **Melissa Woodward:** Victims should be able to have their records expunged easily and without cost.
2. **Wanda Williams:** I was treated like I was trash and not the victim.
3. **Anonymous:** I believe I was charged but not prosecuted, I'm able to seal and expunge if I pay a lawyer to do it.

## 8.2 Time spent in juvenile detention if arrested

- 20% of the respondents served time in juvenile detention for prostitution or related charge.
- 80% of the respondents said that they were not charged or the charges were dropped.
- 30% of those arrested served time in juvenile detention whereas charges were dropped for 70% of the DMST victims who were arrested.

**Expanded answers to:** *If arrested, did you spend time in juvenile detention for prostitution or related charge?*

1. **Ashley Cacho:** When I was younger I also got arrested for robbery which I begged the judge to please keep me in jail because I felt safe there. But still he sent me back home where I started prostituting again the same day I got out.
2. **Barbara Amaya:** Actually, because I was told to lie about my age, I spent time in Rikers Island Prison...
3. **Jessica McFalls:** The longest period served at one time was 30 days.
4. **Leah Albright-Byrd:** I served time in Juvenile detention because of stealing a pimp's car to get away. Police never interrogated or investigated whose car it was.
5. **Melissa Woodward:** I feel that I was viewed as the bad kid, when I was not at fault. I believe we have come far but [there](#) is much progress to be made.



### 8.3 Alternatives to jail time

- 16% of the respondents were provided with an alternative to jail time.
- 84% of the respondents were not provided with an alternative to jail time.
- Only about 11% of the DMST victims were provided with an alternative to jail time whereas 89% were not provided with choices for transitional housing or programs.

**Expanded answers to:** *If yes, were you offered any alternatives to jail time? (e.g. program, transitional housing, etc.)*

1. **Ashley Cacho:** I asked to go to foster care but they told me there was no proof of anything going on in my house and I couldn't go to foster care if somebody in my family wanted me.
2. **Rebecca Bender:** I was never offered ANY services, not counseling, not an officer to talk to in hopes of coming forward about my trafficker, not any trafficking awareness to help me come out of denial of it being "my choice."
3. **Shamere McKenzie:** Yes I was offered services that played a crucial role to my restoration.
4. **Anonymous:** Went through a woman's program that was not specific to prostitution.
5. **Anonymous:** Two weekends at GEMS in 1998.

## 9. Counseling services for early childhood sexual abuse while in a program or facility after trafficking

- 33% of the respondents said they received counseling services for early childhood sexual abuse while in a program or facility after they were rescued.
- 67% of the respondents said they did not receive any counseling services.
- 41% of the DMST respondents received counseling services for early childhood sexual abuse while in a program after trafficking.

**Expanded responses to:** *Did you receive counseling for early childhood sexual abuse while in a program or facility after the trafficking?*

1. **Shannon Kindler:** I attend group therapy 20 hours a week 4 hours a day 5 days a week for multiple years.

## 9.1 Name of program and services if they received counseling services

- 10% of the respondents received services from child advocacy centers or similar programs.
- 70% of the respondents received services from a private therapist.
- 30% of the respondents mentioned receiving services from “other.”
- None of the respondents received services from Detention facilities, DMST-specific programs or hospitals.

## 9.2 Importance of counseling services for early childhood sexual abuse

- 96% of the respondents said that counseling services were “very important.”
- 4% of the respondents said that counseling services were “moderately important.”

**Expanded responses to:** *Do you have any comments in regards to Counseling for early childhood sexual abuse (specifically for abuse prior to trafficking) that you feel could help inform the provider community?*

1. **Anna Beard:** I graduated from a program called Mercy Ministries. It’s an estimated 6 month free-of-charge program that promotes Christian principles and helps girls start their journey to restoration. Throughout their counseling model, I was able to connect the symptoms of abuse and see why I was more vulnerable to trafficking. I used the sexual abuse survivor workbook “Shelter from the Storm.” It took me through everything! I still refer to it when things pop up I need to process. If we don’t teach people how to live, how can they live? If we don’t help these survivors choose life, how can they choose life?
2. **Barbara Amaya:** Listen, believe, validate, and make sure that counseling happens.
3. **Beth Jacobs:** Yes 70% of women in my groups were sexually abused as children, not including child trafficking victims.
4. **El:** People need to be educated before on signs so they can look for answers before it is too late.
5. **Holly Austin Smith:** Counseling for early childhood sexual abuse should be offered to ALL victims of child trafficking. It does not have to be labeled as such, especially because child victims of trafficking often deny early abuse. But I believe any type of counseling beneficial to victims of early childhood sexual abuse would also be beneficial to victims of CSEC until the service provider is CONVINCED that no prior abuse occurred.
6. **Jessica McFalls:** Just that most of the girls I worked with had been abused in this way before they were trafficked.
7. **Kate Price:** In my experience, more emphasis needs to be placed on child sexual abuse prevention for \*all\* children. Currently there is “a lot” of funding and attention around child sexual exploitation;

however, we continue to not want to talk about child sexual abuse, domestic violence, and poverty. Granted, those issues are huge, yet they provide a critical public health threat to all children.

8. **Leah Albright-Byrd:** EMDR and TF-CBT have worked wonders for me and I believe are a very necessary option for childhood sexual abuse victims.
9. **Margaret Howard:** Listen and believe.
10. **Melissa Woodward:** I believe this is a necessity!! It took years before I was able to receive counseling and as a child if I had known how pimps work, if I had known I was not to blame and there was a way out my life would have been far different.
11. **Rebecca Bender:** I was never sexually abused, but I was physically abused by my step-father. Watching abuse in the home callused my heart when it happened to me as a youth by my trafficker. I assumed this was normal behavior and therefore, never spoke out about what was happening to me.
12. **Anonymous:** Sexual abuse is a precursor to sexual trafficking and prostitution. It leaves a person vulnerable to be forced, coerced and beaten by predators.
13. **Anonymous:** Early child abuse prior to trafficking is almost like grooming one's self-esteem to be more vulnerable to being trafficked later on. Traffickers do not want their victims to have good/high self-esteem.
14. **Anonymous:** We need to identify signs prior to trafficking.
15. **Anonymous:** I believe that counseling is important, but with someone who is trained in dealing with childhood sexual abuse.
16. **Anonymous:** Counseling should also address early childhood sexual abuse and childhood abuse could be traumatic. You can't fix one part without fixing the other.
17. **Anonymous:** Acknowledge that both the trafficking and the childhood sexual abuse are hard to talk about. For me, the CSA [child sexual abuse] is harder to talk about because incest seems even more taboo than being trafficked sometimes. It's "easier" to talk about strangers raping me than it is to talk about my mom and my dad raping me.

## 10. Counseling Services for rape/ sexual assault prior to trafficking

- 19% of the respondents received counseling services for assault that happened prior to trafficking.
- 18% of DMST survivors received counseling services for assault that happened prior to trafficking.
- 81% of the respondents did not receive counseling services.

**Expanded responses to:** *Did you receive counseling for rape / sexual assault (specifically for assaults prior to trafficking)?*

1. **Anonymous:** I did not, but I need it though.

## 10.1 Name of program/facility used if counseling services were utilized<sup>347</sup>

- Only 80% of all the respondents said they used private therapist for counseling services.
- 20% of the respondents used other services.
- None of the respondents listed receiving services from detention facility, DMST-specific program and hospitals for counseling for sexual abuse.

## 10.2 Importance of Counseling for rape/ sexual assault in a DMST aftercare program

- 3% of the respondents said it was “slightly important.”
- 4% of the respondents said it was “moderately important.”
- 93% of the respondents said it was “very important.”

**Expanded responses to:** *Are there comments you would like to share regarding your experience with counseling for rape or sexual assault or your thoughts about it to help inform the service provider community about this experience?*

1. **Anna Beard:** The Sexual Abuse Survivor Workbook, “Shelter from the Storm” was phenomenal. I went through a program called Mercy Ministries. Their counseling model is called “Choices that Bring Change.” Along with processing the abuse, they taught me how to make good choices, so now when things pop up I am equipped to fight them!
2. **Holly Austin Smith:** Like early childhood sexual abuse, I believe that counseling for all types of sexual assaults, including statutory rape, should be included in programs for victims of child sex trafficking. Many victims have been assaulted and don’t even realize it because they have not learned about personal boundaries or positive sexual health.
3. **Kate Price:** See previous comments. {In my experience, more emphasis needs to be placed on child sexual abuse prevention for \*all\* children. Currently there is “a lot” of funding and attention around child sexual exploitation; however, we continue to not want to talk about child sexual abuse, domestic violence, and poverty. Granted, those issues are huge, yet they provide a critical public health threat to all children.}

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<sup>347</sup> Only five survivors responded to this question, possibly indicating that most were not provided counseling.

4. **Margaret Howard:** We need to create a culture where children are heard and their experiences honored. In order for this to happen US public school system's way of operating, way of treating children, needs to entirely changed. Of course the same is true for all of the systems that "serve" children, and parents.
5. **Melissa Woodward:** This is a necessity - children need to know the facts and receive help.
6. **Anonymous:** We need to find other ways on getting the word out, about what's going on.
7. **Anonymous:** More CSEC education is needed to service young women with this experience.
8. **Anonymous:** I think there's still a lot of training needed in individual therapists and mental health community in general. During the trafficking I was baker acted by one of the men involved and I showed signs of being an HT victim but no one identified me as a victim. The psychiatrists just want to give you pills and nurses who did recognize trauma just didn't have the tools or power to help. I've seen counselors since being "out" and some of them look at you with shock or don't appear to know how to handle you, I've had therapists not even return my calls once I've told them I was a victim of HT.
9. **Anonymous:** I believe this would be very beneficial in working with victims. They cannot heal if they have not dealt with what has happened. And they need to know that it was not their fault.
10. **Anonymous:** A reminder that the key part of rape trauma is not the physical and sexual violation, but the domination/control and the exploitation of someone's autonomy.

## 11. Counseling or Services received for addiction after trafficking

- 30% of the respondents received counseling or services for addiction.
- 70% of the respondents did not receive any counseling or services for addiction.
- About 40% of the DMST victims received counseling services for addiction.

**Expanded responses to:** *Did you receive counseling or services for addiction after your trafficking situation?*

1. **Sarita:** It was a mandatory class at two of the shelters we were moved to but there were no drugs involved in my case. I had to face what my traffickers did fully awake and aware of every abuse they used
2. **Anonymous:** Could have used that too though. I dealt with several addictions after I left.

## 11.1 Program or facility used for counseling for addiction

- 12.5% of the respondents utilized detention facilities.
- 12.5% of the respondents utilized hospitals for addiction counseling.
- 75% of the respondents utilized some other forms of services that included AA, Mercy Ministries, county social services, Victory Outreach Recovery Facility. Many also received services much later in life.
- None of the respondents mentioned receiving services from DMST-specific program and private therapists for addiction counseling.

## 11.2 Importance of counseling service for addiction in a DMST aftercare program

- 88% of the respondents considered these services to be “very important.”
- 4% of the respondents considered these services to be “moderately important.”
- 8% of the respondents considered these services to be “slightly important.”

**Expanded responses to:** *Do you have any comments about your experience with addiction counseling or services or thoughts about it to inform the service provider community?*

1. **Holly Austin Smith:** I think drug addiction counseling is important, especially to those who abused drugs before/during trafficking. I did not. I was placed in a drug treatment program because the authorities had no other place to put me. I do think addiction prevention/awareness should be part of a DMST program.
2. **Kate Price:** While I personally was not addicted, I found Al-Anon instrumental in my healing. Hearing other people’s stories and experiences helped me to “sort out” what happened to me in my family, particularly to learn that it was not my fault. The supportive community aspect of 12 Step programs is also wonderful, as is the “sponsor” component - lots of “levels” of support that can be drawn on 24/7.
3. **Leah Albright-Byrd:** I did not receive such services but wish that they would have been available to me. I had an addiction to cocaine, meth, and ecstasy as a juvenile and promptly began struggling with food addiction once I relinquished the substance abuse. Having services that were trauma-informed and specifically for someone in my situation would have been highly helpful.
4. **Rebecca Bender:** Treatment for drug addiction helped me heal from the issues that cause me to use drugs a band aid for the REAL issues I was facing.
5. **Sarita:** I don’t think it should be such an assumption that drugs are involved or are a problem in trafficking cases.

6. **Anonymous:** It is very important! A lot of these girls come out addicted to drugs and alcohol to cope with all that has happened.
7. **Anonymous:** These services need to be in conjunction to trauma therapy - people won't give up addictions if they don't have other ways to cope with trauma symptoms.

## 12. Programs to build self-esteem and self-value

- 52% of the respondents said they participated in programs that focused on building self-esteem and self-value.
- 48% of the respondents said they did not participate in any program as such.
- 47% of the DMST respondents reported participating in programs that helped build self-esteem and self-value after initial trafficking.

**Expanded Response to:** *Did you participate in programs which build self-esteem / self-value after your initial trafficking situation?*

1. **Antonia “Neet” Childs:** No I associated myself with various mentors, volunteered, and read a lot about people who didn't have great starts but successful finishes.

### 12.1 Program/facility used for programs to build self-esteem/ self-value:

- 7% of the respondents used detention facility.
- 13% of the respondents said they used DMST-specific program.
- 80% of the respondents utilized other sources that were not listed in the questionnaire
- Some other programs that respondents participated in to build self-esteem and self-value were: WHISPER, Voices of Hope, Mercy Ministries, Victory Outreach Recovery Facility, and AmeriCorps at University of California, Berkeley. Participants also joined various groups such as recovery group of survivors of sexual assault, joined faith based institutions and churches and various sports and education institutions as well.
- None of the respondents received services from hospitals or private therapists.

## 12.2 Importance of programs to build self-esteem/ self-value

- 100% of the respondents recognized this program to be very important in a DMST aftercare program.

**Expanded responses to:** *Do you have any comments about your experience with addiction counseling or services or thoughts about it to inform the service provider community?*

1. **Antonia “Neet” Childs:** I think service providers need to focus on more on the mind states of victims of generational poverty which causes a lot of minority women to fall prey to sex trafficking. The ladies I work with are victims of lack of information on improving their situation therefore it’s harder for them to remove themselves from the environments that traffickers and sexual predators recruit. Lack of knowledge on available resources reduces hope which causes at-risk youth to become victims.
2. **Barbara Amaya:** This is crucial, I had no self-esteem this is at the core of how traffickers target damaged and abused children...crucial
3. **Beth Jacobs:** This is needed. Every survivor I know struggles with guilt, shame, and low self esteem
4. **Holly Austin Smith:** Traffickers often prey on children and teens that lack self-confidence and self-value, like I did. I believe that programs which build these characteristics should be a core part of any DMST program.
5. **Kate Price:** School and sports were my “safe havens” growing up - training teachers is very important - I went to school with black eyes and no one said anything. I was only ever approached by one teacher, and she dropped it when I said that nothing was wrong. Granted, this was in the 1970s, so mandated reporting laws have changed. In HS, a guidance counselor helped me get into therapy without my family knowing since I was almost 18.
6. **Rebecca Bender:** The faith based recovery home I lived in for 18 months was a holistic approach that helped tremendously!
7. **Stacy Jewell Lewis:** Self-esteem programs, mentoring are very, very important for both aftercare and preventative measures
8. **Anonymous:** It is important for a person to understand about the lies and the lies we tell ourselves. It is also important to understand what we have done is not who we are.
9. **Anonymous:** I dealt with an eating disorder for many years. It began while I was being trafficked and I didn’t recover until years after becoming free. Receiving self-esteem building therapy I can see would be very important for DMST survivors. One doesn’t start hurting themselves be it through drug addiction or eating disorder because they love themselves.
10. **Anonymous:** Community service-learning and activism are so important to speaking out and developing skills, empathy, self-care and confidence



## 13. Comments and Suggestions

- Respondents commented on how to provide a safe place so that survivors can transition toward healing and healthy independence. More funding, more education and awareness raising were some of the important issues raised.

**Expanded Responses:** *Your knowledge, feedback, and guidance are critical to building a credible, accurate, and effective Colloquium and ultimate report. Please list any information that you feel should be addressed in the Colloquium or its ultimate report to inform policy makers and service providers on what are core principles in providing services and shelter to survivors of domestic minor sex trafficking.*

1. **Anna Beard:** We become the steps that we take. If our steps are weak, our results are weak. If our steps are strong, our results are strong. If we don't teach these girls how to love themselves, how do you expect them to love themselves? They fell into this crime because they didn't know any better. We can't expect them to know any better after they get out of "the life" if they have no resources. No matter what faith you believe in, everyone believes in love.
2. **Ashley Cacho:** I strongly feel there should be more programs for the older people who were trafficked when they were a child but never got the chance to get out.
3. **Beth Jacobs:** We need to remind people how important it is to have other survivors as part of any therapy or self-help group. Survivors need to see that others have made it through and are respected by the helping population. I got out, obtained a social work degree, and have worked with women who have been sex Trafficked or prostituted for over 10 years. This year I moved to a new state as was fired from a job for my criminal record from 1980 thru 1982 (prostitution Offenses). This does not go away. I think it is very important for workers to assure a full continuum of care. I mean help them with housing, mental health needs; sex, relationship, boundaries, awareness, self-esteem, guilt, shame, grief, loss, loving themselves, future planning, and criminal backgrounds. A person can do wonderfully, and if they lose a job behind the abuse of trafficking and prostitution, everything can fall apart.
4. **El:** Be Aware This can and will happen in peoples own back yard if they don't WAKE UP
5. **Jessica McFalls:** I realize that this survey was for survivors of those who were trafficked as children. I was 21 and therefore was not considered a 'child' at the time my experience began. But the truth is I was still too young to truly understand what I was getting into. The system back then (1994) was set up in a way that I was a criminal. There were no options for help. I was so overcome with shame that the lies in my own mind often became more of a prison than the threats of physical abuse or the promise of some kind of reward. We must stop seeing those under 18 as victims and those over 18 as criminals. Please!
6. **Kate Price:** For service providers, I firmly believe the issues of power and control in relationships must be addressed. CSEC who have been sexually abused (most often by someone they know and trust) have a relational template based on betrayal and violence, which "normalizes" the dynamics of exploitation. Providing services around relational dynamics and development will assist survivors as they go through the most common initial exit-reentry-final exit process. I have recently given a

talk and completed a companion working paper (both with the same title), “Longing to Belong: Relational Risks and Resilience in U.S. Prostituted Children on this topic through the Wellesley Centers for Women at Wellesley College (where I work). I cover the theoretical and practical “steps” of how children enter and exit exploitation. (I was introduced to Holly Austin Smith after she listened to the audio recording of my talk.) I am happy to share this work. Thank you so much for asking for this feedback (and for all that you do). I am grateful to be given a voice during this very important discussion and event.

7. **Margaret Howard:** My area is clinical social work. I study trauma. I would really like to see leading experts in trauma treatment, particularly those addressing neurobiological development, impacts, and treatment such as those coming out of the Van der Kolk, Porges, Schore, et al schools of thought presenting, as well as practitioners using methods these researchers are investigating, such as mindfulness, yoga, and depth psychologies.
8. **Melissa Woodward:** I believe that children should receive extensive counseling one on one and in a group setting in addition to having a mentor, education and life skills. I also believe that they should be educated on the facts and have a safe place to be themselves not conform to rules and regulation but be given love and time to adjust.
9. **Normilita Ranara:** As a single mother Children should be protected as well as to be treated fair and just.
10. **Rebecca Bender:** Mentoring Survivors is a complicated, but rewarding facilitator to the life long process of healing and dealing with triggers. Decriminalizing victims and prosecuting the demand are key components to the mind shift of our culture.
11. **Sarita:** If there is not the funding available to build separate shelters for survivors of trafficking at least make separate space available in the domestic shelters and actually have a separate program and classes etc. for survivors of trafficking. The staff and shelters we experienced were woefully lacking in understanding and the staff kept telling us not to talk about our case but expected us to participate in mandatory classes where I couldn't join in because it would be talking about my case or couldn't relate to the class material because I was not in a domestic violence relationship, drugs and alcohol were not involved.
12. **Wanda Williams:** I went to counseling for a little while but I could not afford to continue. It was just too expensive...so I had to drop out.
13. **Anonymous:** Funding is critical, not only for youth but also for adult women who have aged out of the minor sex trafficking trade. We must acknowledge that when a women turns 18 she is magically and adult and freely chooses this life for herself.
14. **Anonymous:** It is vital for survivors to lead in the movement! Funding for recovery/healing services is very important. Education for providers and knowledge in the different types of DMST and trafficking.
15. **Anonymous:** Ways to identify the male as well as providing funds to organizations that are looking to help the male population.

- 16. Anonymous:** The most important aspect of servicing young women affected by sex trafficking is understanding their greatest need: a platform for transformation, not just counseling, educational services, or shelter. We (they) need empowerment.
- 17. Anonymous:** I think along with all the services mentioned, access to education, job skills training, and higher education is absolutely crucial. I can't tell you how many times I've been desperate for money and unable to get a job because I have no real work experience and this pushes you back into the old life because that's what you know you can have money in your hand instantly and also because at times you feel like it is your only option when doors seem to keep closing. I am incredibly lucky to have financial aid to get my BA and now be in law school but I have still had countless struggles and financial challenges where I need assistance due to the long-lasting effects of trafficking victimization. One day I hope to provide a scholarship for HT victims for college or grad school. I believe we have so much untapped potential beyond what happened to us.
- 18. Anonymous:** I wish the police that ticketed me while being driven around and prostituted would have done something for me. I was only 17! Why didn't they separate me from the car & question me or even arrest me? I think the police could help so much more. They need to be educated about 'choice' and girls that look like they've made a choice but really haven't. Survivors need help! Not judgments.
- 19. Anonymous:** I believe that victims should be able to be helped by survivors who have been healed and have gone through rehab. The victims need to have people they can trust.
- 20. Anonymous:** Promote survivor leadership!!!



# ➤ Appendix E

## National Colloquium Advocate and Funder Survey

This survey was designed to capture information from advocacy and funding organizations to capture their unique perspective regarding shelter and services for victims of domestic minor sex trafficking.

### Respondent Organizations

- 18 relevant expert funding and advocacy organizations responded to this survey. Answers that expanded beyond the general analysis are include in each sections of each section.
- Respondent organizations include:
  - Agape Safe Families
  - Center for Adolescent Health & the Law
  - Chicago Alliance Against Sexual Exploitation
  - CHILDREN AT RISK
  - Covenant House New York
  - Florida Coalition against Human Trafficking
  - Free the Slaves (FTS)
  - Jonathan Todres, Georgia State University College of Law
  - Houston Rescue and Restore Coalition
  - Human Rights Project for Girls
  - Lovelight Foundation
  - National Center for Missing & Exploited Children
  - National Council of Juvenile and Family Court Judges (NCJFCJ)
  - Polaris Project
  - Street GRACE
  - The Salvation Army National Head Quarters
  - Women's Foundation of Minnesota
  - youthSpark

### 1. Program Priorities

- Beyond advocacy and funding expert organizations listed the following as program priorities:
  - Research<sup>348</sup>
  - Training<sup>349</sup>

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348 Five respondents listed research

349 Three respondents listed training

- Policy/advocacy<sup>350</sup>
- Prevention<sup>351</sup>
- Referral<sup>352</sup>
- Shelter<sup>353</sup>
- Case management and counseling<sup>354</sup>
- Legal services
- Grant making<sup>355</sup>
- Job/education
- Medical

**Expanded Responses to:** *What programs are you currently operating that respond to need for shelter and/or services for domestic minor sex trafficking victims and/or survivors? How are you monitoring/evaluating these programs? Please describe any current trends or outcomes of these programs.*

1. **Agape Safe Families:** PROGRAM: We will be providing short term transitional housing (1-2 months) for 18-25 year old victims of sex trafficking. During that time they will be assigned a case manager, develop a safety plan, and begin trauma-focused care. Those choosing will then be placed with well-screened, well-trained, and well-supported caring families. Families will have an on-going support team, as will the survivors. MONITOR: As we are still in the final develop stages, we do not yet have a structured monitoring/evaluation system in place. CURRENT TRENDS: The recidivism rate is high, especially for emancipated minors and young adult victims. There are many who return to the life and it's emotional, material and psychological draw. Programs need to be patient, and welcome victims back, perhaps multiple times, before they actually leave the life.
2. **Center for Adolescent Health & the Law:** We are a nonprofit legal and policy organization that conducts research, issues publications, provides training and consultation, and engages in advocacy. One of the current important areas in which we focus work is sex trafficking and commercial sexual exploitation of adolescents and young adults. We do not provide services directly to victims and survivors. However, we do provide training, consultation, and publications to other professionals, primarily health care professionals, who serve these youth.
3. **Chicago Alliance Against Sexual Exploitation:** CAASE provides legal services to survivors of sexual harm, that could include adult and youth survivors of sex trafficking. The program is working with two clients to file motions to vacate prior prostitution convictions, and expects to file them within the next several months. Therefore evaluation is premature. CAASE's policy department created a litigation guide for Illinois' new motion to vacate law and we have trained the private bar to offer legal services to survivors, again to adults and/or youth. The law is new in Illinois, so it is premature to identify trends or outcomes. CAASE, through the End Demand Illinois campaign,

350 Five respondents listed policy/advocacy

351 Six respondents listed prevention.

352 Four respondents listed referral.

353 Two respondents listed shelter.

354 Three organizations listed this in their response.

355 Two organizations listed this in their response.

has published a proposal for a statewide system of specialized services for survivors of prostitution and sex trafficking - again our work is not confined to any particular age group. End Demand policy staff and survivors are currently meeting with state legislators to raise awareness about the lack of specialized services for those impacted by sex trafficking (men, women, youth, LGBT, etc.) and introduce them to the policy proposal. The proposal is available on End Demand Illinois' website for reference. At this point, legislators are unaware that our state lacks meaningful specialized services, and many are skeptical that given the state budget crisis, that new money would be identified to support their creation.

4. **CHILDREN AT RISK:** We are not a direct service provider, but focus on anti-child trafficking policy advocacy in Texas. We are working on a report to evaluate Texas laws and policies and whether the laws/policies inhibit or facilitate the establishment of shelter and services for DMSTV. We are also working on a statewide database to compile information about every agency, nonprofit, and service provider that works with DMTV. This database will be the first statewide resource in Texas and will be available online to the public. In addition, a second password protected database will be made available to key stakeholders who need access to more sensitive information.
5. **Covenant House New York:** We provide shelter for approximately 300 homeless youth (age 16-21) each night, who are all high risk for trafficking victimization. A recent study has determined that approximately 15% have experienced trafficking. We provide food, shelter, counseling, medical care, job and educational services and legal services for these homeless young people.
6. **Florida Coalition against Human Trafficking:** Case Management Coordination of Victims services with coalition partners Coordination of DMST Regional Working group for the I-4 Corridor in Central Florida Training for shelter personnel DMST Law Enforcement Training School Prevention Program Street Outreach Web monitoring of multiple websites including Craigslist and Backpage. Preparing and delivering "Care Bags" to law enforcement Board member of Sexual Exploitation Board for Central Florida sponsored by State Prosecutors Office. Establishing Policies and Protocols. All have been approved by FBI in Tampa
7. **Jonathan Todres, Georgia State University College of Law:** I currently conduct research on prevention strategies and other issues related to trafficking of children. I also serve as Child Rights Advisor to ECPAT-USA. In advising ECPAT-USA and other non-profit organizations working on these issues, I work on various legislative and policy initiatives. I currently do not provide direct services to survivors.
8. **Houston Rescue and Restore Coalition:** HRRC has been delivering a prevention program to youth ages 12 -18 for the last two years in order to prevent youth from falling victim to the crime of human trafficking. Through this program we have identified several victims of DMST and connected them to services and housing. In addition, HRRC provides an intensive training program on Domestic Minor Trafficking (4 hour training) to front-line professionals such as child welfare providers, homeless shelters, school counselor and educators, juvenile probation/detention, and others. Through delivery of this training program we have seen an increased interest in labor

trafficking and how that affects youth. An interest in the program overall and continued request for additional training. Both programs are evaluated through pre and post testing of knowledge transfer.

9. **Human Rights Project for Girls:** We are primarily a national policy/advocacy org. We do not provide direct services to DMST victims/survivors. Our policy/advocacy work is informed by those providing direct services at the community level. We strive to bring the needs of these organizations to the federal level and advocate for policy reform and appropriations that address the unmet needs of this population. Our primary goal is to rise up the issue of violence against young women and girls as a public health and human rights issue in the U.S. We examine how violence impacts the lives of young women and girls who are marginalized or disenfranchised due to poverty, race/ethnicity, gender, LGBT status, etc. and who too often slip through the cracks of the protective systems such as the education and child welfare system and eventually become juvenile justice involved. This includes young women and girls who have been identified as DMST victims/survivors or who are at risk. Our work also includes reaching out to organizations providing innovative programs that address the needs of marginalized young women and girls who have been affected by violence. Most often these programs take an approach that address the specific gendered realities of young women and girls, acknowledge and address the impact of violence experiences by young women and girls, and strives to build on the strengths of young women and girls that is often neglected in the development of services, programs and standards of care. We also invest in the leadership of young women and girls who are and/or have received services from these innovative programs by providing leadership trainings and opportunities. We do not specifically monitor or evaluate these programs but rely on each organization's evaluation outcomes as evidence of the programs successes, as well as young women and girl's testimony of the benefits of these programs as compared to current punitive approaches. In our advocacy, we have noticed and continue to advocate for a growing trend towards
- a. Increasing funding for residential programs for young women and girls with histories of residential dislocation and instability.
  - b. The decriminalization of behaviors resulting from young women and girls' experiences with violence (e.g., running away, self-medicating behaviors, etc.)
  - c. Cross system (juvenile justice and child welfare - eventually public health and education) approaches to identifying and providing holistic approaches to providing services for young women and girls impacts by violence and DMST.
  - d. Prevention/treatment programs that are based in young women and girls' communities that take a gendered approach to service delivery that is structured to address their specific trauma needs and builds on the strengths of the individual as well as their family and other relevant social supports.
  - e. Further, there is a growing trend to reform the general cultures of various systems - education, child welfare, juvenile justice, etc. - that recognizes the impact of violence on adolescent behaviors and development, and the need to shift existing system cultures to better address the impact of violence on adolescents and children.



- 10. Lovelight Foundation:** Currently we have funded research but may branch out into other areas. We have also made grants to direct service organizations.
- 11. National Center for Missing & Exploited Children:** The Family Advocacy Division of NCMEC works proactively to assist those victim/survivors by assessing their current situation and referring them to an appropriate program that can serve their needs. These are not “blind” referrals as contact is made with the treatment professional or program to discuss the needs of the youth and insure that the program is poised to meet their needs. The Child Sex Trafficking Team collects data from endangered runaway cases to determine if there is the likelihood that the child is the victim of domestic minor sex trafficking. This information is then packaged and forwarded to law enforcement.
- 12. Polaris Project:** Through the National Human Trafficking Resource Center hotline we are regularly connecting individuals in need to housing services. This includes domestic minor victims of sex trafficking who may be calling in on their own behalf and/or through another service provider, law enforcement, or community agency. In order to address the severe lack of shelter available to this population as well as other groups - we conducted a recent Shelter Beds Survey to try and do a 1-time count of the available beds. The regional specialists on the NHTRC hotline regularly check in with our shelter contacts to ensure they continue to provide quality services but we do not engage in any type of formal evaluation or formal monitoring activities. We may also help domestic minor sex trafficking victims to access emergency housing services if we are alerted to them through either our Washington DC or Newark, NJ Crisis Response Team. Typically this would involve connecting the individual to shelter referrals, using hotel points to access emergency shelter with accompaniment, or referring them to another agency for direct services.
- 13. Street GRACE:** We support existing programs but do not directly participate in delivering shelter or services to victims.
- 14. The Salvation Army NHQ:** Our organization is running the following programs: PROMISE STOP-IT Anne’s House Central Ohio Rescue and Restore (managed by The Salvation Army) The Well Project FIGHT Network of Emergency Trafficking Services - Orange County (NETS-OC) SEEDS of Hope. Anne’s House is our only DMST designated shelter facility. Our other programs provide case management services for the full spectrum of human trafficking victims and work with community partners to see that housing is provided as needed.
- 15. Women’s Foundation of Minnesota:** We do not operate shelters or provide direct-service funding. The Women’s Foundation of Minnesota is a statewide community foundation that invests in social change to achieve equality for all women and girls in Minnesota. In Nov. 2011, we launched MN Girls Are Not For Sale, a five year, \$5 million campaign to end the prostitution of Minnesota girls through grantmaking, research, convening and public education. In January 2012, we became the first Minnesota foundation to dedicate funding to end child prostitution, awarding \$366,500 to eight organizations through our MN Girls Are Not For Sale campaign. The priorities for this first round of grantmaking were to develop housing for survivors and models of effective multi-jurisdictional interventions.

- 16. youthSpark:** We don't serve DMST victims directly. We work on the prevention side with those likely to become DMST victims and we work on the demand side of DMST.

## 2. Partnership with other agencies and organizations

- The responses to this question indicate the importance of partnerships regardless of the type of service provided. None of the organizations reported having a vision or mission to address the issue of domestic minor sex trafficking alone and all expressed the need to refer to trusted partners to complete the complex picture of DMST prevention and restoration.
- Several organizations pointed to a trend towards having a collective impact state wide and the power of coalitions to reform policy and treatment approaches.
- While not directly stated, responses indicate that partnerships grow out of experiences of predictable and reliable support from other entities that complement the organization's mission.

**Expanded Responses to:** *What organizations and/or agencies do you partner with to provide shelter and services to domestic minor sex trafficking victims and/or survivors? -How are you monitoring/evaluating these partnerships? -Are there any specific criteria for partnership? -Please describe any current trends or outcomes of the partnerships.*

- 1. Agape Safe Families:** Agape Safe Families is a collaboration of 5 agencies combining efforts to each provide a piece of the puzzle to assist in victim wrap-around aftercare services. City of Refuge: outreach and Rahab's House (transition home) Bridget's Dream: outreach and victim case management & support Safe Families: recruitment, training, screening and support for volunteer families Agape International Missions (US Aftercare division): victims & family screening/assessment; therapy supervision; and on-going victim and family support The GRACE Network: networking and services & resource acquisition for victims (& families) We are currently developing policies & procedures for monitoring & evaluating but nothing is in place yet. Criteria for partnership: dedicated to & aware of the fight against sex trafficking and the desperate need for aftercare services/housing. Must fulfill a needed piece of the puzzle. Partnership Trends: each organization seeks to raise its own support and some of the donors overlap.
- 2. Center for Adolescent Health & the Law:** We do not provide direct shelter and services. However, we work closely with the Society for Adolescent Health and Medicine. We led a half day institute for 80 health care professionals at the 2012 SAHM meeting, and we will lead a two hour workshops for 80 health care professionals at the 2013 SAHM meeting, on issues of sex trafficking and sexual exploitation.
- 3. Chicago Alliance Against Sexual Exploitation:** The Salvation Army PROMISE program in Illinois runs an 8 bed faith based safe home for girls impacted by the sex trade. CAASE is not a formal partner of this project. The program mandates religious observation for the residents, which is a practice discussed in our policy proposal as one to avoid. CAASE is not aware of any other specialized services for domestic minor sex trafficking victims in Illinois.

4. **CHILDREN AT RISK:** CHILDREN AT RISK is a part of several task forces across the state, including the AG's Statewide Task Force on Human Trafficking, the Human Trafficking Rescue Alliance, and the North Texas Coalition Against Human Trafficking. We work with direct service providers, such as YMCA International and Freedom Place to learn about any challenges or obstacles in serving victims, and we formulate the needed policy change to address these challenges. In 2010, CHILDREN AT RISK established the Safe House NOW Taskforce in Houston, TX, bringing together the county judge, sheriff, US Attorney's Office, Children's Assessment Center, and a number of other stakeholders to raise awareness about the need for shelter and services for DMSTV. From the work of this taskforce, Freedom Place, Texas' first facility dedicated exclusively for DMSTV was established in March 2012. CHILDREN AT RISK serves as the convener, bringing together key decision makers and connecting direct service providers, such as Freedom Place, with necessary agency partners, such as the Harris County Juvenile Probation Department. We also develop and implement state policies to ensure that victims receive the services they need to rehabilitate.
5. **Covenant House New York:** When we identify a young person as a trafficking victim who needs more intensive services than we can provide at Covenant House, we try to obtain a placement for them at Girls Education and Mentoring Services (GEMS). Unfortunately, although GEMS is a wonderful program, there is often a wait for a bed. We are hoping to create a similar partnership with the Lifeway Network so that we will have other options for long-term beds when GEMS has a wait-list.
6. **Florida Coalition against Human Trafficking:** Department of Children and Families Youth Shelters Partnerships are based on agency being vetted by FCAHT. Program must be approved by DCF and FCAHT. Partners must go through intense training on DMST. Shelter must also be approved by law enforcement. Program must be in full compliance and approved by DCF and FCAHT. In Florida we have a big issue regarding shelters that have an established program for DMST victims with proven record. The only program as of today only takes girls that will sign a non-runaway promise in order for them to be accepted at shelter. Said shelter is not viewed by law enforcement as a crisis intervention shelter during a rescue. FCAHT is considering opening a shelter if funding is secured.
7. **Jonathan Todres, Georgia State University College of Law:** I advise ECPAT-USA on a regular basis and other organizations on an ad hoc basis, but not on direct services.
8. **Houston Rescue and Restore Coalition:** HRRC has partnered with Planned Parenthood and Empowered Yoga as part of our prevention program. We connect all identified victims of DMST to the YMCA International for services and housing placement as they are the main service providers for all trafficking victims and the funded OVC agency for trafficking in persons. As for specific criteria for partnership, an agency must be a legit (i.e. provide all appropriate paperwork) must have the skill set necessary to provide services to this population. If running a shelter, they must meet all licensing requirements set by the state and hold a current license to run a residential treatment facility.
9. **Human Rights Project for Girls:** This question does not specifically apply to our work. However, we do partner with the following organizations that provide both services and/or residential programs to DMST victims/survivors. Not all of these organizations specifically focus on DMST populations but often encounter DMST populations among the young women and girls that they provide

services for. These organizations include but are not limited to: National Crittenton Foundation, PACE Center for Girls, Girls Incorporated, Center for Young Women's Development, Hawaii Girls Court, Delaware Girls Initiative, National Counsel of Juvenile and Family Court Judges, Westcoast Children's Clinic, and we work with a variety of national coalitions such as the Foster Care Coalition, Act4JJ and NJJD coalitions (juvenile justice focused), Girls at the Margin Alliance, DOJ, OJJDP, DHHS ACF, OVW, NoVo Foundation Move to End Violence Initiative (MEV), and a number of other organizations and state efforts occurring in Florida, Connecticut, and L.A. and Alameda County, California. The biggest trend among these organizations is the push to expand how these organizations and coalitions work to breakdown existing siloed, punitive approaches. Further, many organizations/coalitions/etc. are beginning to recognize that DMST victims/survivors were often overlooked in their assessments, service delivery and reform efforts. Therefore, many of these organizations and coalitions are beginning to reassess their approach and skills to identify and provide services and policy reforms for this specific population. It is a slow but growing trend. There is a definite need for training and policy reform to enable cross system approaches. We primarily seek to partner with organizations/providers/advocates that approach violence against young women and girls, and DMST as a crime against children, and orgs/providers/advocates that seek to expand social services, programs and opportunities for adolescents victimized by violence.

- 10. Lovelight Foundation:** To date, we have partnered with women's funds and direct service organizations. We are interested in research related to who funds in this area as well as research on demand and preventative programs.
- 11. National Center for Missing & Exploited Children:** As NCMEC is not a direct service provider we do not partner with any specific organization, we do however refer to these programs.
- 12. National Council of Juvenile and Family Court Judges (NCJFCJ):** N/A on direct service. Our project is funded by the Office of Juvenile Justice and Delinquency Prevention of the U.S. Department of Justice. We have identified at least two partner organizations for the project we are developing.
- 13. Polaris Project:** We work with several hundred shelters throughout the United States that serve all types of victims of human trafficking. Each organization is vetted through an internal process prior to their inclusion in the database. There is a not explicit criterion for these partnerships that is dictated by one single type of shelter service, so multiple agencies that are included may operate on different philosophies or through different approaches. We do not formally monitor these partners but we do try to follow up on cases that are referred out to ensure that survivors are receiving victim-centered services and assistance.
- 14. Street GRACE:** Wellspring Living for Girls Working on evaluation and reporting through state agencies. We require that they hold a state license, are recognized by the Georgia Care Connection, are a certified 501(c)3 and are presently serving girls. Reporting is difficult for current occupancy, completion rates and comparisons to national norms.
- 15. The Salvation Army NHQ:** Partnerships relating to provision of services to trafficking survivors are established, monitored, and maintained at the local level. Each local Salvation Army may create its own partnerships and create its own criteria for partnership. Several of our programs are deeply involved in county or state-wide anti-trafficking coalitions.

- 16. Women's Foundation of Minnesota:** In January 2012, the Women's Foundation awarded \$366,500 in grants to eight organizations through MN Girls Are Not For Sale. The grant period is through January 31, 2013.<sup>356</sup> Current trends and outcomes: It is still too early to determine with any certainty what trends might unfold as a result of these grants (and all five years of MN Girls grantmaking), but we have seen incredible momentum attached to the work of our grantee-partners toward achieving their grant goals and outcomes.
- 17. youthSpark:** We partner with Wellspring Living and the Georgia Care Connection that provide shelter and services for DMST victims. There isn't any formal method for evaluating partnership - it's more qualitative in that we work together on various projects and serve on committees together to determine priorities and process. The only criteria for partnership are a clearly defined overlap of goals and the willingness to work with integrity toward those goals. Current trends or outcomes of the partnership include the overall progress in Georgia for establishing a statewide response to DMST. We continue to move the needle in our state as a result of the collaboration. Together we are working to achieve collective impact. In another year or so that collective impact will be measurable in that the CSEC Task Force is structurally changing and will have specific goals that will be monitored by the task force.

### 3. Barriers and Challenges to provide services

- The overriding theme to the question of barriers and challenges related to funding, with all respondents listing funding or lack of resources as a major barrier. Several other categories of responses also are directly linked to the funding issue, e.g., staff expertise and lack of long term shelter. Also related to the funding conundrum is the often noted problem of lack of any evidence or outcomes data that points to a particular approach to shelter/service as measurably effective. Several responses noted that public perception still has a long way to go in recognizing DMST survivors as victims, not criminals.
- Respondents listed the following as barriers to shelter and services providers:
  - Lack of funding or resources<sup>357</sup>
  - Staff expertise and training/lack of standards of care<sup>358</sup>
  - Lack of long term shelter and counseling/lack of alternative models<sup>359</sup>
  - Public perception of victims as criminals/lack of social support<sup>360</sup>
  - Lack of outcomes data/evidence<sup>361</sup>
  - Lack of coordinated system response<sup>362</sup>
  - High recidivism rate/transiency<sup>363</sup>

<sup>356</sup> Details of individual grants and criteria for evaluating outcomes on file with the author.

<sup>357</sup> Eighteen organizations listed this in their response.

<sup>358</sup> Eight organizations listed this in their response.

<sup>359</sup> Seven organizations listed this in their response.

<sup>360</sup> Seven organizations listed this in their response.

<sup>361</sup> Six organizations listed this in their response.

<sup>362</sup> Four organizations listed this in their response.

<sup>363</sup> Three organizations listed this in their response.

- Difficulty to license<sup>364</sup>
- Deception<sup>365</sup>

**Expanded Responses to: *What would you believe to be the biggest barrier/ challenge to those working to provide shelter and services to victims/survivors of domestic minor sex trafficking?***

1. **Agape Safe Families:** CHALLENGES: Finances Commitment - at a deeper level High recidivism rate Lack of standardization and training: lots of ‘re-inventing of the wheel’ (or ‘shooting in the dark’) Too many trying to say their way is the only or best way (without the experience or data to back it up) Pride and ego for some - rather than humility and teachability.
2. **Center for Adolescent Health & the Law:** The biggest barriers are negative public attitudes, continued treatment of victims as perpetrators, lack of coordination among government agencies and NGOs, lack of adequate funding to take effective programs to scale, and lack of sufficient evidence of which programs and services are effective.
3. **Chicago Alliance Against Sexual Exploitation:** The two challenges that must be surmounted to service provision are the availability of upfront funding to pay for personnel, staff training, and occupancy costs; the second challenge will be to identify staff and survivors trained to provide trauma-informed services or to offer the professional training to mainstream service providers to enhance their capacity to do the work.
4. **CHILDREN AT RISK:** The biggest challenge/barrier is funding. State funding is severely limited. This creates a barrier of entry for organizations that have the expertise to work with victims. Another challenge for those working with victims is the relationship, if any with juvenile probation and the child welfare system. Differing ideologies of victim/juvenile offender may create confusion as to who has jurisdiction over the child. Another challenge is with the public’s lack of understanding about DMSTV and the long-term requirements for the rehabilitation process. Some funders have been disappointed that the process to rehabilitate these children is slow, and some are also not as understanding about the high cost per child.
5. **Covenant House New York:** Lack of long term shelter and counseling. The Covenant House Crisis Center is a short term program, and due to a scarcity of long-term beds, it is difficult to find long-term placement options without a wait. The transient nature of the population is also difficult; as by the time services are available it is sometimes difficult to reach the clients.
6. **Florida Coalition against Human Trafficking:** Lack of shelters throughout the State of Florida People coming forward as “HT Survivors” later to find out they are not and are using it for personal agendas.
7. **Free the Slaves (FTS):** I am going to answer this question based on what I know is happening in the U.S. The biggest barrier in the U.S. is the lack of appropriate services and support from government agencies, and in the worst-case scenarios even active abuse of the child (e.g. common problem of law

<sup>364</sup> One organization listed this in their response.

<sup>365</sup> One organization listed this in their response.



enforcement sexually exploiting people in prostitution). The child protection system in the U.S. simply does not properly meet the needs of many children who have complex problems, including but not limited to DMST survivors. At the same time, it does not provide sufficient resources to NGOs that have a better track record but lack the ability to scale up due to lack of funds.

8. **Jonathan Todres, Georgia State University College of Law** Funding is a huge issue. Lack of monitoring and evaluations is also a big barrier to developing and disseminating best practices.
9. **Houston Rescue and Restore Coalition:** Being able to operate a program and obtain funding within the reality of working with a very challenging population that will run away from the program regardless of how good it is. Another challenge is being able to meet all the necessary licensing requirements to work with children. They are overly burdensome at times. However, also necessary in making sure it is done correctly and safely. There needs to be a better balance between these two. Finding trained and appropriately educated staff that will be able to understand and deliver a program that will work with this population. There are truly very few people that have the appropriate training to work with this population which makes it challenging to delivery an effective program.
10. **Human Rights Project for Girls:** 1) Funding 2) Identification of DMST victims/survivors 3) Lack of evidence regarding what is considered an appropriate residential setting approach. There continues to be much debate about how these programs should be structured with little available evidence to support these assertions. Further, the current approach to developing residential programs tends to look for residential programs that are a one-fit-for-all approach. Unfortunately, residential approaches may need to vary for DMST victims/survivors depending on where they are in their recovery 4) Lack of standards of care and certification for those providing residential programs 5) Lack of viable economic alternatives for survival
11. **Lovelight Foundation:** Funding
12. **National Center for Missing & Exploited Children:** Financial stability is a huge barrier for these organizations as the needs of this population are specific and require a unique level of expertise. There also appears to be some disagreement within the field about the types of service needed for these victim/survivors.
13. **National Council of Juvenile and Family Court Judges (NCJFCJ):** As funding for juvenile and social services across the country has been cut, lack of resources and inadequate availability of services must be challenging.
14. **Polaris Project:** Evidence-based therapeutic services specialized for this population. Sustainable funding.
15. **Street GRACE:** Appropriate referrals and funding.
16. **The Salvation Army NHQ:** 1). Existing systems and institutions that do not recognize DMST and/or have not adapted to meet the needs of DMST victims. 2). Lack of appropriate facilities. 3). Lack of sufficient financial support. 4). Lack of social supports for survivors. 5). I also believe we need to develop alternative models to shelter care which is complex and costly to establish. There should be more exploration of foster care type alternatives.

- 17. Women's Foundation of Minnesota:** A lack of systemic response in any given state that involves the needed cross-sector involvement and buy-in, and sustainable funding streams. Here in Minnesota, we are poised to be the first state in the nation to create that systemic response to provide housing and treatment for trafficked children -- one that we will share with other states. The Women's Foundation is playing a leadership role in this work to secure the funding needed through a public-private partnership.
- 18. youthSpark:** First and foremost is funding - but intertwined with that is the fact that we have as a movement made no concerted effort to determine how to balance service, outcomes, and cost. Residential treatment is very expensive and we cannot show with hard numbers that it is more effective than another model that might cost less. We must devise some way to come up with cost/benefit analysis and best practices as we move forward.

## 4. Promising practices and services

- Respondents listed the following promising practices:
- Survivor informed/led programs and services<sup>366</sup>
  - Strengths based programming<sup>367</sup>
  - Trauma informed programming<sup>368</sup>
  - Model of care that includes all aspects of healing, including education, job skills<sup>369</sup>
  - Family reunification and family case management<sup>370</sup>
  - Protection and safety without incarceration<sup>1</sup>
  - Psychological care/TF-CBT/Counseling<sup>371</sup>
  - Animal therapy<sup>372</sup>
  - Art therapy/enrichment<sup>373</sup>
  - Peer support groups<sup>374</sup>
  - Long term shelter
  - Statewide referral system
  - Services tailored to individual need<sup>375</sup>

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366 Three organizations listed this response

367 Three organizations listed this response

368 Two organizations listed this response

369 Six organizations listed this response

370 Two organizations listed this response

371 Four organizations listed this response

372 Two organizations listed this response

373 Three organizations listed this response

374 Two organizations listed this response

375 Two organizations listed this response



**Expanded Responses to: *What promising practices are you aware of, or have witnessed in shelter and services delivery models to victims/survivors of domestic minor sex trafficking?***

1. **Agape Safe Families:** Promising Practices: I believe the use and implementation of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), should be encouraged in shelter and delivery models. Why? It is well-researched, labeled “best practices”, flexible, adaptable and inclusive of other trauma methods. It has been implemented in various locations (both domestically and abroad) with reported ‘success’. It incorporates the entire staff in the therapeutic environment and therefore increases the likelihood of positive therapeutic outcomes (healing!).
2. **Center for Adolescent Health & the Law:** Long(er) term shelter and services are essential. Incorporation of survivors in the delivery of services appears to be important. Security and protection without incarceration are also key.
3. **Chicago Alliance Against Sexual Exploitation:** Based on the information we collected from service providers from around the country, there are three key philosophies that must guide service provision: (1) Survivors MUST participate in the design and implementation of shelter and other service delivery models; (2) all services should be trauma-informed; (3) services should follow an empowerment model, recognizing the leadership potential and strengths of those impacted by the sex trade, including youth.
4. **CHILDREN AT RISK:** Freedom Place has expressed that animal therapy has been extremely effective in the rehabilitation process. Freedom Place utilizes rescued animals, and this gives the children an opportunity to bond with the animals because they are helping each other to heal. I believe that there shouldn't be one set model of services that every child receives. Rather, the treatment and services should be tailored according to the individual needs of the child. I have met with well-intentioned individuals and organizations that would like to operate a safe house for DMSTV, but plan on utilizing one service delivery model. Each child will be at a different stage of recovery and will therefore not fit into a single mold.
5. **Covenant House New York:** Comprehensive, holistic models where youth are both given a chance to heal but also are given opportunities for education and job training seem to work best. The traffickers have broken down victims' self-esteem making them think that sex work is the only thing they know how to do. It is important that youth be given the opportunity to see they have talent in academics and other areas. There must also be a heavy emphasis on counseling and psychological care.
6. **Florida Coalition against Human Trafficking:** The biggest problem that we are seeing is the “open door” shelter. Victims are brought in and within 24 hours they escape taking with them other girls. Pimps are using this method to recruit. Shelters that focus too much on religious beliefs and not on breaking the bond between the victim and the pimp. These cause failure within the program as girls escape and later are found with pimp.
7. **Free the Slaves (FTS):** - Peer support is important. Having survivors on staff or in positions of leadership provides children with an example of someone they admire but that they can also relate to closely because of shared experiences with similar trauma. The combination can be effective to help a survivor overcome self-blame. - It is crucial that services be provided not only to the child

but also support is provided to the child's family. Reintegration will be better for her than staying in a shelter, as long as the family can be assisted to overcome the obstacles that made the child vulnerable. - Using drama / poetry / art to help children find the media that work for them to begin to express themselves. - Helping children build skills / learn trade so that they have something they can be proud of (change self-image) as well as something that may help them earn income later on.

8. **Jonathan Todres, Georgia State University College of Law:** I greatly respect the individuals I know who work in shelters and with direct services for victims. Insufficient monitoring and evaluation prevents me from saying particular approaches work better than others. I don't think we have much, if any, evidence-based research evaluating these programs.
9. **Houston Rescue and Restore Coalition:** The most successful service delivery that I have seen is when family reunification is possible and when it is coupled with a large amount of family support including counseling, case management, etc. for the entire family unit including the victim/survivor.
10. **Human Rights Project for Girls:** 1) Real survivor leadership opportunities 2) A strengths-based approach that provides space for young women and girls to have agency in the development of their service plan and goals. Further, this strengths-based approach includes informing young women and girls of their rights, providing them education and awareness programs that are relevant to their lives and are culturally appropriate. 3) Approaches that address behavioral issues from a perspective that is trauma informed and does not re-traumatize victims/survivors. Further, these approaches are developmentally appropriate.
11. **National Center for Missing & Exploited Children:** Given the number of victims/survivors that are currently in the child welfare system those states that provide/offer service intervention to those children in care should be studied as a possible model for all child welfare agencies. The states of Connecticut and Illinois have programs that are proactive in addressing the issues of children missing from care.
12. **Polaris Project:** Youth-driven peer support groups. On-site clinical therapy. Diverse enrichment programming and micro-credit assistance for small businesses. Creative art therapy. Incentive-based education programs. Life skills planning.
13. **Street GRACE:** Statewide program for referrals.
14. **The Salvation Army NHQ:** The incorporation of arts and animal therapies in programming are promising practices.
15. **Women's Foundation of Minnesota:** Much work was done in Minnesota to survey the state for shelter and service-delivery models that work well and could be expanded upon to create the needed housing and supportive services here for trafficked children. In January 2013, the Safe Harbor Trafficking Task Force will deliver "No Wrong Door," a report mandated by the Safe Harbor law passed in Minnesota in July 2011. The report will map out how we get there, including housing models (four), specialized treatment services for this population, training, etc., and what it will all cost (projected \$13.3 million).

- 16. youthSpark:** I don't like to use those words because I feel we have been - with totally good intentions - flying by the seat of our pants. The most promising practice that I'm aware of is the intention of Wellspring to provide ongoing support through schooling and reduced services to victims that have completed treatment. It is a long term project to truly provide stability to these victims. We must define what 'success' means in this field and then determine how best to get there. I think that we may all have different ideas as to what the end goal looks like - and we may not all be on the same page.

## 5. Available Tools and Resources

- Despite barriers and challenges, there exists an abundance of resources to inform and guide those attempting to address the service and shelter needs of DMST victims. Respondents listed the following as examples of tools and resources:
  - Legal and policy research
  - Training and consultation
  - Scientifically validated assessment tools and screening tools
  - Data compiled from law enforcement
  - Legislative advocacy at state and federal level
  - Published training and healing programs
  - Referral networks
  - State wide proposals
  - Books and checklists on TF-CBT
  - Survey-informed models for safe houses
  - Hotlines-state and national
  - Coalition meetings
  - Service guides
  - Survivor advocacy
  - High school and middle school educational programs
  - Social media
  - Fact sheets

**Expanded Responses to:** *What tools and resources do you use to provide or inform, establish or provide restorative shelter and/or services to domestic minor sex trafficking victims and/or survivors?*

- 1. Agape Safe Families:** TOOLS & RESOURCES: Becca Johnson: The soon-to-be-finished booklet Leaving the Life - which focuses on helping victims navigate the emotions of deciding, leaving and then staying out of the Life. Also, several checklists: What I Did in the Life; What Happened to Me in the Life; and presentations TF-CBT for DMST Programs; Understand Trauma; Understanding Trauma Bonding & Pimp Control; and more (training) Bridget's Dream (Leah Albright-Byrd, survivor); Dream Mapping & Dream Navigator (case management for survivors)

2. **Center for Adolescent Health & the Law:** As explained above, we conduct legal and policy research, provide training and consultation, and engage in advocacy. We inform health care and other youth serving professionals about existing laws that can be helpful, gaps and deficiencies in the laws that need to be changed. Our intent is to support health care professionals to engage in the policy process and improve service delivery.
3. **Chicago Alliance Against Sexual Exploitation:** End Demand Illinois' "Proposal: a Statewide System of Specialized Services for Survivors of Prostitution and Sex Trafficking."
4. **CHILDREN AT RISK:** CHILDREN AT RISK, in partnership with Shared Hope International, conducted a national survey on shelter and services providers for DMSTV. CHILDREN AT RISK will use this survey data, with an analysis of Texas law and policy, to publish a resource on the legal requirements of operating a safe house, and to provide examples of different safe house models that prospective providers can learn from.
5. **Covenant House New York:** We have just finished scientifically validating an assessment tool to help us better identify victims of trafficking. After identification, we do a legal and social services screen to come up with a treatment plan and provide appropriate referrals.
6. **Florida Coalition against Human Trafficking:** Full training regarding DMST and Pimp Control Monthly meetings between all service providers and law enforcement Quarterly regional meetings with law enforcement and victim services throughout the I-4 corridor Vetting all agencies to make sure they know and have a program in place to work with the victims. Make sure all services are in place and victim is happy with program. We do a lot of prevention by speaking to kids in Middle and High School Provide law enforcement with "Care Bags" to be given to the victim during a rescue.
7. **Houston Rescue and Restore Coalition:** To deliver our prevention program we have used a local Youth Service Guide (i.e. Youth Yellowpages) in order to educate the youth we work with about all the community services that are available. HRRC has also recently used an Empowerment Yoga studio to teach youth healthy coping mechanism through the use of Yoga.
8. **Human Rights Project for Girls:** 1) Survivor advocacy 2) Networking and assessing needs from service providers 3) Coalition/Alliance building and participation on existing coalitions 4) Continuous advocacy at the federal level 5) Congressional hearings and briefings 6) Fact sheets, reports, etc. 7) Social media advocacy such as twitter and FB
9. **National Center for Missing & Exploited Children:** As a National Clearinghouse for Missing & Exploited Children NCMEC is able to inform victims/survivors and their families (when appropriate) about programs and resources specifically designed to work with those youth victimized by the crime of domestic minor sex trafficking. In addition the Child Sex Trafficking Team compiles information on cases or suspected cases of domestic minor sex trafficking to send to appropriate law enforcement for follow up.
10. **National Council of Juvenile and Family Court Judges (NCJFCJ):** I would like to learn from the field on this. As for the judiciary, raising awareness of DMST and understanding how DMST intersects with family/juvenile law will be our first step.

- 11. Polaris Project:** We assisted Katherine Chon, the co-founder of Polaris Project with her toolkit entitled “Developing Housing Services for Survivors of Human Trafficking ([www.traffickinghousingtoolkit.org](http://www.traffickinghousingtoolkit.org)). We also utilize our access to our referral network to connect organizations in a peer-to-peer fashion so that those who have developed shelters can provide technical assistance to those considering opening a shelter facility. We have also referred people to Celia Williamson with the University of Toledo and Second Chance who has housing resources she may provide to other interested parties. We also have a list of all shelters we are aware of in the United States serving victims.
- 12. Street GRACE:** National and state 800 numbers that can be given to law enforcement and citizens. Legislation recognizing the survivors as victims and designated state funds.
- 13. The Salvation Army NHQ** Training programs: The Commercial Sexual Exploitation of Children Community Intervention Project (CCIP) training program. The Salvation Army Anti-Trafficking Training Manual, 2nd Edition Hands that Heal: An International Curriculum to Train Caregivers of Trafficking Survivors.
- 14. Women’s Foundation of Minnesota:** We do not provide any of these things. We seek to fund the innovative work of experts in the field to ending child sex trafficking in our state. (See list of grantee-partners in Question 4.
- 15. youthSpark:** My tools and resources are legislative advocacy and relationships within the community. I don’t provide direct services to victims but try through training, legislation, and awareness to make the ground more conducive to solutions that are needed in all of the sectors of society if we are to make progress in this arena.



# > Appendix F

## United States Government Agency Request for Report Responses

### U.S. Department of Homeland Security Responses

*The National Colloquium: Shelter and Services Evaluation for Action will inventory and evaluate the shelter and services in place currently to assist victims of DMST (DMST)/commercial sexual exploitation of children (CSEC) and how the victims gain access to them. Development, delivery, and evaluation of these programs may be occurring through federal agencies and your help in thinking through new ways to reach better solutions is essential. Your responses to the following questions relevant to the work of your agency will be critical for our process. We thank you in advance.*

*Questions: (Not all questions may be relevant for your agency's scope of work in this area. For all responses, please describe differences in responses for domestic and foreign child sex trafficking victims, if any, to ensure a complete understanding of the scope of the response.)*

1. What efforts are in place or planned through the agency to provide victim assistance with shelter and services or connect identified victims of DMST/CSEC to shelter and services? (E.g., grants, victim witness coordinators, education within survivor programs or shelter, research, other.)

Response: U.S. Immigration and Customs Enforcement, Homeland Security Investigations (HSI) utilizes a victim centered approach to all human trafficking investigations, including trafficking of foreign nationals and U.S. citizens. The HSI Victim Assistance Program (VAP) is responsible for responding to victims on behalf of the Agency. VAP has 21 full-time Victim Assistance Specialists and over 200 collateral duty Victim Assistance Coordinators who work directly for HSI Special Agent in Charge (SAC) offices in the field and receive training and technical assistance from the VAP at HSI headquarters in Washington, D.C. They are responsible for assessing victims' needs for all victims linked to an HSI investigation, working with agents to integrate victim assistance considerations at the beginning and throughout the duration of the criminal investigation. Specialists and Coordinators ensure that potential Trafficking in Persons (TIP) victims are rescued, have applied for short term immigration relief, are transferred to safe locations, and are provided with referrals for medical, mental health, legal assistance including for long-term immigration relief, case management, and other services.

Many of the HSI Victim Specialists have experience in human trafficking victim service provision, trauma, and victim advocacy, and many are assigned to human trafficking groups within their SAC office. Their presence in the field ensures that there is a full-time subject matter expert and single point of contact on victim issues for all HSI human trafficking investigations. Victim Specialists conduct outreach to organizations involved in the anti-trafficking arena and build partnerships to facilitate comprehensive response, service delivery, and information-sharing.

In addition to the Victim Assistance Specialists and Coordinators, HSI VAP has three full-time Forensic Interview Specialists who are available to conduct developmentally-appropriate, legally-defensible, victim- and culturally-sensitive forensic interviews for all HSI investigations, domestically and internationally.

If an asylum officer in the U.S. Citizenship and Immigration Services (USCIS) Asylum Division suspects at an asylum interview that an asylum applicant has been a victim of trafficking, the officer will give the applicant a list of service providers appearing on the Department of Justice Office for Victims of Crime website (<http://www.ojp.usdoj.gov/ovc/grants/traffickingmatrix.html>). The asylum applicant can then contact one of these service providers as he or she sees fit. The USCIS Asylum Division would only learn of such potential victims of trafficking if they apply for asylum and appear for their mandatory asylum interview. An asylum officer would also contact ICE HSI personnel if the asylum officer suspects an ongoing trafficking situation to give ICE HSI the opportunity to open an investigation.

2. For an agency that is involved in the shelter and services management or referral of a DMST/CSEC victim:
  - a. What determines the ability for the agency to become involved? (For example, must a victim be involved in a prosecution to receive assistance from the agency? Must a victim be involved in an investigation or prosecution to receive assistance from a grantee service provider?).

Response: HSI Victim Specialists and Coordinators respond to all victims identified in an HSI investigation. There is no requirement for cooperation with the investigation or prosecution in order to receive assistance through the HSI Victim Specialists or Coordinators. HSI's victim centered approach recognizes that the provision of and referral to appropriate victim services is crucial for the long-term recovery for the victim, which will also benefit the investigation if the victim becomes a witness for the prosecution of the criminal case.

For foreign national minor victims of trafficking, HSI victim specialists coordinate closely with HHS's Administration for Children and Families, which has the lead on placement and support for all identified Unaccompanied Alien Children and for minor foreign victims of trafficking. For U.S. citizen minor victims of trafficking, HSI victim specialists work closely with local service providers and child protection agencies to facilitate the most appropriate placement based on the circumstances and identified needs of the minor.

USCIS does not have or provide funding for shelter and services management for DMST/CSEC or other trafficking victims, as this is done by other agencies. The role USCIS plays for trafficking victims (minor or adult) is adjudicating the T nonimmigrant status for human trafficking victims and the U nonimmigrant status for victims of human trafficking and other qualifying crimes.

USCIS also conducts outreach and training on the T and U nonimmigrant status to law enforcement and the public. This outreach is also frequently done in conjunction with ICE to raise awareness of human trafficking and immigration options available for victims.

In order to be eligible for T and U nonimmigrant status, applicants have a requirement to be helpful or cooperative with law enforcement investigations or prosecutions. However, exceptions exist for T nonimmigrant



status applicants in certain situations. If a T nonimmigrant status applicant is unable to cooperate due to physical or psychological trauma, or is under 18 years of age, the applicant may still be eligible for T nonimmigrant status, even without meeting the cooperation requirement. Even though there are no statutory exceptions for U nonimmigrant status applicants from the helpfulness requirement, a parent, guardian, or next friend can provide the helpfulness on behalf of a U nonimmigrant status applicant who is under the age of 16 or is incompetent or incapacitated.

Those who are granted T nonimmigrant status are eligible for certain federal benefits and assistance, which are provided by HHS. Those granted U nonimmigrant status are not eligible for federal benefits by virtue of their immigration status.

- b.** Does the agency have per capita or designated funding for shelter and services for victim placements and what are the parameters of that funding? If there is no funding, how does the agency arrange for the shelter and services for the victim?

Response: HSI Victim Specialists establish working relationships with local victim service providers to identify the most appropriate placement given the individual circumstances and needs of the minor victims. This includes partnering closely with HHS and DOJ funded grantees for victims of human trafficking, as well as runaway and homeless youth.

In the absence of local victim service provider services for human trafficking victims, HSI administers the Federal Crime Victim Assistance funds, provided by the Office for Victims of Crime. The fund is available for victims of a federal crime when there are no other local or state resources available. Funds can be used to respond to emergency needs and are accessed via HSI Victim Specialists or Coordinators to provide safe housing, food, clothing, emergency medical care, mental health care, and other urgent needs of victims. The funds can also be used to provide interpreters to support assessment of victim assistance needs for identified victims. These resources are available for victims identified in HSI investigations for up to 30 days of emergency assistance.

- c.** What is the duration of the agency's involvement in the provision of shelter and services and what protocols are in place for continued care, if any?

Response: HSI Victim Specialists and Coordinators work closely with non-governmental service providers as well as other systems based victim specialists, including the Victim Witness Coordinators within the U.S. Attorneys' offices, to ensure seamless coordination of victim assistance services throughout the life of the investigation and prosecution.

- 3.** Does the agency evaluate shelter and services for victims of DMST/CSEC before referring or placing a victim there, or before awarding funding to a service provider grantee? Are these evaluations available publicly or inter-agency? What is the evaluation tool?

Response: HSI Victim Specialists and Coordinators are responsible for identifying appropriate victim services within their geographic area of responsibility to respond comprehensively to the needs of victims of human trafficking. They are identified based on particular victim population needs. Specialists and Coordinators

routinely interface with local service providers to establish working relationships that support the most appropriate placement options based on a particular victim's needs. VAP Headquarters program staff also works with other federal agencies and national service provider organizations to identify any new or changing resources for victim services.

4. What are the types of placements used by the agency for DMST/CSEC victims under agency case management or referral, or funded by the agency through a grant program? Is there a pre-approved shelter or service placement list and what are the criteria for being approved (e.g., licensing, security, location)?

Response: HSI Victim Specialists and Coordinators initiate direct referrals based on their identified network of victim service providers within their geographic area of responsibility. Common referrals include shelter or housing assistance and placement, mental health support services, substance abuse treatment programs, medical care, legal assistance including to address immigration issues, and case management assistance. VAP Headquarters program staff also work with other federal agencies and national service provider organizations to identify any new or changing resources for victim services.

5. Do the multiple categorizations of DMST/CSEC victims (e.g., homeless runaway youth, delinquent, dependent, at-risk) affect the agency's ability and procedure to provide for shelter and services to DMST/CSEC victims?

Response: There is no direct impact on the role of the Victim Specialists or Coordinators in providing victim services to human trafficking victims as long as they are part of an HSI investigation. However, in identifying resources and making referrals within their geographic region, Specialists' and Coordinators' options for assistance may be impacted by programs that restrict placement and provision of services to victims based on these classifications.

6. How is the agency informing its positions and planning for the development, delivery and evaluation of shelter and services for DMST/CSEC victims? For example, are they survivor-informed, NGO and service provider-informed, based on pre-existing models (e.g., domestic violence, homeless and runaway youth, behavioral treatment programs)?

Response: DHS is a co-chair, along with HHS and DOJ, in the development of a Victim Services Strategic Action Plan to strengthen and enhance victim services available for all victims of human trafficking. DHS also participates in the Victim Services Working Group of the Senior Policy Operating Group. HSI VAP supports these efforts through its membership and support of the DHS Blue Campaign. The Blue Campaign is the unified voice for the U.S. Department of Homeland Security's efforts to combat human trafficking. Working in collaboration with law enforcement, government, and non-governmental and private organizations, the Blue Campaign strives to protect the basic right of freedom, and to bring those who exploit human lives to justice. As part of its efforts, the Blue Campaign regularly hosts listening sessions with key stakeholders and receives feedback on DHS activities to combat human trafficking, including DHS efforts to provide victim services and immigration relief for victims of human trafficking.

## U.S. Department of Justice Collective Responses

The National Colloquium: Shelter and Services Evaluation for Action will inventory and evaluate the shelter and services in place currently to assist victims of DMST (DMST)/commercial sexual exploitation of children (CSEC) and how the victims gain access to them. Development, delivery, and evaluation of these programs may be occurring through federal agencies and your help in thinking through new ways to reach better solutions is essential. Your responses to the following questions relevant to the work of your agency will be critical for our process. We thank you in advance.

Questions: (Not all questions may be relevant for your agency's scope of work in this area. For all responses, please describe differences in responses for domestic and foreign child sex trafficking victims, if any, to ensure a complete understanding of the scope of the response.)

7. What efforts are in place or planned through the agency to provide victim assistance with shelter and services or connect identified victims of DMST/CSEC to shelter and services? (E.g., grants, victim witness coordinators, education within survivor programs or shelter, research, other.)

### Answer:

**Criminal Division:** The Child Exploitation and Obscenity Section (CEOS) of the Criminal Division of DOJ prosecutes federal child exploitation offenses and works closely with the 93 United States Attorney Offices in investigations, trials, and appeals related to these offenses. CEOS prosecutors work in collaboration with the many Victim Witness Coordinators (VWCs) within USAOs to ensure the health, safety and well-being of DMST/CSEC victims. It is imperative for the successful prosecution of these crimes that victims are in appropriate facilities, being cared for by professionals experienced with this specific population, and that they are mentally and physically present as the investigation moves forward. In addition to the many VWCs, CEOS recently hired an in-house Child Victim Witness Program Coordinator who is available to provide support on complex/demanding cases as well as collaborate with agency partners to improve the response to DMST/CSEC victims and develop best practices on handling the needs of these victims.

**Civil Rights Division:** The Human Trafficking Prosecution Unit of the Criminal Section of the Civil Rights Division in DOJ also provides Victim Witness Coordinators to address victim needs for services and resources to ensure that they are healthy, secure and available to assist with prosecutions.

**Office of Justice Programs:** Additionally, the DOJ, through the Office of Justice Programs (OJP) and Office of Juvenile Justice and Delinquency Prevention (OJJDP) provide major grants for service providers to develop and implement the type of shelter and services necessary for victims of DMST/CSEC. OJP cannot speak to what funding might be available in FY13. However, during the last fiscal year, funding was made available, through competitive solicitations, to service providers to offer a comprehensive array of services, to include emergency, transitional, and long-term shelter for adult and minor victims of all forms of trafficking.

**United States Attorney's Offices/EOUSA:** The Executive Office for U.S. Attorneys (EOUSA) works with, and for, US Attorneys' Offices (USAOs). USAOs do not have an organized national system of placement and referrals for trafficking victim services. Referrals for such services are made by Victim/Witness Coordinators and prosecutors in each USAO in each case on the basis of their knowledge of the services needed, the services available, and the funding available. In an attempt to regularize and improve that ad hoc system, EOUSA is taking steps to improve USAO knowledge and utilization of services available. EOUSA has recently provided USAOs with links to organizations that can suggest appropriate referrals around the country to programs that provide services often needed by trafficking victims. In December, EOUSA will be sponsoring a webinar aimed at relevant personnel discussing services needed and available to such victims.

**Federal Bureau of Investigation:** The FBI has 122 Victim Specialists (VSs) who are available and trained to assist DMST/CSEC victims in FBI cases. Forty-one of these VSs work in Indian Country. These VSs work to establish relationships with state and local government agencies and non-government organizations (NGOs), so that when DMST/CSEC victims are recovered they can (as soon as possible) be placed in an appropriate shelter situation. Many of these shelters provide short-term accommodations. FBI VSs have developed a national resource list which provides information on short and long-term shelters, as well as programs and services designed to meet the needs of DMST/CSEC victims.

8. For an agency that is involved in the shelter and services management or referral of a DMST/CSEC victim:
  - a. What determines the ability for the agency to become involved? (For example, must a victim be involved in a prosecution to receive assistance from the agency? Must a victim be involved in an investigation or prosecution to receive assistance from a grantee service provider?).

Answer: FBI VSs interact with DMST/CSEC victims through investigations initiated by the FBI and cooperative investigations with state and local law enforcement agencies. Identified victims in these investigations are referred to VSs for information and assistance.

- b. Does the agency have per capita or designated funding for shelter and services for victim placements and what are the parameters of that funding? If there is no funding, how does the agency arrange for the shelter and services for the victim?

Answer: There is no designated funding for shelter and services for FBI DMST/CSEC victim placements. However, the FBI's Office of Victim Assistance administers Federal Crime Victim Assistance funds provided through the Office for Victims of Crime to assist victims of federal crime and their families when no other (state or local) resources are available. These funds can be used for services that respond to emergency needs that are a direct result of DMST/CSEC victimization for shelter assistance that does not exceed 30 days. The majority of shelters that FBI VSs utilize to place DMST/CSEC victims are federally and/or privately funded and no funds are required of the victim and/or agency.

- c. What is the duration of the agency's involvement in the provision of shelter and services and what protocols are in place for continued care, if any?

Answer: FBI VSs work with DMST/CSEC victims for the life of the investigation and into the prosecutorial phase. The VS works with the United States Attorney's Office Victim Witness Coordinator to transition the victim to services during the prosecution and ensure that he/she receives assistance from investigation through prosecution (if there is one).

9. Does the agency evaluate shelter and services for victims of DMST/CSEC before referring or placing a victim there, or before awarding funding to a service provider grantee? Are these evaluations available publicly or inter-agency? What is the evaluation tool?

Answer: The FBI VSs obtain information on shelters and services for DMST/CSEC victims through their interactions and liaison with personnel, as well as past placement experiences. They consider the shelters based on their experience with the victim population and the specific needs of the victim. FBI VSs have developed a comprehensive national resource list that provides the contact information and the types of services and programs available to assist DMST/CSEC victims.

10. What are the types of placements used by the agency for DMST/CSEC victims under agency case management or referral, or funded by the agency through a grant program? Is there a pre-approved shelter or service placement list and what are the criteria for being approved (e.g., licensing, security, location)?

Answer: The types of placements used by the FBI for DMST/CSEC victims are generally direct referrals. VSs use a national shelter/service list. Plans are underway to create a similar list for victims of child sex tourism cases.

11. Do the multiple categorizations of DMST/CSEC victims (e.g., homeless runaway youth, delinquent, dependent, at-risk) affect the agency's ability and procedure to provide for shelter and services to DMST/CSEC victims?

Answer: The multiple characterizations do not affect the FBI procedures in and of themselves; however, the characterization could affect our ability to place a victim within state-government facilities that limit placement based on certain categories.

12. How is the agency informing its positions and planning for the development, delivery and evaluation of shelter and services for DMST/CSEC victims? For example, are they survivor-informed, NGO and service provider-informed, based on pre-existing models (e.g., domestic violence, homeless and runaway youth, behavioral treatment programs)?

Answer: OJP, through its Office of Victims of Crime (OVC), is serving as a co-chair (along with HHS and DHS) of the Victim Services Working Group of the Senior Policy Operating Group (SPOG). This working group has been tasked with developing the first-ever federal strategic action plan to strengthen services for trafficking victims. This plan will be informed through the input of relevant federal agencies, as well as

external stakeholders. OJJDP coordinates with OVC and will provide input through them to the SPOG. In recent years, OJJDP has supported “survivor-informed” mentoring programs for DMST/CSEC victims.

The FBI OVA utilizes the knowledge, skills, and abilities of the VSs in the field to inform and train FBI personnel and state and local stakeholders on current and promising delivery systems concerning shelter and services for DMST/CSEC victims.





United States Department of State

Washington, D. C. 20520

April 16, 2013

Dear Colleagues:

I write in response to the request for information from U.S. government agencies for the *Report to the National Colloquium: Shelter and Services Evaluation for Action*. The Department of State's Office to Monitor and Combat Trafficking in Persons (DOS TIP Office) is not authorized to fund programs that support the delivery of victim services in the United States. As a result, the request for information is not directly applicable to our programming.

The DOS TIP Office manages the only foreign assistance program dedicated solely to combating human trafficking outside of the United States. Through its International Programs section, the DOS TIP Office has supported more than 650 projects to combat modern slavery in 106 countries over the past nine years. These federal funds, awarded to international and nongovernmental organizations, are strategically placed to target both sex trafficking and labor trafficking through implementation of the "3P" paradigm of **Prevention** (including demand reduction), **Protection** of victims, and **Prosecution** of traffickers. **Partnership** is also a critical element in the majority of our programs.

Through our international work and grants to service providers, we work to ensure a comprehensive response to serving victims of all forms of human trafficking. The *Trafficking in Persons Report*, published annually in June, provides a diagnostic assessment of the efforts of more than 180 governments to combat modern slavery, and is strategically linked to our anti-trafficking foreign assistance priorities. More than half of funded projects include a protection component and more than half provide direct services to victims. Sixty-five percent of funded projects build capacity of local law enforcement and prosecutors to apprehend and prosecute traffickers; victim protection is a critical component of these as well. Seventy-five percent of projects address both labor and sex trafficking.

In lieu of responding to questions about programs for shelter and services to minor sex trafficking victims in the United States, we are submitting a compendium of fifteen promising practices published by the Senior Policy Operating Group, *Promising Practices: A Review of U.S. Government-Funded Anti-Trafficking in Persons Programs*. While by no means exhaustive, it provides an important starting point upon which to build a more comprehensive learning resource. The promising practices are drawn from all regions of the world and cover all forms of trafficking – whether for sex or labor, domestic or international – as well as the core components of counter-trafficking programming (prevention, protection, and prosecution). Our intent is that, in reading the compendium, practitioners and other key stakeholders will identify ideas and approaches for combating trafficking worth testing in their own countries and communities, and spur greater information-sharing. The document can be found at <http://www.state.gov/documents/organization/207712.pdf>.

Sincerely,

Ambassador-at-Large Luis CdeBaca  
Office to Monitor and Combat Trafficking in Persons





## > Appendix G

State Comparison: Factors Affecting Child Protective Services Involvement in Commercial Sexual Exploitation of Minors Cases			
State	State law defines child abuse and neglect to include commercial sexual exploitation. <sup>5</sup>	State defines “caregiver” or similar term broadly enough to include non-familial traffickers who have custody or control of a minor victim.	Is CPS involvement likely? (Is abuse defined to include CSEC and is caregiver broadly defined?) <sup>6</sup>
Alabama	Yes	No	No
Alaska	Yes	Yes	Yes
Arizona	Yes	No	No
Arkansas	Yes	No	No
California	No	No	No
Colorado	Yes*	Yes	Yes
Connecticut	No	No	No
Delaware	No	Yes	No
DC	Yes	No	No
Florida	Yes*	No	No
Georgia	Yes	No	No
Hawaii	Yes	No	No
Idaho	Yes	No	No
Illinois	Yes*	Yes	Yes
Indiana	Yes	Yes	Yes
Iowa	Yes	Yes	Yes
Kansas	Yes	No	No
Kentucky	Yes	Yes	Yes
Louisiana	No	No	No
Maine	No	No	No
Maryland	Yes*	Yes	Yes
Massachusetts	No	Yes	Yes
Michigan	Yes	No	No
Minnesota	Yes*	No	No
Mississippi	Yes	Yes	Yes
Missouri	No	No	No
Montana	Yes	No	No
Nebraska	Yes	No	No
Nevada	Yes	No	No
New Hampshire	Yes	No	No
New Jersey	Yes	Yes	Yes
New Mexico	Yes	Yes	Yes
New York	Yes	Yes	Yes

State Comparison: Factors Affecting Child Protective Services Involvement in Commercial Sexual Exploitation of Minors Cases			
State	State law defines child abuse and neglect to include commercial sexual exploitation. <sup>5</sup>	State defines “caregiver” or similar term broadly enough to include non-familial traffickers who have custody or control of a minor victim.	Is CPS involvement likely? (Is abuse defined to include CSEC and is caregiver broadly defined?) <sup>6</sup>
North Carolina	Yes	Yes	Yes
North Dakota	No	No	No
Ohio	Yes	Yes	Yes
Oklahoma	Yes	No	No
Oregon	Yes	Yes	Yes
Pennsylvania	Yes	No	No
Rhode Island	Yes	No	No
South Carolina	No	Yes	No
South Dakota	No	No	No
Tennessee	Yes	No	No
Texas	Yes*	No	No
Utah	No	No	No
Vermont	Yes	Yes	Yes
Virginia	No	No	No
Washington	Yes	No	No
West Virginia	No	Yes	No
Wisconsin	Yes	Yes	Yes
Wyoming	No	No	No
<b>TOTALS:</b>	<b>37</b>	<b>20</b>	<b>16</b>

376 In response to this question Traffick911 listed that they are working to open Triumph House, a 168-acre ranch that will be turned into a safe home for victims of domestic minor sex trafficking

377 In response to this question Veronica’s Voice noted the following: We are in partnership with an organization that does the residential care piece for those under 23. We serve adult women victims, many were victims of DMST. The brutality and trauma of trafficking/ prostitution does not change at age 18. When organizations act as though there’s a big difference in the effects of trafficking/prostitution whether over or under 18 it further marginalizes the victims and sends the message that they are less worthy of help than those 18 years old and under.

378 Original response was under “residential services.” Moved to other for consistency within survey.

379 The assumption was made if the organization did not respond that they are not currently providing services.

380 Evaluations of state laws are based on legislation enacted before August 1, 2012 discussed in the 2012 Protected Innocence Challenge Report and supporting analysis for each state, available at <http://sharedhope.org/what-we-do/bring-justice/state-by-state-grades/>. For purposes of this chart, “commercial sexual exploitation” includes exploitation through child pornography or prostitution. Fields with an asterisk (\*) indicate that sex trafficking is specifically included in the definition of abuse or neglect.

381 Responses are solely based on statutory law and do not reflect regulatory or practice-based responses by agencies providing child protective services in cases of commercial sexual exploitation. Statutory analysis in this chart is taken from the 2012 Protected Innocence Challenge Report and supporting analysis for each state, available at <http://sharedhope.org/what-we-do/bring-justice/state-by-state-grades/>. Evaluations of state laws are based on legislation enacted before August 1, 2012.



