Final Project Report on
Addressing the Needs of Domestically Trafficked Adolescents in New Jersey

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Acknowledgments

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Executive Summary

The New Jersey Department of Children and Families has recognized human trafficking to be a significant social and legal problem and an issue of particular concern to governmental departments as well as non-governmental agencies within the State of New Jersey. As part of their efforts to strengthen their ability to identify and serve DMST-involved youth DCF has invested resources to train caseworkers and to develop services for survivors of domestic minor sex trafficking (DMST). However, DCF also recognized that there are gaps in the literature surrounding the needs of youth involved with DMST as well as limited evidence-based practices that have been identified for service providers working with this population. To that end, in 2014 DCF contracted with the Center on Violence Against Women and Children to conduct an exploratory study with the goal of further developing best practices for working with DMST survivors in New Jersey.

The overall goal of the current study was, therefore, to identify best practices for working with DMST survivors in New Jersey. This study uses both qualitative and quantitative methodologies to identify best practices for working with youth involved with DMST through four approaches: 1) a literature and website review of existing research and best practices for working with youth involved in DMST; 2) interviews with key stakeholders regarding the needs and experiences of survivors of DMST in New Jersey; 3) a review of the case records of eight youth who have been identified as survivors of DMST; and 4) an analysis of child welfare data of youth suspected of being involved with DMST. The outcomes of this study are intended to inform best practices for serving youth involved with DMST and to recommend strategies that will guide practice, policy, and future research. This executive summary provides a snapshot view of the results; the final report delves further into the results, discussion, implications and limitations of this project.

Methods

Data collection for this study took place over the span of approximately one year from July 2014 to June 2015. A comprehensive literature review was conducted beginning July 2014 which informed the development of three research briefs related to service provisions for at-risk and DMST-involved youth. Key stakeholder interviews were conducted from August through December 2014 and the review of case records of eight DMST-involved youth was initiated in December 2014 and concluded in February 2015. Lastly, the quantitative analysis of child welfare data was completed in June 2015.

Literature Review. A comprehensive literature and website review focusing on research and program services developed for domestically trafficked youth. As part of the literature review, a number of primary databases were searched. After an initial list of articles were compiled, grey literature, websites, and reference lists from primary sources and reviews were utilized until the research team reached data saturation. The literature review was then used to guide the development of three research briefs, as well as guide the development of the key stakeholder interviews and the instruments developed as part of the qualitative analysis of case records.

Key Stakeholder Interviews. Twenty in-depth semi-structured interviews were conducted with key stakeholders whose work provides them with a unique vantage point on the needs and

experiences of survivors of DMST in New Jersey. These interviews provided the research team with insights into best practices for working with youth involved in DMST. The face-to-face interviews with key stakeholders were semi-structured, following an interview guide with several domains of questions, while allowing enough flexibility for stakeholders to speak to their own areas of expertise. The interview guide included questions about the person's role, their involvement with the program designed to support youth involved in DMST, and their beliefs about valuable outcome measures for program evaluation. Thematic analyses were conducted on the qualitative data collected from key stakeholder interviews using ATLAS.ti. Codes were grounded in the data, but also derived from interview questions and existing research on human trafficking. Once consensus was reached on the codes, research team members grouped them based on underlying similarities into categories, followed by subthemes, and eventually into several themes.

Quantitative Analysis of Child Welfare Data. To provide an expansive picture of the statewide trends in reports to DCF's Division of Child Protection and Permanency (DCP&P) for youth where domestic trafficking (both labor and sexual exploitation) is alleged, data was analyzed from DCF's child welfare database (their statewide case management data system). The data we analyzed pertained to two different sources of data: (a) Initial reports or referrals to DCF where domestic trafficking is alleged (CPS = 73 cases; CWS = 102 cases) and (b) All reports, which were the intake records on youth, including those from the set of initial reports, in which domestic trafficking is alleged. The analyses are descriptive in nature and depict broad comparisons between CPS and CWS youth concerning report and case information for alleged domestic trafficking. Information about statewide patterns of these reports, case record information (i.e., demographics of youth), and outcomes of the allegations of the reports are presented. All analyses were done in SPSS, version 22.

Qualitative Analysis of Case Records. The purpose of the qualitative analysis of case records was to identify risk and protective factors that make youth more vulnerable to involvement in DMST. This component of the research project was completed through the review of case records of eight youth who were referred to a residential treatment program for domestically trafficked adolescents. Three sources of data were reviewed: 1) Electronic records within the child welfare database for each of the eight youth identified; 2) Paper files with collateral information from the youths' child welfare cases; 3) Electronic records within the Children's System of Care (CSOC) Electronic Youth Record Database for each of the eight youth. Three tools were initially developed to capture the data found in the case records. These were developed based on key risk factors for domestic minor sex trafficking (DMST) that were identified in the literature, and included tools on: 1) child maltreatment, 2) service provisions, and 3) individual and family-level risk and protective factors. Given the expansive amounts of information presented in each case record, the forms were used as a guide when recording notes from the case records.

Thematic analyses were conducted on the qualitative data collected from the case record review using ATLAS.ti. After the data was collected, a coding guide was created to assist the research team with identifying recurring concepts within the timelines, such as: 1) key themes, 2) significant life events, and 3) the actions and behaviors of the youth, their families, and the service providers involved with the youth. The notes compiled during this process were then

utilized to generate a codebook representing codes and major themes (merging of codes) and a working codebook was developed. Codes and themes generated from the analysis emerged from the research team's interpretation of the notes recorded as part of data collection.

Results

Literature Review. The literature review produced three research briefs including:

- From Research to Practice: Identification and Assessment of Domestic Minor Sex Trafficking Available online at: https://socialwork.rutgers.edu/Libraries/VAWC/DTA_Identification_Research_Brief_Final_1.sflb.ashx
- From Research to Practice: Secondary Trauma & Domestic Minor Sex Trafficking (DMST) - Available online at: http://socialwork.rutgers.edu/Libraries/VAWC/DTA_Research_Brief_2.sflb.ashx
- From Research to Practice: Interventions for Youth Involved in Domestic Minor Sex Trafficking (Available online at: TBD)

Key Stakeholder Interviews. The three major themes to emerge from the interview data include: 1) Understanding Youth Involved in Domestic Minor Sex Trafficking (DMST); 2) Best Practices for Service Provision and 3) Organizational Best Practices.

> Understanding youth involved in domestic minor sex trafficking. Several subthemes emerged under the first theme: a) importance of understanding the unique experiences of youth involved with DMST; b) population specific-challenges; and c) adult beliefs and attitudes about youth involved in DMST.
>
> Best practices for service provision. Results from key stakeholder interviews highlighted beliefs about best practices for providing services to youth involved with DMST. These results are grouped into the following subthemes: a) identification and assessment; b) best practices for serving youth involved in DMST; and c) models for service provision, and d) therapeutic modalities.
>
> Organizational best practices. Key stakeholders identified best practices for the organizations that offer programs serving youth involved with DMST. These best practices were: a) staffing and hiring, b) program administration, c) multi-agency collaboration and coordination, d) outcome measures

Quantitative Analysis of Child Welfare Data. The patterns uncovered in the SPIRIT data reveal some noteworthy trends, primarily around the nature of the referrals and the demographics of the youth. Three counties had relatively higher number of refers associated with domestic trafficking: Hudson, Essex, and Atlantic counties. For referrals to CPS regarding domestic trafficking, there were increasing number of referrals in the spring and summer of 2014; for the CWS referrals, there was an initial peak in this same time period of spring 2014, though the number of referrals quickly declined in the late spring.

The gender of the youth associated with both CPS and CWS-related domestic trafficking referrals is predominately female. From these data we can see that most of the reports were for either African American or White youth, for both CPS and CWS referrals.

The source of the reports, form of trafficking reported, and service needs identified vary according to CPS or CWS referrals. For the former, the most frequent sources were Anonymous, Friends/Neighbors, and Other, which do not provide much specificity about how these youth are coming to the attention of DCF. For CWS referrals, Police accounted for the most frequent referral source, followed by community individuals and Other. Our data further indicate that Labor-related trafficking is more likely associated with CWS referrals than CPS referrals. For CPS cases, sexual abuse and neglect were the most frequent identified types of alleged maltreatment; moreover, biological parents were the most frequently identified alleged perpetrator. For cases referred to Child Welfare Services, services for youth and children were the most frequently identified need.

Qualitative Analysis of Case Records. Three major themes of risk and protective factors emerged from the case record review data and were framed using an ecological framework. Hence, the themes included risk and protective factors found at: 1) the Structural Level; 2) the Family Level; and 3) the Individual Level.

Structural level risk and protective factors. These structural barriers were not identified as perpetrated by any one entity but were noted generally as factors contributing to the youth's inability to navigate away from trafficking and other risky situations. This theme included five codes: a) lack of permanency; b) poverty/economic stress; c) poor responses to mental health; d) poor medication regulation; and e) lack of providing emotional outlets for youth.

There were several times throughout the cases in which the systems involved responded in positive ways. These promising responses and protective factors make up the second theme under structural level factors. This theme consists of three codes: a) utilization of assessments; b) utilization of system interventions; and c) utilization of therapeutic interventions.

Family level risk and protective factors. In each of the cases that were reviewed, there were some family level factors that were viewed as hindering desired outcomes. This theme consists of three codes: a) drug environment; b) family factors that hinder healthy youth development; and c) perpetration of interpersonal violence.

Many family factors within the youths' case records supported healthy youth development. This theme consists of five codes: a) shows concern; b) attempts at compliance; c) attempts to show support; d) strong family bonds despite problems; and e) attempts to remove youth from situation.

Individual level risk and protective factors. In each of the cases that were reviewed, there were a multitude of individual factors that were viewed as hindering desired outcomes. This theme consists of six codes: a) avoidance strategies; b) perceived antisocial

behaviors; c) aggression; d) school-related challenges; e) hypersexuality; and f) internal challenges with gender or sexual identity.

There were also several individual factors that were viewed as positive. The primary codes under this theme were: a) coping strategies; b) willingness of youth to receive services; 3) school-related improvements.

Recommendations

The overall goal of this exploratory study was to identify best practices for working with survivors of domestic minor sex trafficking in NJ. The recommendations presented below emerged based on an analysis collected from four data sources: 1) a comprehensive review of the literature, 2) interviews with 20 key stakeholders whose work provides them with a unique vantage point on the needs and experiences of survivors of DMST in New Jersey, 3) a quantitative analysis of child welfare data for youth where domestic trafficking (both labor and sexual exploitation) is alleged, and 4) a review of the case records of eight youth selected by the New Jersey Department of Children & Families (DCF) based on their participation in a residential treatment program for domestically trafficked adolescents. These recommendations emerged from the results of analysis from all four data sources collectively. The recommendations suggested are for all personnel tasked with working with youth vulnerable to or survivors of DMST, including staff from DCP&P, CSOC, and all DCF affiliates, as well as individuals from the fields of law enforcement, criminal justice, mental health, and education and are as follows:

1. Continue to build on becoming trauma-informed by utilizing a strengths-based, empowerment approach.
2. Foster a work environment that supports the professional development and self-care of staff working with youth involved with DMST.
3. Recognize and respond to the heterogeneity of the population.
4. Strengthen protective factors for youth.
5. Develop a continuum of services for all youth vulnerable to DMST.
6. Ensure collaborations between providers are comprehensive and have established polices and protocols to be successful in working with survivors of DMST.
7. Pursue more research to fully recognize the challenges youth involved with DMST face.
8. Utilize two risk assessment tools for DMST, with one designed to assess for initial vulnerability and a second for identifying indicators of trafficking.

Introduction

Human trafficking is a significant social and legal problem globally, and is an issue of particular concern to governmental departments as well as non-governmental agencies within the State of New Jersey. Due to its location, New Jersey is a point of entry, transit, and a final destination for victims of human trafficking, partially because it is situated in close proximity to several large cities and major hubs for interstate and international transit. To combat the issue of human trafficking within the State, a number of programs and initiatives have been established to promote awareness, increase education, and encourage prosecution of traffickers.

Further, to better meet the needs of minors and young adults who are victims of human trafficking, the New Jersey Department of Children and Families (DCF) has invested resources to train caseworkers and to develop services for survivors of domestic minor sex trafficking (DMST). Additionally, there are gaps in the literature surrounding the needs of youth involved with DMST as well as limited evidence-based practices that have been identified for service providers working with this population. To that end, in 2014 DCF contracted with the Center on Violence Against Women and Children, Rutgers University, School of Social Work to conduct an exploratory study with the goal of further developing their best practices for working with DMST survivors in New Jersey.

To achieve this goal, the project had four aims:

1) Determine best practices for working with youth involved with DMST,
2) Identify risk and protective factors that may make youth more vulnerable to involvement in DMST,
3) Develop recommendations on best practices for youth involved with DMST based on a review of the literature and findings from primary data collection and analysis, and
4) Identify next steps for practice, policy and future research.

This study uses both qualitative and quantitative methodologies to identify best practices for working with youth involved with DMST through four approaches: 1) a literature and website review of existing research and best practices for working with youth involved in DMST; 2) interviews with key stakeholders regarding the needs and experiences of survivors of DMST in New Jersey; 3) a review of the case records of eight youth who have been identified as survivors of DMST; and 4) an analysis of child welfare data of youth suspected of being involved with DMST.

This report will outline the methods that were used in this study, as well as the research findings associated with each of these methods. This report will conclude with recommendations for best practices serving youth involved with DMST, as well as an outline of next steps for practice, policy and future research, developed by synthesizing previously existing literature on youth involved with domestic minor sex trafficking and the findings from primary data collection and secondary data analysis completed as part of this study.

We begin this report by synthesizing the research literature that exists on youth involved with DMST. We then describe the research methods utilized in this study and present the research findings from interviews with key stakeholders, case record reviews, and the analysis of child

welfare data of suspected DMST-involved youth. We conclude the report with recommendations on best practices for serving youth involved with DMST.

Literature Review

Overview of Trafficking

The Victims of Trafficking and Violence Protection Act (TVPA, 2000) defines sex trafficking as a violation "in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age," (TVPA, 2000). As such, in DMST, a trafficker uses the body of a young person as a source of profit. As a result of this exploitation, survivors of trafficking may experience serious physical and psychological health effects including short and long term emotional, behavioral, and cognitive consequences (Clawson & Goldblatt Grace, 2007; Macy & Johns, 2011; van der Kolk, 2005).

An estimated 199,000 incidents of sex trafficking occur within the United States each year; 244,000-325,000 American youth are at-risk for becoming involved in sex trafficking (Estes & Weiner, 2001). The actual figures are believed to be much higher than the given estimates, as it is difficult to obtain accurate numbers about this population due to its hidden and transient nature (Clawson, Dutch, Solomon, & Goldblatt Grace, 2009; Countryman-Roswurm & Bolin, 2014). Due to the clandestine nature of human trafficking, service providers may have limited opportunities to identify and intervene on behalf of youth involved in DMST. Traffickers are able to maintain dominance over their victims through the utilization of power and control (Clawson et al., 2009; Raphael, Reichert, & Powers, 2010). Through these mechanisms, victims may be led to believe that they that they are engaging in criminal activity themselves and become fearful of interacting with those systems (e.g. law enforcement, human service providers) that provide assistance (McClain & Garrity, 2011). Frequently, these youth are often arrested for other types of crimes; unfortunately, law enforcement officials fail to identify them as victims (Countryman-Roswurm & Bolin, 2014; McClain & Garrity, 2011). For this reason, it is important that service providers have a clear understanding of the stages of trafficking, as well as risk factors for these youth.

McIntyre (2014) developed a conceptual framework that maps four stages of the trafficking experience. These stages may look different from one victim to another and may be murkier in real life than the model might suggest; however, providers who understand these stages and trafficking indicators may be more likely to identify youth in need of assistance. The four stages of the Trafficking Progression Framework developed by McIntyre (2014) are as follows:

1. Initial vulnerability,
2. Recruitment,
3. Primary trafficking process, and
4. Intended exploitation.

During the initial vulnerability stage, a young person is considered vulnerable to recruitment, even if he/she has not yet met the trafficker. This is particularly true if there is some sort of emotional or familial void that a trafficker can fill. There are a number of "push and pull" risk factors that increase a young person's vulnerability to DMST (Hodge, 2014). "Push" factors are those that make a child more vulnerable to traffickers, such as poverty, the hyper-sexualization of women and girls in the media, or experiences with interpersonal violence (Institute of Medicine and National Research Council, 2014; United Nations, 2008). "Pull" factors include

the perceived benefits that might arise from association with the trafficker, such as opportunities to make money (Hodge, 2014).

During the recruitment stage, the trafficker identifies a potential victim and engages in initial contact. From one study with former pimps (Raphael & Myers-Powell, 2010), one respondent stated, "I would look for girls who needed sh-- who would do whatever to come out of the messed up homes and escape from their f---ed-up parents. I pulled these girls. Women who had been abused by some sucker and wanted better treatment and nice things," (p. 5).

In this next stage, called the primary trafficking process, the trafficker aims to gain the victim's confidence and trust through a grooming process similar to child sexual abuse, in which the trafficker tries to "get the child to acquiesce to abusive activities" (Gillespie, 2002, p. 411). The trafficker may use positive tactics such as kindness, romance, or gifts or negative tactics such as threats or actual violence to trap a child (Kennedy, Klein, Bristowe, Cooper, & Yuille, 2007). During this stage, the trafficker may also relocate the victim to the place that she/he will be performing the sexual acts (McIntyre, 2014).

After the primary grooming process is complete, the trafficker will engage in the "intended exploitation" as the fourth stage (McIntyre, 2014). This stage will continue for the period in which the victim is under control of the trafficker. During this stage the trafficker may exploit the youth for monetary gain, either by forcing the youth to engage in commercial sex acts or by selling the youth to another trafficker.

Identification of Trafficking Victims

While the profiles of youth who have been trafficked may vary widely, studies have found a number of risk factors associated with vulnerability to DMST. In fact, the profiles of domestically trafficked minors may look similar to those youth involved with the child welfare system and involvement with this system is one risk factor for DMST (Countryman-Roswurm & Bolin, 2014; Institute of Medicine and National Research Council, 2014). Below are some of the risk factors for DMST that are most frequently cited in research studies and reports. Service providers who are familiar with these risk factors may be more successful in identifying trafficked youth. Through early identification, service providers can connect youth with necessary resources and potentially prevent them from ever entering into the trafficking cycle.

Demographics. While all children are vulnerable to sex trafficking, some children may be at higher risk. Generally, females are more vulnerable than males, although males may also be victims (Hodge, 2014). Some studies suggest that males may be as equally vulnerable as females to exploitation (Holger-Ambrose, Langmade, Edinburgh, & Saewyc, 2013). The average age of entry into trafficking is between the ages of 12 to 14 years old (Estes & Weiner, 2001). Additionally, individuals belonging to ethnic or sexual minority groups, such as African Americans and individuals identifying as transgendered, have an increased vulnerability due to oppression, stigmatization and lack of supports (Hodge, 2014; Holger-Ambrose et al., 2013; Institute of Medicine and National Research Council, 2014).

History of abuse and neglect. A prior history of abuse or neglect is consistently cited as one of the greatest risk factors for DMST. This may be true for a number of reasons. For one, youth living in abusive or neglectful homes may be more likely to run away, thus making themselves more vulnerable to traffickers (Holger-Ambrose et al., 2013). The trauma associated with abuse and neglect may also negatively impact a child's mental health, fostering feelings of powerlessness, or motivating the child to seek support outside of the home environment (Reid & Piquero, 2014). In some cases, children are trafficked by their immediate family members as well.

Runaway, homeless and throwaway youth. Although youth may end up on the streets for a number of reasons, studies have found that youth who have run away from home, have been kicked out of their homes, or are currently homeless are at increased vulnerability for DMST (Institute of Medicine, 2014; Klatt, Cavner, & Egan, 2014). Once on the streets, these youth need survival items such as food, clothing, and shelter which may become more acute over time. For this reason, homeless youth are more likely to engage in survival sex (Colby, 2011), which is the process of exchanging sex to meet survival needs. In some cases, being trafficked may arise from survival sex (McClain & Garrity, 2011).

Family stressors. Family stressors, such as parental addiction (Reid & Piquero, 2014), family dysfunction (Klatt et al., 2014) and financial strain (Clawson & Dutch, 2008; Hodge, 2014) can also serve as a risk factor for DMST. Such stressors may propel youth to run away; alternatively, parental addiction and financial strain may push the family into exploiting a child sexually for monetary gain. In some instances, the child may try to seek employment opportunities herself. Prior family involvement in the commercial sex industry can also result in youth being recruited (Hardy, Compton, & McPhatter, 2013).

Delinquency. A number of risky behaviors have been identified as risk factors for DMST. These include alcohol and drug use (Reid & Piquero, 2014; Klatt et al., 2014), gang involvement, or a prior history with the juvenile justice or criminal justice system (Institute of Medicine and National Research Council, 2014).

Unhealthy peer relationships. Lastly, unhealthy peer relationships can place youth at greater risk for DMST. For one, youth can be recruited into DMST by peers who have already been trafficked (Estes & Weiner, 2001). The Institute of Medicine and National Research Council (2014) also listed peer pressure as a community-level risk factor for DMST. Youth may easily be influenced by promises of employment, love, or material gain or may feel inadequate due to a lack of these things. Dating violence has also been identified as a risk factor, particularly for female youth (Countryman-Roswurm & Bolin, 2014). Abusive relationships may cause youth to feel powerless and can negatively impact their physical and mental health. In addition, the individual that the youth considers her "boyfriend" may actually be a trafficker grooming her for DMST.

There have also been a number of trafficking indicators identified within the literature. Trafficking indicators are red flags that service providers can look for when assessing clients for trafficking. As such, these indicators may become more visible as victims move through the stages of trafficking. Indicators identified by the Department of Health and Human Services

(n.d.) include signs of fear or depression, evidence of physical abuse, or the appearance that a child is being controlled by another individual. Victims may also present with signs of forced sexual intercourse, such as bruising on the arms or legs, and may answer questions evasively (Hodge, 2014). The A21 Campaign (http://www.a21.org/index.php) identified additional signs of minor trafficking, which include a lack of trust in adults, or a child in possession of a cell phone while missing other basic necessities.

Screening Trafficking Victims

When a service provider encounters a youth that he or she believes may be a victim of trafficking, screening interviews and assessments can be utilized to learn more about the youth's experiences. Several instruments have been developed for the purpose of screening for human trafficking, such as the Protocol for Identification and Assistance to Trafficking Persons Training Kit developed by Anti-Slavery International, the Trafficking Victim Identification Tool developed by the Vera Institute for Justice, the Human Trafficking Interview and Assessment Measure developed by Covenant House, and the Human Trafficking Assessment for Runaway and Homeless Youth created by the National Human Trafficking Resource Center and Polaris Project. In addition, a risk assessment tool was drafted as part of this research project (see Risk Assessment Tool in Appendix A). While the utilization of appropriate tools is important to the screening process, researchers agree that how screening questions are asked is equally important.

Victims of DMST have likely endured a great deal of trauma and powerlessness. In addition, they have been told repeatedly by their traffickers not to trust adults. As a result, the way in which victims are identified and interviewed initially can significantly impact the way a victim engages with service providers and systems (Brunivskis & Surtees, 2012). It is important that service providers are sensitive to the needs of DMST victims and utilize trauma-informed interview techniques when meeting with vulnerable youth.

The trauma-informed approach is based on three central goals when working with survivors of complex trauma: safety, connections, and managing emotions (Bath, 2008). These three concepts can also be used to guide interviews with youth vulnerable for DMST. Polaris Project (http://www.polarisproject.org) recommends that assessments begin with casual conversation in order to develop a connection with the youth and make them feel more comfortable. It is also important not to interview a potential victim in front of a third-party for her or his own safety (Department of Health and Human Services, http://www.acf.hhs.gov). The initial goal of an assessment should be to meet the immediate needs of a child, such as food, clothing, and shelter (Casey Family, n.d.). It is also important that the service provider be honest about which needs they can meet immediately and which may take more time to meet. While service providers may not have the opportunity to do much in terms of managing emotions during the initial screening, active listening (Bath, 2008), maintaining eye contact (Polaris Project, http://www.polarisproject.org), and acknowledging that the victim is the expert in her or his own situation are important steps to supporting her/him.

Cultural sensitivity is also important during the screening process. Assessments should be conducted in the victim's own language and terminology used should mirror theirs (Polaris Project, http://www.polarisproject.org). Service providers should consider the words they use

when discussing the situation, as terms such as "prostitute" de-identify the child as a victim and may come off as victim blaming (Kalergis, 2009). Sexual minority youth and individuals identifying as transgendered are also vulnerable to DMST and service providers should be sensitive to their unique needs and the marginalization they may have already experienced (Robertson & Sgoutas, 2012).

Lastly, when service providers are screening youth, the focus initially should be on assessing youth for their immediate needs. Additional questions can be asked when appropriate, and less invasive questions should be asked before those that focus on higher degrees of controlling behaviors, such as questions exploring their experiences with violence (Polaris Project, http://www.polarisproject.org). It is not uncommon for children to answer the same question differently each time it is asked, as they may assume their initial answer was incorrect (Hopper, 2004). It also may take children some time before they develop the trust needed to feel comfortable disclosing their full story (Department of Health and Human Services, http://www.acf.hhs.gov).

Treatment Principles for Trauma-Informed Care

It is important to note that due to the complex nature of human trafficking, youth may not be willing to disclose trafficking experiences initially or even after extended periods of time. However, given that youth involved in DMST may share similar risk factors with other vulnerable groups such as homeless youth or traumatized youth, similar treatment principles and interventions can be utilized to help support their short and long-term needs.

There are a number of treatment principles that guide the provision of services to survivors of abuse and trauma. First, any therapeutic intervention with youth involved in DMST must begin with an understanding of the impact that complex trauma can have on young people. Exposure to interpersonal abuse or other forms of trauma beginning in early childhood can significantly affect a child's neurobiological development (Black, Woodworth, Tremblay, & Carpenter, 2012; van der Kolk, 2005). When children experience overwhelming distress at the hands of caregivers, they fail to learn how to regulate their own emotional responses. The developing brain's ability to integrate sensory, emotional and cognitive information into a coherent narrative is impacted, leading to unfocused responses to stress (van der Kolk, 2005). Consequently, traumatized children can easily become flooded by intense emotions and respond to reminders of the trauma as if they are experiencing traumatic events all over again (van der Kolk, 2005).

Youth who have experienced complex trauma may perceive adults as sources of threat rather than of comfort or support (Bath, 2008). Further, youth with complex trauma may demonstrate difficulties in a range of domains, including attachment, behavioral self-control, self-concept, and emotional regulation (Bath, 2008; Courtois, 2004; van der Kolk, 2005).

As mentioned previously, in recognizing the unique developmental impacts of complex trauma, common to so many youth involved in DMST, Bath (2008) identified three important therapeutic components that help to foster healing: safety, connection and emotion regulation. Personal safety is recognized as a priority for trauma treatment with children and adolescents (Black, et al., 2012; Kagan & Spinazzola, 2013). The intense traumatization that accompanies DMST

leads to strong needs for physical and emotional safety in youth (Clawson & Goldblatt Grace, 2007). Physically, residential programs for DMST youth must be kept secure and their location confidential from traffickers (Clawson & Goldblatt Grace, 2007; Macy & Johns, 2011). While some would argue that additional security measures are also necessary to protect youth in treatment facilities, providers must find ways to balance youths' security with their right to autonomy. Youth involved with DMST are encouraged to develop safety plans to help them avoid traffickers and navigate daily life after leaving the residential facility (Clawson & Goldblatt Grace, 2007).

In terms of emotional safety, the development of trust and feelings of security are developmental tasks typically established in infancy (Bath, 2008). For individuals exposed to complex trauma as children, the establishment of safety is a necessary first step in healing from trauma (Courtois, 2004). Traumatized youth may be "adult wary"; in response, adults can help create an environment of safety by being consistent, reliable, available, honest and transparent in their interactions with youth (Bath, 2008). Adults can also help traumatized youth feel emotionally safe by allowing them to have appropriate power and control over their circumstances whenever possible (Bath, 2008). It is common for youth with complex trauma to behave in challenging ways that communicate intense inner pain; adults caring for these youth must remain self-aware and avoid responding with personal reactions that are punitive or controlling (Bath, 2008).

Because emotional safety plays such an important role in the healing process for survivors of DMST, Macy and Johns (2011) recommend that survivors of sex trafficking work with a single case manager who can coordinate their multiple services and work to build a trusted relationship. In a group setting, group leaders can work to create a safe environment for exploration and understanding by helping members manage strong emotions and using activities that allow for exploration without group members feeling overwhelmed (Hickle & Roe-Sepowitz, 2014). Brodie, Melrose, Pearce and Warrington (2011) recommend that adults ask youth about their own perspectives on safety: how they understand safety and what it means to them to be safe from perpetrators and from other forms of social disadvantage, such as poverty, negative school experiences, or involvement with the criminal justice system. The authors add that youth involved in DMST need stable, supportive relationships with adults in an environment that feels like a family but does not seek to replace theirs, since maintenance of family ties is also important for these youth (Brodie, et al., 2011).

The emphasis on emotional safety highlights the importance of healing relationships for recovery from complex trauma. Fundamentally, interpersonal trauma threatens a young person's connections with others, which are necessary for healthy growth and development (Bath, 2008). Children who have survived complex trauma, including youth involved with DMST, have learned to associate adults with negative emotions and thus respond to adults with suspicion, avoidance or hostility as a survival strategy (Bath, 2008; Kennedy, Agbényiga, Kasiborski, & Gladden, 2010). In particular, survivors of DMST may form a traumatic bond or attachment to their traffickers. Youth may be particularly vulnerable to such an attachment if: 1) victims believe the traffickers can threaten their survival; 2) traffickers provide them with small kindnesses such as material objects or gifts; 3) victims are isolated from others; and 4) victims perceive they are unable to escape (Hardy, et al., 2013).

The work of building trust with these youth is slow but essential – a challenge for settings where services are time-limited, such as shelters with limited stays (Clawson & Goldblatt Grace, 2007; Kidd, et al., 2007). Researchers recommend that staff work continuously to build trust with youth involved with DMST and maintain the connection with youth even after they leave residential treatment (Clawson & Goldblatt Grace, 2007; Macy & Johns, 2011). One study of youth in a homeless shelter found that the development of caring relationships with staff was the foundation for all other interventions (Kennedy, et al., 2010). These relationships were fostered through services that provided a continuum of care, which allowed residents to experience a sense of belonging and chances to offer as well as receive help from others (Kennedy, et al., 2010). Similarly, the experience of mutual aid in group settings has been found to be beneficial for youth involved with DMST (Hickle & Roe-Sepowitz, 2014). Staff members need to help youth distinguish between adults who are potentially harmful to youth and those who are helpful; the ways that adults respond to youth behaviors can function to build trust and sustain connection (Bath, 2008).

In a therapeutic setting, service providers can also assist youth in their healing process by teaching them to regulate the intense emotional reactions that are a consequence of experiencing chronic, interpersonal violations and neglect. Adults may use reflection, active listening, or problem solving approaches to help youth "co-regulate" with them rather than responding automatically and coercively (Bath, 2008). In a parallel fashion, group activities (including expressive arts) can help youth involved in DMST express and manage strong emotions without feeling overwhelmed (Hickle & Roe-Sepowitz, 2014). Many trauma-informed cognitive behavioral approaches teach affect regulation as a component of their skill development (Black, et al., 2012).

Recognizing Stages of Change

It is important for service providers working with survivors of complex trauma to understand that recovery is not a linear process. Research on interventions for youth involved with DMST or street-involved youth more generally advocate the use of the stages of change model in working with these youth (Berckmans, Velasco, Tapia, & Loots, 2012; Thomson, Hirshberg, Corbett, Valila, & Howley, 2011). The Transtheoretical Model of Change, often referred to as the stages of change model, conceptualizes behavior change as a gradual process (Zimmerman, Olsen, & Bosworth, 2000). This model recognizes that it is common for individuals engaged in problematic behavior (such as cigarette smoking or disordered eating) to have mixed feelings about changing the behavior. Rather than labelling individuals as "noncompliant" or "resistant to change", this approach focuses on understanding a person's readiness to make change and their perceptions of barriers to change (Zimmerman, et al., 2000). Relapses are not seen as evidence of failure but as part of the process of change. While recognizing that any stage model inherently oversimplifies complicated issues, this model groups individuals' attitudes towards change into five stages:

1. **Precontemplation**, when individuals do not acknowledge that they have a problem and indicate no desire to change.
2. **Contemplation,** when individuals acknowledge having a problem but feel ambivalent about change.

3. **Preparation,** when individuals can both acknowledge having a problem and have decided in favor of making a change.
4. **Action,** when individuals actively take steps to effect the desired change.
5. **Maintenance,** a stage characterized by integrating the new behavioral change and preventing relapse (Thomson, et al., 2011; Zimmerman, et al., 2000).

Although involvement in commercial sexual exploitation is more complicated than deciding to quit smoking, the stages of change model has been used successfully in a program for sexually-exploited girls known as Acknowledge, Commit, Transform, or ACT (Thomson, et al., 2011). Following a program redesign, admission to the ACT group home was limited to girls who were at least at the contemplation stage, indicated by their willingness to acknowledge a history of sexual exploitation and work on this issue in the therapeutic group home setting (Thomson, et al., 2011). These dimensions are continually assessed throughout intake and treatment, recognizing that the girls in their treatment program often go back and forth between the stages of change several times. Educational groups, including those co-led by a survivor, may help youth progress to the next stage of change by learning to identify and acknowledge sexual exploitation. Residents who have achieved the maintenance level of change can work to sustain their progress in relapse prevention groups and may have opportunities to serve in a leadership or mentorship role (Thomson, et al., 2011).

Researchers have noted that it is very common for youth involved in DMST to deny that they are victims of sexual exploitation, a position parallel to the "precontemplation" stage of change (Clawson & Goldblatt Grace, 2007; Hickle & Roe-Sepowitz, 2014). In part, this may be due to the trauma bond between a victim and a trafficker, which can lead to unhealthy attachments to perpetrators (Clawson & Goldblatt Grace, 2007). Common depictions of "glamorous" sex work in the media also serve to obscure the harsh realities of sex trafficking for many teens (Hickle & Roe-Sepowitz, 2014). Youth may be reluctant to identify themselves as victims, preferring instead to see their willingness to engage in sex trading as a consequence of poor individual choices (Hickle & Roe-Sepowitz, 2014).

However, another barrier to identifying as a victim is the intense stigma associated with sex trafficking or prostitution (Clawson & Goldblatt Grace, 2007). It is common for youth involved with DMST to experience feelings of guilt and shame, as well as to internalize negative societal messages about themselves and others involved in sex work (Hickle & Roe-Sepowitz, 2014). Both staff and clients in treatment programs for youth involved in DMST struggle to address the stigma associated with trafficking without reinforcing it. Having survivors in leadership roles, particularly in group settings, can help clients gain insight and share their experiences without fear of disapproval or shame (Thomson, et al., 2011). Groups that provide psychoeducation about sex trafficking can also challenge stigma through allowing members to discuss taboo subjects that are rarely broached in other clinical settings, such as transactional sex and the stigma associated with prostitution (Hickle & Roe-Sepowitz, 2014). In a group setting, members can self-disclose and receive validation from peers, connecting their unique experiences to a shared concern; in this way, issues related to sex trafficking are normalized and explained in terms of structural factors such as oppression and the sexualization of girls (Hickle & Roe-Sepowitz, 2014).

Continuum of Care for DMST-Involved Youth

Because youth involved in DMST have a wide array of short and long-term needs, the literature on services for youth involved in DMST recognizes that therapeutic interventions are only one component of a broad continuum of services needed by trafficked youth, ranging from crisis intervention to after care (Macy & Johns, 2011). Crisis services involve provision of basic necessities, emergency medical care and shelter, and crisis legal advocacy (Macy & Johns, 2011). The provision of material resources is just as important as services that utilize relational support, particularly for youth who have experienced homelessness (Kennedy, et al., 2010).

Once survivors' immediate needs are met, they have ongoing needs for recovery and stability that are best addressed through comprehensive case management services. In addition to providing support with housing, legal issues and physical and psychological health, youth leaving DMST situations need assistance with pursuing educational goals and gaining vocational and living skills (Brodie, et al., 2011; Macy & Johns, 2011). Providers acknowledge that youth involved in DMST need to acquire work experience that will allow them to earn money in safer ways. Some programs, like GEMS, provide financial incentives as rewards for survivors' educational achievements in order to support their movement towards economic independence (GEMS, 2014). The ACT program provides educational and career counseling as part of their discharge plan, including assistance with job applications and college campus visits (Thomson et al., 2011).

Youth who have been involved in DMST have often been exposed to negative messages about their self-worth from adults; some programs, like GEMS, work hard to counter this message by providing programming that emphasizes the strengths of survivors while holding members to high expectations (GEMS, 2014). Programs that work with youth involved in DMST note the importance of utilizing survivors in positions of leadership in ways that complement and enhance more formal professional supports (Thomson, et al., 2011). A focus on the development of leadership skills for trafficked youth is important both for their personal growth and development and as a way to effect change on a micro and macro scale. As a manifestation of its strong belief in youth-led change, GEMS has a curriculum to help youth develop leadership skills in order to end sexual exploitation and domestic trafficking of youth (GEMS, 2014). The program involves training in critical thinking, an internship component and one-on-one and group peer mentoring. While the survivor leadership model is widely used, most notably at GEMS, more research is needed to document its effectiveness (Clayton, et al., 2013).

There is little existing research on family interventions with youth who have been involved in DMST. Thomson et al. (2011) describe efforts to include families in the treatment they provide to sexually-exploited girls through the ACT group home. The program offers both in-home and on-campus family therapy and family dinner nights, as well as efforts to address linguistic and cultural barriers (Thomson et al., 2011). Berckmans et al. (2012) note that family reunification is frequently a common goal of services provided to street youth, but there is not enough research on the success of these interventions or the value of family reunification for homeless youth. There is a clear need for additional research on family-level interventions for youth involved with DMST, particularly with regard to family violence as a trigger for youth leaving home (Berckmans et al., 2012).

Because of trauma's wide-ranging physical, emotional, cognitive and behavioral impacts, treatment of its symptoms is necessarily multimodal (Courtois, 2004). Trauma-specific treatment may focus attention on a client's physical body awareness, psychological processes, relationships with others and the impact of larger social factors. Treatment with severely-traumatized children and youth has three main goals: establishing safety and competence; dealing with traumatic reenactments, or triggers; and integration and mastery of physical and emotional symptoms (van der Kolk, 2005). Trauma treatment commonly follows three stages. The first stage focuses on safety; it involves building a therapeutic alliance, providing information about trauma reactions and helping the client learn to regulate emotions (Courtois, 2004). Once these have been put in place, the second stage focuses on helping the client process the traumatic material. The third and final stage involves helping clients consolidate their gains and restructure their lives (Courtois, 2004). Courtois (2004) notes that it is common for treatment to proceed in starts and stops, and that treatment is often more like a spiral than a linear process. Throughout the process, Courtois (2004) urges therapists to build a RICH relationship with survivors (one that is infused with **r**espect, **i**nformation, **c**onnection and **h**ope).

Black, et al. (2012) conducted a literature review to identify research on evidence-based trauma-informed therapies that have been used with adolescents. They identified five main therapeutic approaches: Multimodal Trauma Therapy (MMTT); Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Stanford Cue-Centered Therapy (SCCT); Seeking Safety (for co-occurring trauma symptoms and substance abuse); and Trauma Affect Regulation: Guide for Education and Therapy (TARGET). All of these treatment approaches they discovered shared five common techniques. First, they all provided psychoeducation to youth and families about common trauma symptoms and the impact of trauma on neurological functioning. Second, all the approaches involved teaching clients coping skills to help them relax, identify triggers, and regulate their emotions. Third, the approaches had clients create a trauma narrative, either oral or written, in order to make sense of a confusing and disjointed traumatic experience. Fourth, the approaches all involved cognitive restructuring, which teaches clients to identify and challenge maladaptive thoughts and beliefs. Fifth, the therapeutic approaches all involved creating a post-treatment plan for coping in the future, so that clients can consolidate their gains and plan for upcoming challenges (Black, et al., 2012).

The research on interventions for youth involved with DMST emphasizes the importance of trauma-specific treatment as a central intervention for these youth (Clawson & Goldblatt Grace, 2007; Clayton, et al., 2013). However, a barrier to engagement that many acknowledge is the extreme mistrust felt by many youth who feel betrayed by their previous experiences with adults (Clayton, et al., 2013; Hardy, et al., 2013).

Because many trafficked youth spend time on the streets, and many homeless youth are victims of trafficking or engage in survival sex in their efforts to support themselves (Hickle & Roe-Sepowitz, 2014; Lalor & McElvaney, 2010), therapeutic approaches with homeless youth may also guide the provision of services for domestically trafficked youth. The research on interventions with homeless youth paints a mixed picture. While there is some evidence for the impact of family therapy, cognitive-behavioral therapy (CBT) and case management in addressing substance abuse, psychological distress and measures of housing and social stability

(Altena, Brilleslijper-Kater, & Wolf, 2010), there is little support for interventions such as motivational interviewing (MI) or specific interventions offered in isolation, such as to those designed to reduce HIV risk (Slesnick, Dashora, Letcher, Erdem, & Serovich, 2009). One example is the Runaway Intervention Program (RIP) developed by Saewyc & Edinburgh (2010). This 12-month intervention offered home visiting, case management and group support for sexually exploited runaway girls, and was found to improve protective factors and decrease risk factors and symptoms of distress (Saewyc & Edinburgh, 2010).

Qualitative research on homelessness emphasizes the voices and experiences of homeless youth and the front-line workers who work with them (Kennedy, et al., 2010; Kidd, Miner, Walker, & Davidson, 2007; Slesnick, et al., 2009). Kennedy et al. (2010) interviewed 14 adolescent mothers from an urban homeless shelter. The youth reported that effective interventions depended on the formation of trustworthy, nonjudgmental, caring relationships with staff, which helped youth explore their options, solve problems, access material support and process their trauma (Kennedy, et al., 2010). Researchers urge providers to consult with homeless youth when designing services for them, keeping in mind their strengths, differences and needs for inclusive and non-punitive services (Kidd, et al., 2007; Slesnick, et al., 2009).

Lastly, the literature includes research on residential interventions for youth who have been involved in DMST. One prominent example in the literature is the ACT (Acknowledge, Commit, Transform) residential program for girls who have been involved in DMST (Thomson, et al., 2011). This program took place on the campus of a larger residential treatment facility, but in a separate group home setting. Girls at the larger residential campus could participate in weekly group sessions ("My Life, My Choice") focused on understanding sexual exploitation, but were only admitted to the ACT program once they were able to acknowledge a history of sexual exploitation and indicate a willingness to participate in treatment. Treatment consisted of weekly group sessions, weekly individual therapy sessions and regular meetings with a staff mentor who was a residential counselor (Thomson, et al., 2011). The group home was described as a welcoming, home-like environment with rules and structure that was less restrictive than the typical residential treatment setting. Residents earned money for attending group and completing chores; they also had opportunities to practice advocating for themselves at community meetings. After the first year, 62% of participants completed the program successfully. Compared to the earlier version of the program, this version of the program had a 78% decrease in the number of clients who failed to achieve their treatment goals due to running away, hospitalization or incarceration.

Alumni of the program were still in at-risk situations when contacted for follow up, but none had reports of continuing sexual exploitation (Thomson, et al., 2011). Similarly, Hickle & Roe-Sepowitz (2014) conducted a group for adolescents at a residential treatment facility who had been involved with DMST. Their group was designed to provide knowledge about DMST, reduce shame and stigma, foster mutual aid and help participants manage strong emotions through activities. There is a need for more research that evaluates interventions with youth involved in DMST (Hardy, et al., 2013).

Organizational Practices

In addition to individual-level interventions, the literature recommends a number of organizational-level practices to support treatment for youth involved with DMST. First, research suggests that services offered to domestically trafficked youth should be separate and focus predominately on issues of trafficking (Hickle & Roe-Sepowitz, 2014; Macy & Johns, 2011). Researchers also recommend that whenever possible, shelters serve a homogeneous population in terms of age and sex, given the difficulties youth involved in DMST have with forming relationships (Clawson & Goldblatt Grace, 2007). Programs have also had success grouping residents according to their stage of recovery (Clawson & Goldblatt Grace, 2007; Thomson, et al., 2011). Additionally, Thomson et al. (2011) found that allowing youth to experience a gradual transition into and out of the specialized treatment setting was more successful than treating youth with a variety of problems in a single setting.

The literature recommends that staff working in settings serving youth involved with DMST be able to forge consistent, respectful and nonjudgmental relationships with youth (Berckmans, et al., 2012; Clawson & Goldblatt Grace, 2007; Kennedy, et al., 2010). Staff must be well-trained on issues related to trauma, trafficking and cultural awareness (Berckmans, et al., 2012; Clawson & Goldblatt Grace, 2007; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005). Some authors advocate hiring survivors or peer educators to enhance opportunities for building trust, modeling hope and optimism, decreasing stigma, and offering advice from a background of shared experience (Berckmans, et al., 2012; Clawson & Goldblatt Grace, 2007; Markoff, Fallot, Reed, Elliott, & Bjelajac, 2005).

As discussed previously, other challenges in service provision to DMST victims stem from a lack of understanding of the layers of trauma that result from being trafficked (Lebloch & King, 2006). It is essential for service providers to understand the many ways that trafficking impacts youth (Brodie, et al., 2011; Clayton, et al., 2013; Lebloch & King, 2006). Services designed to be short-term may not allow for trust-building with staff to occur, an element that is essential for successful interventions (Clawson & Goldblatt Grace, 2007; Kidd et al., 2007). Some argue that sexual exploitation cannot be properly or fully addressed in group homes, foster homes, or juvenile detention centers (Clayton, et al., 2013; Thomson et al., 2011). Programs also require an adequate knowledge-base in order to provide effective services for youth involved with DMST.

Service providers' beliefs about the role children should have in decision-making about their own lives greatly shape the effectiveness of services provided to victims of DMST (Berckmans et al., 2012; Clawson & Goldblatt Grace, 2007; Clayton, et al., 2013). Western conceptualizations of children as passive, inexperienced individuals incapable of making good decisions without adult guidance often conflict with the life experiences of youth involved in DMST, many of whom have been forced to assume adult roles and responsibilities in adolescence (Bath, 2008; Brodie, et al., 2011). Service providers need to recognize these youth as active agents interested in making their own decisions and protecting their own autonomy, a challenge that must be balanced against the need to keep youth safe and away from dangerous and exploitative relationships (Berckmans, et al., 2012). An inherent challenge to providing

services to this population is the need to respect the adolescents' autonomy while establishing a positive, trusting relationship.

While a key piece in providing services to youth who have experienced DMST involves the work of individual service providers, imparting lasting positive change requires a more comprehensive service approach. Thus, interagency collaboration is of paramount importance when working with this population. However, collaboration can become increasingly more difficult when serving populations whose needs are unpredictable, when best practices for the population is unclear, and where there may be differing philosophical views and values surrounding the populations' needs (Johnson, Wistow, Rockwell, & Hardy, 2003). While research on barriers to providing services to domestically trafficked adolescents is still emerging, this study's findings suggest that these exact challenges are being faced by agencies working with survivors. Challenges with collaboration, particularly due to poor communication and lack of coordinated care have been cited as barriers to meeting the needs of domestically trafficked adolescents (Macias-Kaonstantopolous, Munroe, Purcell, Tester, & Burke, 2015). Agency collaboration can be hindered when there is a lack of clearly defined goals and ineffective information sharing systems in place (Sloper, 2004).

Further, because survivors of domestic minor sex trafficking have a wide array of needs, a multitude of individuals from different professional backgrounds must work together to ensure that the youth is receiving appropriate services. This may be particularly challenging when professionals hold differing values and ascribe different meanings to the experiences of the youth. In addition, this field currently has limited evidence based practices to guide how service providers are responding. In the absence of evidence based practices, well-intentioned professionals may use potentially harmful practices, such as detention (Bounds, Julion, & Delaney, 2015).

To guide interagency collaboration, research has identified several promising practices for service provision. First, there is recognition that there are a number of different terms that are utilized to describe the experiences of survivors of domestic minor sex trafficking. In order for collaboration to be effective, service providers must agree upon and utilize consistent, non-stigmatizing terminology (Bounds, Julion, & Delaney, 2015; Kalgeris, 2009). In addition, collaborating service providers must utilize uniform assessment tools that are age and population appropriate (Bounds, Julion, & Delaney, 2015). This will assist with the identification of youth as they enter different systems, as well as enable service providers to communicate the needs of youth more efficiently. It is also important that service providers recognize that survivors of domestic minor sex trafficking have experienced complex trauma and a trauma-informed approach to care should be taken (Macias-Konstantopoulos et al., 2015). In order to provide trauma-informed care to survivors, specialized trainings on complex trauma should be provided to all staff involved with providing collaborative services to these youth.

Qualitative Analysis of Interviews with Key Stakeholders

Overview

As part of the overall project, twenty in-depth semi-structured interviews were conducted with key stakeholders whose work provides them with a unique vantage point on the needs and experiences of survivors of DMST in New Jersey. These interviews provided the research team with insights into best practices for working with youth involved in DMST.

Methods

Sample. Potential interview candidates were initially suggested through key contacts of New Jersey Department of Children & Families (DCF), the funder for this project. In addition, at the conclusion of every interview, each interviewee was asked to suggest additional candidates for future interviews, so that a growing list of key stakeholders was iteratively generated over the course of conducting the interviews. Twenty-five key stakeholders were contacted by the project coordinator at the Center on Violence Against Women & Children with a request to participate in a one-time interview. Ultimately, 20 key stakeholders participated in interviews between August and December 2014. Key stakeholders were identified as anyone with valuable insight to share on the service needs of youth involved with DMST in the state. Key stakeholders represented law enforcement, state child welfare administrators, nonprofit agencies focused on human trafficking, and both staff and administrators from social service agencies involved in serving youth involved in DMST.

Data collection. Key stakeholders were invited to participate in an in-person interview through an email sent from the research team at the Center on Violence Against Women & Children. Interviews were held at a time and location that was convenient for the interviewee. Two research assistants attended each key stakeholder interview, with one conducting the interview and the other recording detailed notes on a laptop or tablet. The research team also implemented protocols to protect the confidentiality of key stakeholders. Each key stakeholder was assigned a numerical identifier which was used in place of his or her name. Interview notes used these identifiers and did not include any information that would identify individual people or their organizations. Following each interview, the notes were uploaded to a password-protected secure folder location on the Rutgers University server, to which only members of the research team had access. Throughout the period of data collection, members of the research team who were involved in conducting interviews met periodically to discuss whether new themes were emerging in interviews. Once it was apparent that interviews were no longer yielding new information, the research team agreed to cease conducting further key stakeholder interviews.

Instruments. The face-to-face interviews with key stakeholders were semi-structured, following an interview guide with several domains of questions, while allowing enough flexibility for stakeholders to speak to their own areas of expertise. The interview guide included questions about the person's role, their involvement with the program designed to support youth involved in DMST, and their beliefs about valuable outcome measures for program evaluation. This semi-structured qualitative approach to data collection is appropriate for topics about which little has been published in the literature. Qualitative research is valuable for providing in-depth and

nuanced depictions of a particular issue in a specific time and place; it is not appropriate for generalizing outside these bounds to other times, places, or issues.

***Data analysis*.** After the first four interviews were conducted, two members of the research team independently reviewed the notes from these interviews and categorized the data using codes that represented concepts found in responses to interview questions (e.g. "Establishing safety"). These initial codes were grounded in the data, but also derived from interview questions and existing research on human trafficking. After each researcher developed these preliminary codes, the two research team members met to compare their lists and reconcile discrepancies. Approximately 60% of the researchers' initial codes overlapped, and the remaining codes referred to unique concepts. As a result of this meeting, a working codebook was developed to use for coding the remaining interviews. This codebook also grouped the codes into themes, based on recurring patterns of codes across interviews.

Using this codebook, two members of the research team coded the remaining interviews, making notes of possible new codes that were not present in the initial codebook. Four members of the research team met to discuss and consolidate the codes into categories, subthemes, and eventually themes. New codes were evaluated to determine whether they reflected new ideas or could be incorporated into existing codes. Once consensus was reached on the codes, research team members wrote them on note cards and grouped them based on underlying similarities into categories, followed by subthemes, and eventually into several themes.

Results

The three major themes to emerge from the interview data include: 1) Understanding Youth Involved in Domestic Minor Sex Trafficking (DMST); 2) Best Practices for Service Provision and 3) Organizational Best Practices. Each theme is comprised of multiple subthemes and categories and will be described in turn. Whenever possible, we included quotations from the interview notes with key stakeholders to illustrate themes, subthemes and categories. We provide pseudonyms to maintain the confidentiality of the stakeholders who willingly participated in interviews.

Understanding Youth Involved in Domestic Minor Sex Trafficking (DMST)

During the interviews, key stakeholders described unique aspects of youth involved with DMST that they believed were crucial for service providers to understand in order to serve this population. These responses formed the first major theme of the interviews and included three main subthemes: a) the importance of understanding the unique experiences of youth involved with DMST; b) the specific challenges this population presents; and c) adult beliefs and attitudes towards youth involved with DMST that can impact services.

a) The importance of understanding the unique experiences of youth involved with DMST

Key stakeholders insisted that it is vital for service providers to understand several key psychosocial dimensions of trafficking in order to provide sensitive, appropriate services to youth involved with DMST. These dimensions, or categories of this sub-theme, included the

concept of complex trauma, the theory of stages of change, and gender-specific aspects of trafficking.

Complex trauma. In seeking to understand the emotional experiences of youth who have been trafficked, key stakeholders emphasized the importance of understanding their behavior as symptoms of complex trauma. Complex trauma refers to a constellation of symptoms that manifest in children and adolescents who have suffered chronic patterns of maltreatment in childhood (Cook et al., 2005). Youth who have repeatedly been victims of or witnesses to violence in childhood may display difficulties with attachment, physiological and emotional regulation, concentration, and self-esteem, among other areas (Cook et al., 2005).

Interviewees stressed that for many of the youth they worked with, being trafficked in commercial sex work was simply the most recent in a long line of interpersonal betrayals and violence at the hands of adults, often beginning with experiencing domestic violence and/or sexual abuse in childhood. One stakeholder, Alicia, who worked with survivors of human trafficking, estimated that 85% of survivors had experienced child sexual abuse. Another stakeholder, Nathalie, said, "This is a complex trauma symptom. It is not a first pain for this child."

Indeed, key stakeholders noted that early childhood traumatic experiences, including witnessing domestic violence and being a victim of child sexual abuse, functioned as risk factors that made youth more vulnerable to traffickers and other predators. Justin, another key stakeholder, described how traffickers exploit the vulnerability of young women with histories of violence, abuse and low self-esteem. Traffickers may use social media to contact young women and offer gifts and attention, but then maintain the exploitative trafficking arrangement through psychological manipulation. Stakeholders emphasized that service providers need to be able to interpret the behavioral reactions of youth involved in DMST (such as difficulties sleeping, unwillingness to trust adults, self-injury, etc.) as symptoms of complex trauma and not as evidence of "delinquency" or "promiscuity." Another key stakeholder, Mark, suggested that the symptoms of complex trauma can be aggravated for transgender youth by their intense experiences of oppression and discrimination based on their gender identity:

> *"It takes a long time when talking to transgender youth to get them to be non-hostile. And I have to say, 'Why the anger, what's up?' and touch their shoulder to show that you aren't afraid of them."* (Mark)

These key stakeholders emphasized that recognizing the intense, chronic trauma in the life histories of youth involved in DMST was necessary for understanding their reactions and placing their behavior in context. The results discussed by key stakeholders in this section surrounding complex trauma echo the research by van der Kolk (2005) and Bath (2008) on manifestations of complex trauma symptoms among severely traumatized youth.

Stages of change. One consequence of the complex trauma associated with DMST is that progress in recovery is rarely a linear process. Key stakeholders emphasized in their interviews that it is essential for service providers to recognize that for youth involved in DMST, the

decision to leave "the life" is complex, arduous and not straightforward. One key stakeholder observed:

> *"They don't see themselves as trafficking victims for some time, especially because the boyfriending model is used often… These types of victims are the most difficult to interview, they don't see themselves as victims, and may see themselves as compliant with trafficking."*(Priscilla)

Given the reality that many youth involved with DMST leave and return to trafficking situations several times during the process of recovery, stakeholders described how their agencies sought to acknowledge and respond to this challenge. In an effort to find a treatment approach that recognizes "relapse" as part of the process of change, some service providers chose to frame their work using a stages-of-change model, an approach that has been used in other treatment programs for youth involved in DMST, as described in Thomson et al. (2011). Using this language helped these stakeholders assess clients in terms of their readiness for change, while working to provide them with appropriate and beneficial services:

> *"Maybe they weren't ready for this phase, but did they get referral information or any support?"* (Linda)

> *"If they are in the pre-contemplation phase, it is important that they have concrete resources that they can draw back on."* (Alicia)

The key stakeholders agreed that different services may be appropriate for youth involved in DMST, depending on how far removed from "the life" they are:

> *"*[This organization] *provides services to individuals at different stages of change and we will have a diverse group of survivors in a women's support group but you need to use framing devices to create those connections."* (Alicia)

As Alicia emphasizes, recognizing the slow and non-linear process of change with youth involved in DMST is also crucial for staff's ability to form and sustain transformative relationships with youth. The approaches to treatment discussed by key stakeholders in this section surrounding complex trauma are similar to the findings of Berckmans et al. (2012) and Thomson et al. (2011).

Gender issues. Key stakeholders indicated that an understanding of DMST as gender-based violence was necessary to comprehend the complexity of youths' experiences, as well as the attitudes of adults they may have encountered. Providers need to recognize that youth involved in DMST identify as male, female, and transgender, and they may experience distinct trajectories and risk factors accordingly. Mark expressed the belief that young women may be more likely to be psychologically recruited into trafficking out of a desire for love and attention, while male youth involved in DMST may be recruited out of a need for money.

> *"I'm not sure that there is an understanding that there are males engaged in survival sex."* (Mark)

Another stakeholder (Alicia) agreed that male victims of trafficking are under-recognized and under-served, perhaps reflecting a prevalent way of discussing sex trafficking that focuses on "rescuing" girls and young women.

LGBTQI youth involved in DMST may be among "the most underserved population" (Mark) and are at heightened risk of experiencing violence on the street. Mark described the other factors that heighten their vulnerability, including a lack of understanding by their families of origin as well as law enforcement. This lack of support translates into a greater need for LGBTQI youth to self-support by engaging in survival sex, especially if transgender youth are looking to pay for hormones as part of their transition. Greater vulnerability on the street also implies being at higher risk of violence and more serious mental health problems. Understanding these vulnerabilities and triggers are key to providing sensitive and trauma-informed services for these youth. The results discussed by key stakeholders in this section surrounding the vulnerabilities of LGBTQI youth are similar to the dynamics discussed by Martinez & Kellie (2013).

Two key stakeholders (Alicia and Mark) suggested that there is a dearth of positive role models for transgender youth. Both suggested that it would be important for agencies serving youth involved in DMST to hire transgender men and women as staff to serve as mentors for transgender youth. Key stakeholders also acknowledged that there are currently insufficient resources to support the needs of LGBTQI youth who are commercially sexually exploited.

b) Population-specific challenges

The second sub-theme under the larger theme of understanding youth involved with DMST includes population-specific challenges. Across the board, key stakeholders agreed that youth who have been trafficked are an especially challenging population to serve. Categories of this subtheme include the following difficult aspects of providing services to these youth, as described by interviewees: challenges with attachment and engagement, running away, returning to the life, challenges with mixing populations, and complications with technology.

Challenges with attachment and engagement. Key stakeholders referenced the difficulties that youth involved in DMST have with engaging in services and forming healthy, positive attachments with adults. One key stakeholder described her impression of how youth involved with DMST might initially respond to staff outreach:

> *"You want me to open up to you? You people who are you? You want to talk to me today? Oh no!"* (Michelle)

Another interviewee described advice she received from another colleague who had experience working with adult victims of sex trafficking:

> *"The first 25 times that you touch [i.e., engage with] these women you will be unsuccessful. They are trying you. They are not going to trust you."* (Nathalie)

Other key stakeholders described their perceptions that it may be easier for youth involved with DMST to form attachments with peers, rather than adults who could serve as mentors:

> *"Lots of these kids haven't connected to these people* [referring to adult mentors] *but instead connected to the other kids. Didn't feel safe around adults so connected with each other in a way that they didn't trust adults."* (Danielle)

Another stakeholder (Wendy) echoed this concern, stating that when youth bond to each other instead of to staff, it risks re-traumatization by recreating power dynamics from trafficking situations. The perspectives of key stakeholders in this section regarding challenges with attachment and engagement are similar to the concepts discussed by Bath (2008) in terms of clients who have experienced complex trauma.

Running away. One of the most frequent concepts that recurred across key stakeholder interviews was the issue of youth running away from treatment programs. Key stakeholders all agreed that this was a challenging issue in serving the population, but had different ideas about how to interpret the meaning of youth running away and how best to respond as a result. One key stakeholder identified the tension between programs' need to keep youth safe, while at the same time acknowledging their developmental needs as adolescents:

> *"Kids need to be secure but they are adolescents so you have the issues of their drives as young people…* [this is an] *inherent conflict that we don't know how to work out."* (Theresa)

Key stakeholders emphasized that it is the responsibility of programs to keep youth involved in DMST safe and away from trafficking situations, and consequently some interpret youth running away from programs as evidence of the program's failure. For example, Mark argued that a measure of a program's success is the number of "involuntary departures" or youth who run away. This stakeholder claimed:

> *"If you looked at DCPP records and see what programs that kids run away from the most, and then you went and observed, then you would think, 'I would run away from here too. I would be headed for the door.' Some programs might not be the best because they are far away and it might be too far away to run, but kids are resilient so they would still try."* (Mark)

In contrast, other key stakeholders understood running away to be a pathological behavior associated with DMST that is best controlled through secure (and ideally remote) placement. One key stakeholder who worked in law enforcement, Justin, described youth who run as a "flight risk" who need to be placed in a short term facility; he also discussed how frequent running creates additional hours of work for law enforcement and others involved in the youth's care and protection. Justin believed that detaining youth in secure placement would help "so they can be in [a] safe environment and calm down."

Still other key stakeholders understood running away as a common behavioral symptom of the extreme trauma endured by youth involved in DMST, but were not willing to impose a "lock-

down" model of services on the population. These stakeholders endorsed a flexible approach to service provision that acknowledges the reality of running away in the same way that substance abuse programs recognize relapse as part of the process of recovery. Felicia expressed this belief in this way:

> *"Young people are going to be running away, coming back, leaving, coming back as part of the program. If you have programs that ask them to leave for the reasons they're there – it doesn't work. They need to be flexible."* (Felicia)

Whereas some key stakeholders suggested that measuring a decrease in running away would be a valid outcome measure for a program, Felicia suggested that program staff need to examine program statistics and be realistic in expecting runaways, "so kids/programs are not seen as unsuccessful because of running away."

Returning to the life. Stakeholders acknowledged that it is very common for youth involved in DMST to leave a trafficking situation, only to return to it later. One key stakeholder who works with youth and adults involved in sex trafficking (Alicia) described a former client who had left a program and was now "back in high risk situations which is not uncommon." Olivia, another key stakeholder who worked in an urban agency addressing the commercial sexual exploitation of children (CSEC) described her agency's approach:

> *"One of the things we monitor is them exiting the life. Not as an outcome, because we wanted our outcomes to be things that we can control and in the city there are so many factors that impact entry into the life. So we do not consider it an outcome. It's hard as a CSEC program but never returning to the life is a long time. We work with girls at all stages so it gets very blurry. When is somebody really 'out'?"* (Olivia)

Linda, another key stakeholder, echoed this belief that whether or not clients "abstain" from any return to the life is an inappropriate outcome measure for a program. Again, these key stakeholders emphasize an approach to service provision that recognizes the reality of "relapse":

> *"*[Programs] *can't just teach new skills, have to let them practice and relapse is going to happen; all of these folks keep the door open; you have to."* (Linda)

These service providers understand the concept of a "revolving door" as a reality of providing services to this population and not as an indictment of a program's success or failure.

Challenges in mixing populations, including recreating trafficking hierarchy. In response to this recognition that youth in the early stages of leaving "the life" are likely to return, key stakeholders argued that it is inadvisable for programs to combine in a single program youth who have recently left trafficking situations with those who are further along in their recovery.

> *"Our recommendation is that you cannot mix crisis and transitional. Clients need a specific place – first you do work for 30-60 days and then you do transitional. If there is not buy-in after the first 30-60 days, you disrupt that entire community for people who are coming and going and may not be ready to exit commercial sex trafficking."* (Alicia)

> *"You should not be bringing the kids that are rescued in with kids who are in for treatment… The mixing of the newly rescued kids in crisis mode brought down the sophomore kids who were getting more stable."* (Nathalie)

Yet another stakeholder, Jenna, concurred, "Mixing populations (kids in recovery with kids from right off the street) was an issue."

A related concern about providing residential services for youth involved in DMST was the possibility for traumatized youth to recreate a trafficking hierarchy within a residential program. Jenna described the implications of this for programs:

> *"They really needed to look at who was going to be together. A lot of times they feed off each other and incite each other. We would never recommend having three girls from one pimp stay together when we recover them, so we would probably not have them in the same shelter."* (Jenna)

More than one key stakeholder recommended providing distinct services for youth who are different points in their recovery. Felicia made the following recommendation for programs:

> *"Two separate types of entries: one that takes youth who are self-identified, more ready, vs. a girl who got picked up off the street, there's more risk of going back."* (Felicia)

Danielle recommended that programs invest more in engaging youth at the outset, rather than taking youth off the street and introducing them to a more structured treatment program. Theresa echoed these concerns:

> *"We didn't understand how much putting different children in would affect the dynamic… [we were] advised not to take kids as soon as they were recovered and to give some time, but didn't take that advice and I think that could have been done differently."* (Theresa)

The perspectives of these key stakeholders regarding having separate programs for youth at different stages of their recovery also echoes findings in the literature, specifically the approach utilized in the Acknowledge, Commit, Transform (ACT) program described in Thomson et al. (2011).

<u>Complications with technology</u>. The final recurring category in the family of challenges encountered in serving youth involved in DMST referred to issues around access to technology. Key stakeholders acknowledged that access to cell phones and social media are both an important way for youth involved in DMST to maintain social connections, and also a vehicle for them to contact and be contacted by traffickers. Mark expressed trepidation around youth having access to social media:

> *"Technology 'kills us' - so easy for them to create a plan and someone to create a plan for them. It is clear that a girl communicated via social media and picked her up and now they don't know where she is."* (Mark)

Justin described the role of the internet and social media in trafficking recruitment:

> *"*[A trafficker] *may send out 500 emails to friend list (hope somebody responds), modeling ads (e.g., make $1500 a day; get kids' info and start communicating that way), emails are targeted at kids with low self-esteem being told special things that will entice them."* (Justin)

However, Felicia emphasized the need for flexibility with regard to technology:

> *"This population needs more flexibility. Most programs don't let youth come in with their cell phones. It's tough because they're there because they want help, but they still have a connection to their pimp or the gang and there's fear if they don't answer the phone – these are real safety concerns. You also have girls recruiting other girls. Contacting the pimp. Coming to look for them. So a program needs to figure out how they would program around that."* (Felicia)

Similarly, Theresa argues that "asking youth to drop phones at the door or not access internet is totally unreasonable," particularly for youth who may not have ongoing social support from their families.

c) Adult beliefs and attitudes about youth involved in DMST

The third and final sub-theme of the overall theme of the importance of understanding youth involved in DMST includes adult beliefs and attitudes about youth involved in DMST. One of the many challenges inherent in providing services to youth involved in DMST involves adult beliefs and attitudes about adolescents involved in commercial sex work. Domestic minor sex trafficking (DMST) is an emotionally and politically fraught topic in the United States, since youth involved in DMST exist at the intersection of societal attitudes and beliefs about victimized children in need of protection, on the one hand, and adolescents at risk of posing harm to society on the other (Berckmans et al., 2012). Some of these attitudes and beliefs were referenced in our interviews with key stakeholders.

Key stakeholders made reference to beliefs about the balance programs need to strike between protecting youth and respecting the individual agency of youth involved in DMST. Some might argue that child welfare services in the U.S. have traditionally emphasized the protection of children, which can have the unintended effect of framing children and youth as passive recipients of services and not active decision-makers in their own lives (Watt, Norton, & Jones, 2013). One way that this theme manifested was in different opinions expressed about the extent to which youth involved in DMST must be constantly monitored and supervised by adults. Mark expressed the belief that it is important for youth involved in DMST to be in a secure placement "where they are safe and it is difficult for them to get away," possibly in a remote location. However, this stakeholder added:

> *"A successful program is a place where kids are enriched and educated and comfortable and are not locked off in the world but are integrated back into it - holding anyone in a facility just to hold them doesn't do anything"* (Mark).

Renee expressed a similar belief: "They need 24/7 supervision because girls will leave at night and/or bring pimps/adult men over." In describing the challenges of bringing multiple stakeholders together from social services and law enforcement to support DMST youth, Justin seemed to reference the desire for adults to rescue children from dangerous situations: "Everybody wants to help and be a hero."

Other statements made during key stakeholder interviews seemed to reflect a dismissive attitude towards youth, such as one key stakeholder who explained that services for adolescents are different because "their drama levels are much higher." Another statement by Renee labeled the youth response to adult efforts to implement structure as "resistance." While a term like "resistance" can place blame with clients who are not compliant with services, Alicia observed that it is entirely reasonable to expect DMST youth to be assertive about their needs:

> *"You have three young people who have experienced child sexual abuse for 10 years and now coming out of a pimp controlled situation and they will tell it like it is and if they don't feel comfortable they will leave"* (Alicia).

Together, these statements suggest that it is important for service providers to recognize the agency of youth involved in DMST and provide services to them in a way that is both respectful and developmentally appropriate. Mark recommended instituting a mentoring program for youth involved in DMST to connect them with adults who respect them as youth "and not treat them like a helpless victim." This theme will also be discussed in the next section on best practices for service provision. The beliefs of these key stakeholders in this section surrounding adult beliefs and attitudes about youth involved with DMST echo arguments made by Berckmans et al. (2012) and Brodie et al. (2011) regarding the importance of respecting youth agency.

Best Practices for Service Provision

The second major theme to emerge from the interviews reflected beliefs about best practices for providing services to youth involved with DMST. These consist of four subthemes including: identification and assessment; best practices for treatment; models of service provision; and therapeutic modalities. Each of these will be discussed in turn.

a) Identification & assessment

Key stakeholders described two categories of concepts that were relevant to identifying youth involved in DMST: push factors and pull factors, and red flags.

Push factors vs. pull factors. Practitioners who work with youth involved in DMST often distinguish between "push factors," that is, those factors that make individuals vulnerable to trafficking such as poverty or family violence, and "pull factors," that is, the factors that lure

potential victims into trafficking situations, such as a "boyfriend" who buys clothing and gifts for a young woman with low self-esteem (Hodge, 2014). The key stakeholders we interviewed emphasized the importance of understanding these push and pull factors when providing services to youth involved in DMST. One stakeholder who works with victims of human trafficking explained:

> *"Push factors are important – survivors are on a continuum of abuse. We have yet to see someone decide to work in commercial sex industry."* (Alicia)

Mark stated that push and pull factors vary for male, female and transgender victims of DMST, suggesting that transgender youth are most likely to have been pushed out of their homes, or "thrown away" leaving them vulnerable as they try to survive on the street. Linda suggested that most youth who end up in DMST situations have experienced push factors in the form of experiencing abuse, neglect, or domestic violence in early childhood.

Red flags. Key stakeholders also mentioned several red flags that indicate a client is at high risk for involvement in DMST, and suggested that child protective services workers be familiar and alert to these red flags in the youth they serve. Below is a list of red flags as identified by interviewees:

- Repeat visits to the ER for harm to self or others
- Bruises or marks on the body (not specified by the stakeholders)
- Referring to an older boyfriend as "daddy" or "pimp"
- Frequent running away
- Tattoos which indicate branding
- Unexplained keys, money, jewelry, clothing or cell phone
- Coming and going at odd hours for unexplained reasons

The risk factors discussed by key stakeholders in this section are similar to those discussed by the Department of Health and Human Services (n.d.) and the A21 Campaign (n.d.).

b) Best practices for serving youth involved in DMST

The second sub-theme under the "Best Practices for Service Provision" theme focuses on best practices for serving youth involved in DMST. Key stakeholders spoke frequently about best practices for providing effective services to youth involved in DMST. These responses were grouped into two sets of categories: the importance of taking an individualized approach to youth, and the importance of establishing physical and emotional safety in service environments.

Individualized approach. Key stakeholders emphasized the importance of providing individualized services to youth involved in DMST. For stakeholders, this meant different things. Some, like Jenna, emphasized the importance of simply acknowledging that "every kid is so different" and that each youth's trajectory of recovery will be distinct as well. Others argued that service providers need to approach each youth holistically and learn about their specific likes, wishes and needs:

> *"Do you want to go to the Y? Do you want to go to the library? Music? iPods? Identify what their likes are! When you start to take away things, you have to find a replacement for those! You are taking away her family that is out there so what are you going to replace it with?"* (Michelle)

Similarly, Mark recommended that DMST youth be paired with mentors who could provide ongoing, individualized support, facilitate their transitions into and out of services, and complement the more formal counselling services.

Key stakeholders expressed the belief that the variability of presenting problems among DMST youth requires providers to be able to "meet the clients where they're at." Olivia described her agency's approach to responding to fighting, breaches of confidentiality, and other discipline concerns within their residential program. Later in her interview, she elaborated on the "low threshold" approach embraced in her agency's residential treatment program:

> *"We're very much a meet-them-where-they-are-at agency. We have few concrete rules: again fighting, breaches of confidentiality and recruiting are the only things that would make a girl be asked to take a break from the space or leave a residential program."* (Olivia)

In contrast, Linda suggested that a treatment home model could better provide the kind of individualized one-to-one services required by this population, rather than a group home. This belief was echoed by other key stakeholders, who also believed that youth involved in DMST would be better served by specially-trained therapeutic foster families. They asserted that such a setting would provide one-on-one attention in which youth would receive individualized, consistent, positive attention from adults.

Establishing safety. Given the extreme violations suffered by youth involved in DMST, it is not surprising that key stakeholders referenced the idea of safety in their interviews. In describing best practices for serving youth involved in DMST, stakeholders spoke about two different forms of safety: physical, in terms of the physical setting and location, and emotional, in terms of interactions between staff and clients.

a. Physical Safety

Key stakeholders emphasized the importance of a residential program's physical setting being welcoming and warm for DMST youth, and recommended that programs avoid "sterile" and "not warm and welcoming, not home like" settings in cinderblock buildings. Mark explained:

> *"Long term placements are great, but it has to be somewhere that the kids want to stay. The kids need to feel comfortable, safe, or as nice as an average hotel room."* (Mark)

A stakeholder involved with another program serving youth involved in DMST described their approach to creating a welcoming environment:

> *"Language is important. Not having signs about STDs everywhere. Having color. Being conscious about the environment and power dynamics."* (Olivia)

In terms of program size, key stakeholders agreed that a 10-bed program is too large for the needs of this population. Most believed that youth involved in DMST would be better served in a smaller, more personalized home-like environment with no more than 5 or 6 youth.

Finally, stakeholders were divided about the ideal location for a program serving youth involved in DMST. On one side, stakeholders believed that services need to be geographically accessible for both program staff and administrators. At the same time, programs need to protect their security by maintaining a confidential location that is not accessible to traffickers. To uphold the security of the program location, one residential program for youth involved in DMST requires residents to protect the confidentiality of the program location:

> *"To live in the house you need to make a commitment that you will not go into the life while living there. If a girl does go back, she will not be discharged. But it often goes with a confidentiality breach. In a matter of time a pimp shows up and picks her up out front and violates confidentiality. That is only for residential though."* (Olivia)

In contrast, when discussing best practices for program locations, other stakeholders believed that youth involved in DMST are best served in remote environments where they cannot easily return to trafficking situations. Settings in remote, rural environments might be best because "it was hard to run away because it was all farms" (Mark). Linda also thought that being in a busy location "made the temptation greater" for youth involved in DMST and felt that some of the best programs for this population "are in the middle of nowhere." However, others believe that it is more important for treatment to take place in the environment to which youth will be returning. Danielle noted that a program can be "in middle of nowhere and if kids want to run, they would still run. It's about environment in the building, not physical locale."

b. Emotional Safety

Key stakeholders discussed two different ways that staff can promote emotional safety for youth involved in DMST: through their thoughtful use of language, and maintaining an honest approach to service provision. Interviewees emphasized the importance of staff avoiding pejorative language when discussing youth involved in DMST. Felicia expressed concern about encountering victim-blaming language that described a youth involved in DMST as a "child prostitute" or displaying "out of control and delinquent behavior." Alicia agreed that language can make or break rapport very quickly, explaining:

> *"If you use the phrase 'child prostitute' or 'prostitute' just one time it comes off as judgmental and has a big impact on whether clients have bought into services."* (Alicia)

Another important dimension of staff promoting an emotionally safe climate is having an open and honest approach to service provision. Alicia explained:

> *"Do not make promises you cannot keep because otherwise they will not come back for services. For example, don't tell them you can find them housing in one night if you know it is not realistic. It is okay if you can't. You need to be very realistic about what you can and cannot do."* (Alicia)

One organization that serves youth involved in DMST refers to the recipients of their services as "members" or "residents," rather than "clients." Olivia urges service providers to be aware and reflective of the power dynamics within the organization, especially with regard to the role of survivors in program leadership:

> *"Talk about the -isms. The survivor piece is so important because they pick up on things you may not. Be open to blind spots. We have a strong level of trust and accountability. We are constantly putting each other in check."* (Olivia)

The attention to emotional safety translates to other aspects of program operation. One organization that works with survivors regularly brings in outside evaluators to conduct program evaluations. When asked how their clients respond to outsiders coming into the space, Alicia explained:

> *"I think what we've seen is you want to create trusting relationships – if there is trust within that environment, there is trust with the people who are being brought in. Our survivors have a basic level of trust that we would not bring in someone who is not safe."* (Alicia)

The results discussed by key stakeholders in this section surrounding establishing safety for survivors of DMST is similar to the findings discussed by Bath (2008) and Clawson & Goldblatt Grace (2007).

c) Models of service provision

The third family of subthemes regarding best practices elaborated on models of service provision. Key stakeholders discussed various approaches to organizing services for youth involved with DMST. Some, as discussed earlier, advocated a more remote and restrictive approach to services. Holly described the model of service provision in another state:

> *"In* [another state] *we had locked facilities; honestly it's hard for them to stay in one place even if it's in the middle of nowhere. They need to consider it being a locked placement for safety."* (Holly)

Others prefer a less restrictive approach for the youth they serve, as Olivia explained:

> *"Our model works for us. There's very different models. We are a low threshold program. That is where our girls are at so that girls who need services get them. We do not believe in a lock-in model. Some programs literally lock the girls in."* (Olivia)

Regardless of the model of service, stakeholders agreed that it is crucial for programs to have a clear clinical approach that guides practice. Having a clear clinical model was also considered important for the agency's partners and collaborators, who benefit from understanding the agency's approach in serving a traumatized and vulnerable population.

d) Therapeutic modalities

The final subtheme related to best practices in service provision referred to therapeutic modalities used in services for youth involved in DMST. While a range of trauma-informed therapies were discussed, most of them shared two characteristics: being grounded in an empowerment approach and incorporating alternative or recreational therapies.

Empowerment approaches. Key stakeholders discussed the importance of programs maintaining a strengths-based empowerment perspective that affirmed youth involved in DMST as whole, complex people with rights and agency. Alicia described her organization's approach:

> *"We believe in empowerment and strengths based programming. It is not us deciding what the clients want to do – we are here to support clients to meet their goals and over time their goals change."* (Alicia)

Similarly, Felicia emphasized the importance of a nonjudgmental, accepting approach to working with youth. She described how programs could support a young person's longer term goals from a perspective of empowerment:

> *"If the young person is in a safe setting, working, pursuing education, working towards goals they have identified. Even if a job working at a local go-go bar – as long as it's a safe place. Important not to be judgmental. Don't say to the kid, 'That's horrible – why would you want to do that?'"* (Felicia)

Embracing an empowerment approach to services also involves seeing survivors of trafficking as leaders and service providers, not just as victims. Olivia discussed this concept in terms of survivor leadership:

> *"I think the survivor led model speaks volumes. That is empowerment. We never want it to feel like a program. We are a family. We never use client. Girls are members or residents. We take sense of allyship that we don't know any better them."* (Olivia)

All of these stakeholders emphasized the importance of support services for youth involved in DMST being informed by an empowerment perspective. This approach to services is in keeping with the description of trauma-informed services provided by Elliott et al. (2005) and Clawson and Goldblatt-Grace (2007).

Alternative/recreational therapies. Key stakeholders agreed that therapy with youth involved in DMST often takes different forms from traditional therapeutic interventions with adults, believing that less traditional and less verbal approaches to therapy were better suited for this population. Alicia talked about how trauma therapy work is about "bringing people back into

their bodies and sensory experiences," and added, "There is so much to be done with mindfulness, yoga, animal therapy." Linda also recommended the use of movement, body work and art therapy, explaining:

> *"Art therapy was a critical method for this population especially since talk therapy isn't always best for those who have been told that they can't tell anyone."* (Linda)

Other key stakeholders mentioned cooking, gardening and art as possible recreational therapeutic activities that could engage youth. Therapies that integrate the body as well as the mind are common approaches to treating trauma, as described by van der Kolk (2005) and Courtois (2004).

Organizational Best Practices

The final theme that emerged from the interviews identifies best practices for the organizations that offer programs serving youth involved with DMST. This theme is composed of four subthemes: a) staffing and hiring; b) program administration; c) multi-agency collaboration and coordination; and d) outcome measures. Each of these subthemes will be discussed in turn.

a) Staffing and hiring

Key stakeholders referenced several categories of staffing and hiring that they believed contributed to the success or failure of a program, including screening/vetting, training, staff salaries and turnover.

Screening/vetting. Key stakeholders emphasized the importance of programs thoroughly screening and vetting the staff they hire to work with youth involved in DMST. Alicia explained her own organization's perspective:

> *"We are extraordinarily cautious about who comes into our office – had they had a background check, confidentiality training"* (Alicia).

Similarly, notes from the interview with Olivia describe the rigor of her organization's approach to hiring, which includes the input of program members (service recipients):

> *"People apply. Go to an interview with HR. If they pass through that they then meet with the person who would be their supervisor. Then they would meet with at least three colleagues and six members. Directors are interviewed a fourth time by* [the CEO]. *Background check for child abuse and criminal background check. Criminal check is flexible. Girls' input taken very seriously. Administrative office staff get the same screening. The process takes a while."* (Olivia)

In particular, the issue of male staff working with young women involved with DMST came up repeatedly. Key stakeholders expressed concern about having male temporary employees staffing overnight shifts and making comments that made clients feel uneasy. Felicia reported:

> *"Youth didn't like hearing from male employees how they looked. Male staff commenting on how a 17-year old looked pretty that day. Learning from the youth that those comments made them uncomfortable, felt like the person wanted to have sex with them."* (Felicia)

Theresa added that having a male supervisor or program director for youth involved in DMST risks "replicating the scenario on the street" and added that programs should "be careful not to set up staffing that is going to trigger the kids" (Theresa).

Staff training and experience. Key stakeholders described several important aspects of hiring, training and supporting front-line workers. First, stakeholders recommended hiring employees who had work experience in domestic violence or sexual assault support services, so that they would be familiar with the complex trauma that accompanies repeated victimization. Nathalie explained:

> *"You need people with experience in domestic violence, sexual abuse and early childhood trauma. The human trafficking was a symptom of those three things."* (Nathalie)

Stakeholders also emphasized the importance of staff receiving comprehensive training in issues pertaining to survivors of human trafficking, including specific trafficking-related challenges, issues facing LGBTQI youth, as well as the ongoing impact of earlier interpersonal trauma and betrayal on this population. Interviewees emphasized the importance of staff being prepared to respond appropriately to youth who behave aggressively, run away, or try to recruit others within the treatment program. Stakeholders suggested that training needs to be both comprehensive and specific; Nathalie explicated this point:

> *"Words are important and part of the training…if they say this, say this – use these words. That is one of my strong recommendations is that part of the training is about how to talk to children in a way that is not parental."* (Nathalie)

Stakeholders also acknowledged that even extensive training "takes some time to sink in" (Heather).

Given the intense challenges, particularly of vicarious trauma, posed by working with this population, staff training and support needs to be on-going. Heather noted that a best practice would involve "staff self-care, secondary trauma – needs to be concrete plan for helping staff manage this." Olivia described the efforts of her organization to support staff on an on-going basis:

> *"Self-care is really important. All staff are strongly encouraged to go therapy on* [this agency's] *dime during the week. Weekly supervision is done and biweekly group supervision. Investment in staff is important."* (Olivia)

Salary issues. Interviewees referenced salary issues in their comments about challenges pertaining to staffing programs for youth involved in DMST, particularly with regard to burnout and staff turnover. Michelle stated:

> *"If you want good staff and you want to pay them – the individuals who are all day every day in there as the direct care staff – they must be compensated; the work is hard."* (Michelle)

Olivia described her organization's pay grades as "above normal," explaining that they were looking for "a certain level of person" in their hires.

Staff turnover. Key stakeholders identified staff turnover as a major barrier to organizations' ability to provide consistent, effective services to youth involved in DMST. Specifically, stakeholders expressed concern about the impact of staff turnover and temporary staff on a vulnerable population with histories of relational violations and difficulties with attachment. In reflecting on her work with trafficking survivors, Alicia stated:

> *"I know from our clients (who have had challenges with attachment) that when staff leave it is really damaging."* (Alicia)

Wendy explained that youth involved in DMST can experience staff changes as "another adult being transient in their lives." These concerns about staff turnover were linked to stakeholder recommendations for screening, hiring, training and paying staff appropriately.

b) Program administration

Key stakeholders discussed several administrative-level dimensions of best practices for organizations serving youth involved with DMST. These included communication, program structure and leadership, a reflective approach to service provision, and an emphasis on relationships as the modality for change.

Communication. A recurring theme across interviews was the importance of direct, constant communication both within and across programs serving youth involved in DMST. Stakeholders emphasized the value of clear communication between administrators and staff, between staff and clients, and between organizations seeking to collaborate, including law enforcement, medical providers and school staff.

Clear program structure & leadership. More than one interviewee emphasized that programs benefit from having clearly-delineated goals and procedures. Stakeholders also discussed the value of programs recognizing their limitations and not seeking to provide services beyond their capabilities. Olivia recommended:

> *"Know your population. Know your capacity. This is what we can do and this is what we will refer out for. Be realistic about you can serve and who you can't."* (Olivia)

Alicia recommended that programs be strategic in setting goals and not seek to incorporate multiple populations (such as parents and children) into a single program.

In order to emphasize the importance of clear program structure, stakeholders expressed concern about programs that lack leadership and structure. Linda explained:

> *"Absence of strong leadership without an intact team really compromises the effectiveness [of programs]."* (Linda)

Danielle linked problems with poor leadership and structure with the youth having difficulties forming supportive relationships with staff:

> *"[Youth don't] feel safe around adults so [they connect] with each other in a way that [shows] they didn't trust adults. This is a feature of a program that isn't well managed – kids run together, kids lead the program."* (Danielle)

Reflective approach to service provision. Another administrative-level best practice that emerged from interviews referred to programs maintaining an openness to change and avoiding rigid adherence to any single model or approach. Felicia explained:

> *"All kids in these programs have trauma, but need to know what and when that trauma was, so they can be careful not to re-trigger. Certain modalities may or may not work. … Be flexible, not rigid in terms of treatment modalities."* (Felicia)

Nathalie spoke about the importance of staff being flexible in providing services to youth involved in DMST, which is different than the structured approaches in more traditional residential treatment facilities for youth with emotional and behavioral problems:

> *"When you hire staff with residential experience – they want structure, they want rules."* (Nathalie)

Olivia agreed and offered the following advice to other agencies:

> *"Don't commit to your model. Always be open for review. Things change. Social media changes. The world changes. Be open to change. Every year as a team we change things."* (Olivia)

This openness to change is reflected in one program's commitment to regularly evaluating the services they provide to victims of human trafficking:

> *"We have focus groups after new creative arts therapy programs so people can express how they are feeling. Clients vote on snacks in the office. Having the voice to make choices about what is in the office has helped them to think that this is their space. We actually even evaluate the pet presence and do you pet the pets? Does it alleviate anxiety? Our programs have changed every year based on recommendations."* (Alicia)

Alicia described the questions they ask of their clients in surveys and focus groups:

> *"Have you been able to build positive communities since coming to the office? Which services are you utilizing? Have you been able to access employment? Have these services been useful?"* (Alicia)

Felicia wondered about the opportunities for program evaluation in a group home environment:

> *"Are there house meetings? Is there voting? These girls are used to not having much of a say, except for what they think is freedom on the street."* (Felicia)

In keeping with this reflective approach to program administration, stakeholders agreed that programs do well to educate themselves thoroughly about this population and allow adequate time for program development as well as the screening, hiring and training of staff. If the process to develop a program is rushed, then certain areas of that program development may be compromised.

Relationships as modality for change. When interviewees discussed best practices at an organizational level, they referenced the importance of transformative relationships. Several stakeholders expressed the belief that the core of treatment with youth involved in DMST is finding an adult – a relative, a mentor, a therapist or a treatment parent – who can invest the time and patience to build a restorative relationship with the young person. Mark declared:

> *"The kids need a good listener. You can't make that, but you can teach them when they should listen and not give advice, what they should listen for…"* (Mark)

Jenna agreed about the importance of this quality in staff members:

> *"It doesn't have to be people with a million letters after their name. You can be the smartest person in the room but you might not be able to connect. And this population is street smart – they can… tell when someone is genuine. Genuine connections are important."* (Jenna)

Nathalie concurred, describing her beliefs about therapy with youth involved in DMST:

> *"I think the first place you go is to establishing a transformative relationship."* (Nathalie)

Later in the interview, she expanded on what this work looks like in the early stages:

> *"You need them to be able to be locked onto somebody and be the beginning of a restorative relationship – saying I will be with you walking next to you, I'm not judging you, I'm not trying to change you."* (Nathalie)

This emphasis on relationship-building also informed some key stakeholders' concerns about the inappropriateness of staff responses to youth actions on a purely behavioral level, rather than trying to understand the emotional significance of their actions. Renee mentioned that a display

of anger by these youth need to be understood "from a clinical perspective, [instead of calling] the police." These responses were experienced as punitive and seemed to undermine the potential for positive relationship-building in the treatment facility.

c) Multi-agency collaboration and coordination

Across interviews, one of the most commonly-recurring themes in discussions about program administration was the necessity for collaboration and coordination of services across multiple agencies. Along the lines of agencies needing to recognize their limitations, stakeholders recommended that service providers for youth involved in DMST work to build collaborative relationships with law enforcement, schools, and other treatment providers. Olivia described the many relationships her organization maintains with other agencies providing services for mental health, domestic violence, substance abuse, LGBTQ youth, pregnant and parenting youth, educational supports, and legal assistance. She explained:

> *"Strong relationships are very important. It is important to recognize what your capacity is… What do we do the best and what do other folks do the best and how do we strengthen them?"* (Olivia)

Theresa agreed that it is important for agencies to identify providers who are skilled and trained in working with youth involved in DMST to create a support system of services for referrals. Felicia also argued for the importance of working together:

> *"There should be more collaboration with schools, training programs… in smaller group homes, youth might be in the community for clinical providers. Get to know the people who are touching the youth's life, bring them in quarterly at least to talk about the planning."* (Felicia)

Two key stakeholders emphasized that agencies need to continue to partner with law enforcement and maintain open communication even once youth involved in DMST are enrolled in treatment programs, in order to provide a consistent response if and when youth run away. Another stakeholder discussed the importance of maintaining consistent communication between school and program personnel.

A specific challenge facing agencies that provide services to youth involved in DMST is the legal challenges that accompany serving minors. Stakeholders discussed the challenges of organizations needing to collaborate while seeking to protect the confidentiality of the youth they served. Michelle described the challenges of providing sufficient information to schools that educate youth involved in DMST without violating confidentiality:

> *"I know the schools are aware once they are in treatment because the provider is taking them there and are the emergency contact, but do they know if they are victims? I don't know. Should they? I don't know."* (Michelle)

Other key stakeholders also spoke to this tension, of wanting to protect the confidentiality and safety of the students while recognizing that limited information about their circumstances could hinder educators' ability to provide appropriate educational services.

Another challenge for collaboration was the fact that law enforcement and social services often had different ideas about the best ways to help youth involved in DMST. Stakeholders from law enforcement acknowledged that "social work and law enforcement are not always on the same page" (Mark). These stakeholders argued that the monitoring and surveillance of youth involved in DMST by law enforcement could help locate youth who run away from services. Mark described the belief that arresting youth for prostitution is a way to connect them with services:

> *"NGOs view that law enforcement is out to hurt the kids, not help them. When you arrest someone you hurt them. But that is unfortunately the mechanism is to get them in the system - get a photo of a kid, lack of fingerprinting (important for helpful identification), get them into services. We don't care if they are prosecuted or not. Using prints for identification is not a bad thing. If the same girl were uncovered next week in California we would never be able to identify her as the same girl. A lot of girls go back onto street because we don't identify them as a minor. We need to do a better job of cataloging them in a way that isn't stigmatizing for identification. Protect their information - maybe purge it, but it would help us to find them when they go missing."* (Mark)

In contrast to this viewpoint, other stakeholders emphasized that Child Protective Services (CPS) should be more proactive in identifying and serving youth involved in DMST, particularly since many youth involved in DMST have multiple reports of child abuse and neglect in their histories. Theresa argued that CPS workers need more training about risk factors for trafficking including complex trauma, so they can be aware and educate parents around vulnerabilities to prevent future episodes of trafficking. She added,

> *"I think CPS needs to be at the table once the victims are ID'ed; can work with law enforcement and are a good counter balance."* (Theresa)

Another stakeholder connected to law enforcement (Jenna) agreed that CPS workers need better training about DMST in order to better collaborate in a timely fashion with law enforcement personnel who encounter minors.

d) Outcome measures

Each key stakeholder was asked to share his or her thoughts on effective ways that organizations serving youth involved with DMST could measure progress, both on an individual level and program-wide. A common challenge in identifying and measuring progress, noted by several interviewees, was that while the goal of these agencies may be to keep youth and young adults safe and away from exploitative relationships and dangerous situations, the reality is that many of their clients will return to "the life" several times during the process of getting help.

"Most of them are going to go back to the life, most of them are not going to come out of it right away. I think it is even overreaching to say they get out of the life and never go back – that's ideal but not realistic." (Jenna)

Consequently, there is a need for more nuanced outcome measures and smaller ways of measuring success and progress. Jenna explained, "Residential treatment specifically should be focused on baby steps." This section of the report will first present stakeholders' suggestions for individual-level outcome measures, followed by outcome measures for programs.

Outcome measures for individuals. In discussing ways that programs could measure whether or not individual clients are making progress as a result of service utilization, stakeholders distinguished between short-term goals, such engagement in services, and longer-term goals, such as pursuing a GED and showing a reduction in PTSD symptoms.

1) **Safety**. Despite the reservations described above in identifying a complete departure from DMST as a goal, some interviewees identified "leaving trafficking" as a significant outcome to measure. One stakeholder suggested that youth gaining some distance from exploitative, manipulative relationships as a meaningful outcome. Other stakeholders suggested that programs could monitor frequency of exploitation or duration of time spent away from "the life" as a dimension of stages of change, rather than a single "yes or no" outcome.

2) **Engagement**. Nathalie identified an initial goal for clients to be their willingness to accept and participate in services. Other outcomes related to engagement in services included identifying and working towards goals, reduced elopement from the program, and maintaining contact with the program even after leaving. Some key stakeholders observed that youth involved in DMST may be reluctant to participate in traditional therapies, but that their willingness to engage in a relationship with the therapist could be a valuable measure of their general engagement in services. Jenna added:

   "Trust is a huge thing. Even getting them to stay in the program – the fact that they are willing to stay in the program, that is a huge step – that's a success." (Jenna)

3) **Life Skills**. Stakeholders emphasized that programs can equip clients with life skills ranging from immediate crisis management to working towards long-term goals. As an example, Felicia explained, "Success could be – she stayed overnight, got clean clothes, left with number for hotline." In keeping with the recognition that progress in these programs is rarely linear, Alicia emphasized measuring the acquisition of skills necessary to support exiting the life:

   "Do you know where you can access resources when you want to get out of the life? Are they prepared to get back? Do they know how to pack a suitcase? Find transportation back to that location? Do they know where they are? These are the skills that will be necessary for them to exit again." (Alicia)

Other interviewees added that programs could measure the extent to which clients possess the social skills necessary to find and maintain safe housing and employment upon discharge, including the ability to cook and access resources in the community.

4) **Education**. Stakeholders identified engagement in school as a valuable short-term outcome measure for youth. Danielle noted that the school would ideally be a small, stable environment where youth can experience academic success. Other stakeholders mentioned educational gains, such as a diploma or college registration, or identification of future plans as meaningful educational outcomes to measure.

5) **Employment**. Key stakeholders noted that it is important for youth involved in DMST to gain job skills during the process of recovery so that they can earn money in safe, non-exploitative ways.

6) **Physical Health and Mental Health**. In addition to obtaining regular medical care, stakeholders identified several outcomes related to addressing mental health needs. Olivia listed four outcomes by which their agency measures recovery from trauma: reduction in trauma symptoms (such as flashbacks), reduction in trauma's impact on daily living, reduction in high-risk behaviors, and increase in use of positive coping strategies. Other stakeholders suggested measuring decreases in risky or self-injurious behavior, participation in mental health services, decreased substance use, and improved emotion regulation and coping skills.

7) **Connectedness.** Interviewees identified a primary goal of services to be connecting youth with a positive adult with whom the youth can form a healthy, supportive relationship. Some mentioned family reunification as a meaningful outcome of services, but added that programs would need to provide aftercare follow-up and linkage to services once youth are reunited with their families. For those situations where the goal is family reunification, Felicia noted that family outcomes would be measured in terms of the extent to which parents can convey acceptance, empathy, warmth, and understanding of the trauma behind the behavior of youth involved in DMST. Other stakeholders, like Vanessa, identified social outcomes in terms of healthy social recreational activities or the extent to which clients are able to find social support outside the program. Olivia explained that programs may succeed in establishing transformative relationships within the program setting, but an important outcome measure of success is clients' ability to build on these positive relationships to develop safe and reliable support outside the program as well.

8) **Leadership.** Olivia added that their program measures clients on their levels of self-sufficiency and ability to manifest leadership within the program.

<u>Outcome measures for programs</u>. Stakeholders also identified a number of measures by which programs can measure their effectiveness in providing services to youth involved in DMST. These include the extent to which clients' basic needs are met in terms of health care, education, shelter, and safety, among others. Another commonly mentioned outcome measure was attendance at program measured in days, as well as the extent of client enrollment in educational

or vocational programs. Jenna suggested that the frequency of referrals from other sources is another measure of a program's success over time.

Interviewees emphasized the importance of programs proactively identifying service goals and developing measures that can be used by clients and staff to measure progress towards goals. Alicia noted that this is a way for programs to hold staff accountable for program goals, such as improved resiliency or self-esteem. Another stakeholder echoed this concern, noting that organizations that serve youth involved with DMST may have potentially conflicting goals of reuniting youth with their families and building independent life skills.

Key stakeholders also emphasized that it is important for youth to be actively involved in setting their own goals, collaborating in defining success with staff, and determining the criteria by which they map their own progress at regular intervals. Alicia explained:

> *"Sometimes survivors have the best recommendations. What do they want to evaluate themselves on? Do they want to create their own evaluations to hold themselves accountable?"* (Alicia)

Felicia agreed that youth should be involved in the evaluation of services, wondering, "Were they treated with respect and not judged? They're the ones who really know." Alicia linked this element of program evaluation to individual-level outcomes, noting that if clients have concerns, a measure of both program and individual success is their ability to express their concerns, needs and wants, rather than just leaving. Additionally, at least one program utilizes external evaluators who come to the program once a year and use surveys and focus groups to allow clients to evaluate themselves and the program.

Finally, Mitchell contended that programs need to adopt a strengths-based approach in measuring outcomes that focus on youth building a strong sense of self:

> *"If you can get a kid to develop strong sense of self – who they are, where they've come from, etc. – the strength of a program that helps a kid understand that choices exist, and the kid has the ability to make those choices, that's the first order of business. Really helping kid develop skills, sense of self to not make choices that will harm them, it's really about a program that gives kids sense of self, sense of understanding that they can make their own choices and understand that they can determine that they can make their own future. If you get too caught up in over-diagnosing, that doesn't help. Has to be strengths-based. Kids need to understand they have choices and control over their lives."* (Mitchell)

Mitchell's recommendation sums up many of the recurring themes across interviews – the need for programs to maintain a strengths-based orientation and the challenges of balancing a respect for youth agency with a desire to ensure safety. This theme is also discussed by Bounds, Julion & Delaney (2015) in their study about the commercial sexual exploitation of children and the child welfare system in Illinois.

Quantitative Analysis of Child Welfare Data: Referrals Related to Human Trafficking

Overview

To provide an expansive picture of the statewide trends in reports to DCF's Division of Child Protection and Permanency (DCP&P) for youth where domestic trafficking (both labor and sexual exploitation) is alleged, we analyzed data from DCF's child welfare database (their statewide case management data system). The data we analyzed pertained to two different sources of data: (a) INITIAL REPORTS: the initial reports or referrals to DCF where domestic trafficking is alleged (CPS = 73 cases; CWS = 102 cases) and (b) ALL REPORTS: the intake records on youth, including those from the set of initial reports, in which domestic trafficking is alleged. These data also include information on subsequent reports that may have occurred after the initial report. For both sources of data, they involve reports for both Child Protective Services (CPS) and Child Welfare Services (CWS)[1]. For cases involved with CWS, they include all siblings and associated family members and not just the focal youth for whom trafficking is alleged. Therefore, CPS reports are person specific, while CWS reports may go beyond the specific child.

Our analyses are descriptive in nature and depict broad comparisons between CPS and CWS youth concerning report and case information for alleged domestic trafficking. We provide information about statewide patterns of these reports, case record information (i.e., demographics of youth), and outcomes of the allegations of the reports. All analyses were done in SPSS, version 22. For some of the analyses, there may have been missing data for a small number of the cases, resulting in marginally different sample sizes for some of the tables.

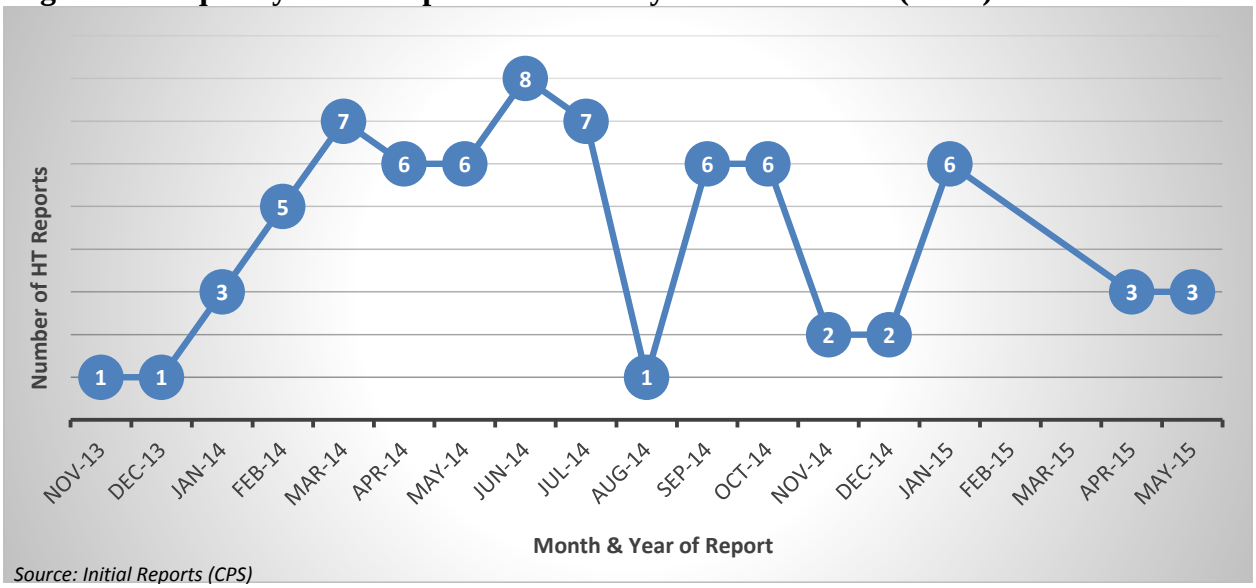
[1] Child Welfare Services or Child Welfare Assessment pertains to services for families where there is a need for assistance to ensure the basic health and welfare of a child; there is insufficient risk to justify abuse/neglect investigations.

Results

INITIAL REPORTS: ***Statewide Patterns Associated with CPS and CWS Referrals***

We begin with a broad overview of the timing of the CPS and CWs referrals associated with domestic trafficking; these varied throughout this time period. Figure 1 illustrates the number of referrals to CPS that occurred during a given month between November 2013 to May 2015. For CPS referrals, the busiest month (i.e., received most referrals) was June 2014 with a total of eight, followed by March and July 2014 with a total of seven referrals. The fewest referrals were received during November 2013 and December 2013 (each with one report per month) and August 2014, also with one report. For the remaining months, there were six referrals in April, May, September, and October of 2014 as well as six in January 2015; five referrals were filed in February 2014; three referrals in January 2014 as well as three in both April and May 2015; and lastly, two referrals were filed in November and December 2014.

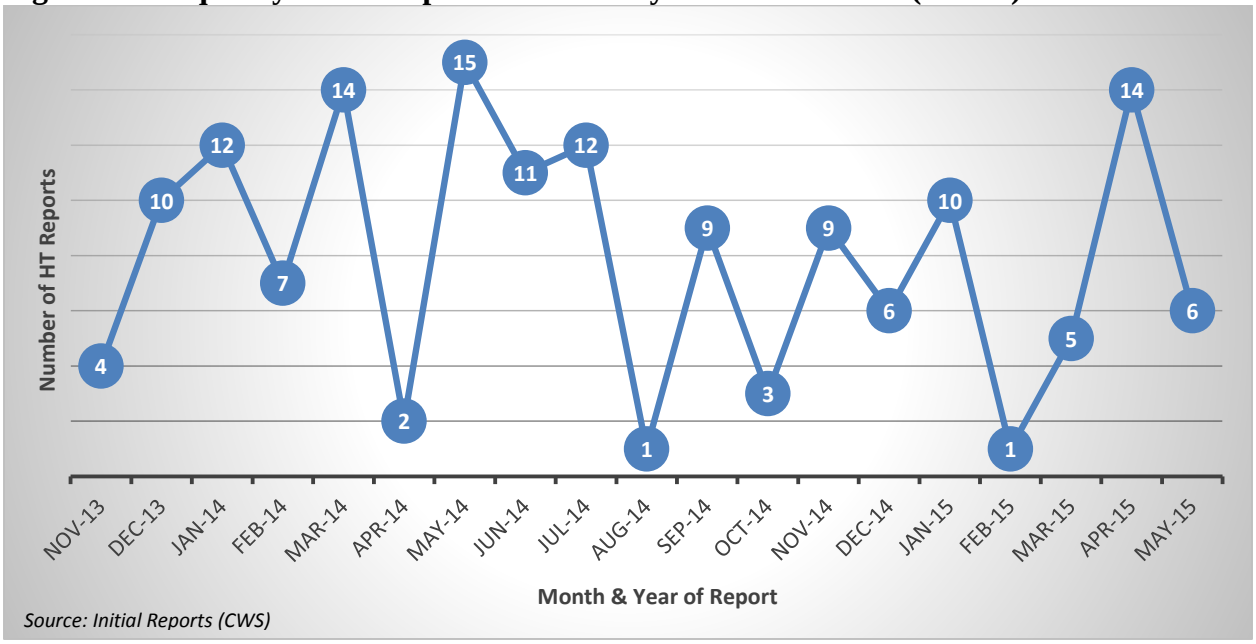
Figure 1. Frequency of HT Reports Received by CPS Over Time (N=73)



Source: Initial Reports (CPS)

Figure 2 illustrates the number of referrals that were made during a given month to CWS between November 2013 to May 2015. Overall, the busiest month was May 2014 with fifteen referrals, followed by fourteen referrals filed in both March 2014 and April 2015. The fewest referrals were received during the months of August 2014 and February 2015 (each with one report per month). For the remainder of the months, twelve referrals were filed in both January 2014 and July 2014; eleven referrals were filed in June 2014; ten referrals were filed in both December 2013 and January 2015; nine referrals were filed in both September 2014 and November 2014; seven referrals were filed in February 2014; six referrals were filed in both December 2014 and May 2015; five referrals were filed in March 2015; four referrals were filed in November 2013; three referrals were filed in October 2014; and two referrals were filed in April 2014.

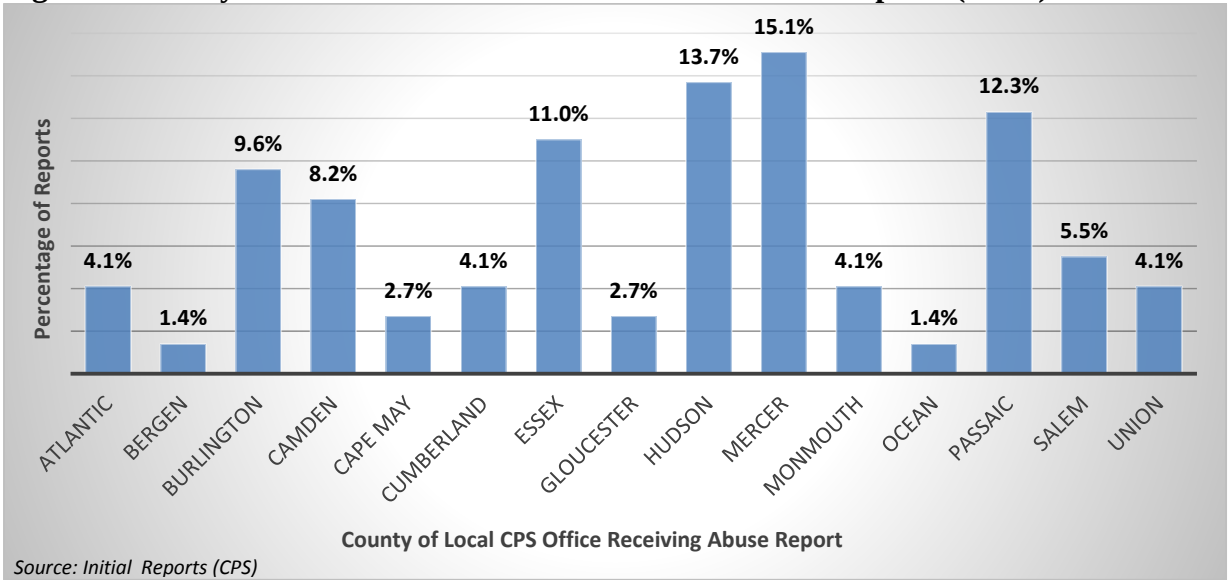
Figure 2. Frequency of HT Reports Received by CWS Over Time (N=151)



Source: Initial Reports (CWS)

The following is a broad overview of the pattern of CPS and CWS referrals in New Jersey that were associated with domestically trafficked adolescents between November 2013 through May 2015. Regarding the location of the CPS reports, the most frequent local office where referrals occurred was Mercer County (15.1%). The next most frequent source of referrals was Hudson County with 13.7%, followed by Passaic County (12.3%), Essex County (11.0%), Burlington County (9.6%), Camden County (8.2%), and Salem County (5.5%). Union, Monmouth, and Atlantic Counties each received 4.1% of the overall referrals, while Case May and Gloucester Counties received 2.7% of the referrals. Lastly, Bergen and Ocean Counties each had one case reported (1.4%) (see Figure 3).

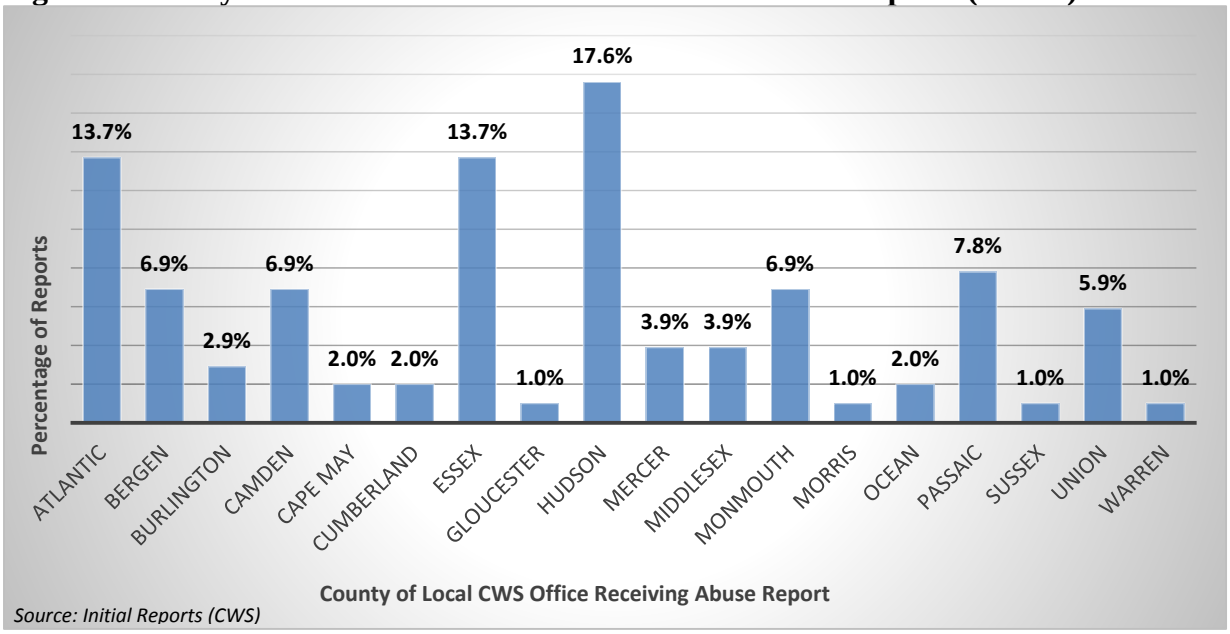
Figure 3. County of Local CPS Office Associated with Abuse Reports (N=73)



Source: Initial Reports (CPS)

As depicted in the following figure (Figure 4) of the 102 referrals to CWS during this same time period, 17.6% occurred in Hudson County. The next most frequent number of referrals occurred in Atlantic and Essex Counties, with fourteen each (each 13.7%), followed by Passaic County (7.8%), Bergen, Camden, and Monmouth Counties (each 6.9%), Union County (5.9%); Mercer and Middlesex Counties (each 3.9%); Burlington County (2.9%); and Cape May and Cumberland Counties (each 2.0%). Lastly, Gloucester, Morris, Sussex, and Warren Counties each had one case reported (1.0%).

Figure 4. County of Local CWS Office Associated with Abuse Reports (N=102)



Source: Initial Reports (CWS)

INITIAL REPORTS: *Patterns Associated with the Youth: Initial CPS and CWS Reports*

In this section we present the findings from the data on referrals to CPS and CWS that were associated with domestic trafficking allegations. For this set of findings, the data for CPS referrals pertain only to the child or youth involved in the domestic trafficking allegation. Therefore, the findings described for the CPS data are specific to the child. For the data pertinent to the CWS referrals, these include the focal child, but may also include information about siblings as well. In other words, CWS reports are not just specific to the child. In this section, for the data from both CPS and CWS referrals, the findings we describe are for the initial report only.

Youth Demographics. In Figures 5-7, we present the demographic characteristics of the youth referrals related to domestic trafficking. Overall, the majority of youth reported to both CPS and CWS were female. For both males and females, allegations concerning sexual exploitation comprised most of the referrals (80.6% of the 72 youth[2] reported to CPS; 92.2% of the 102 youth reported to CWS).

Figure 5. Gender of Youth Reported to CPS (n=72)

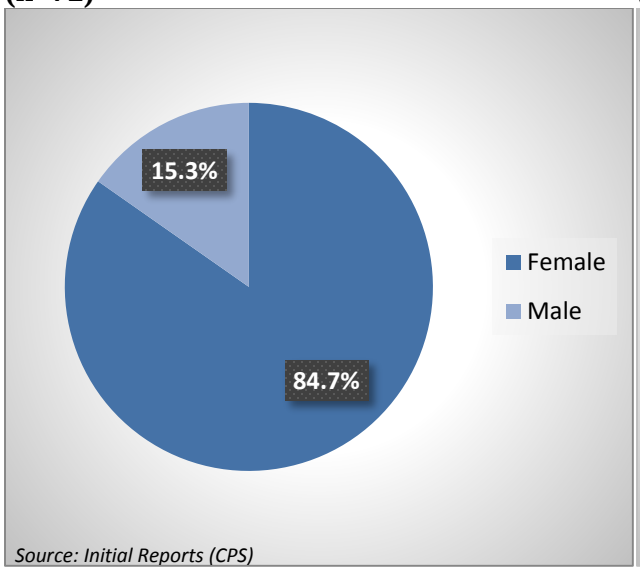
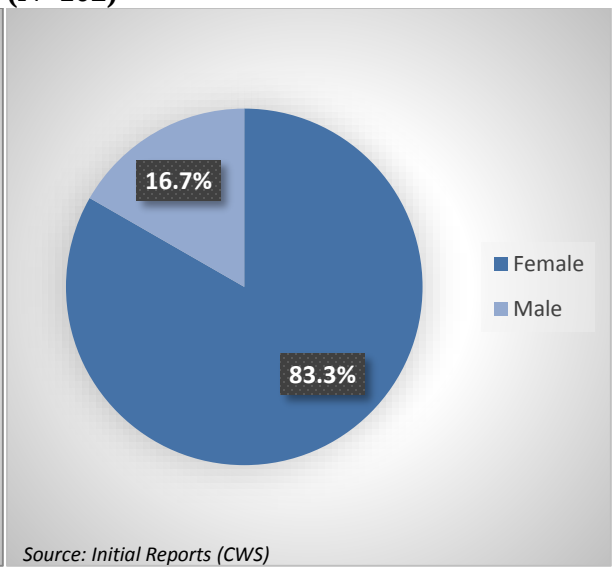


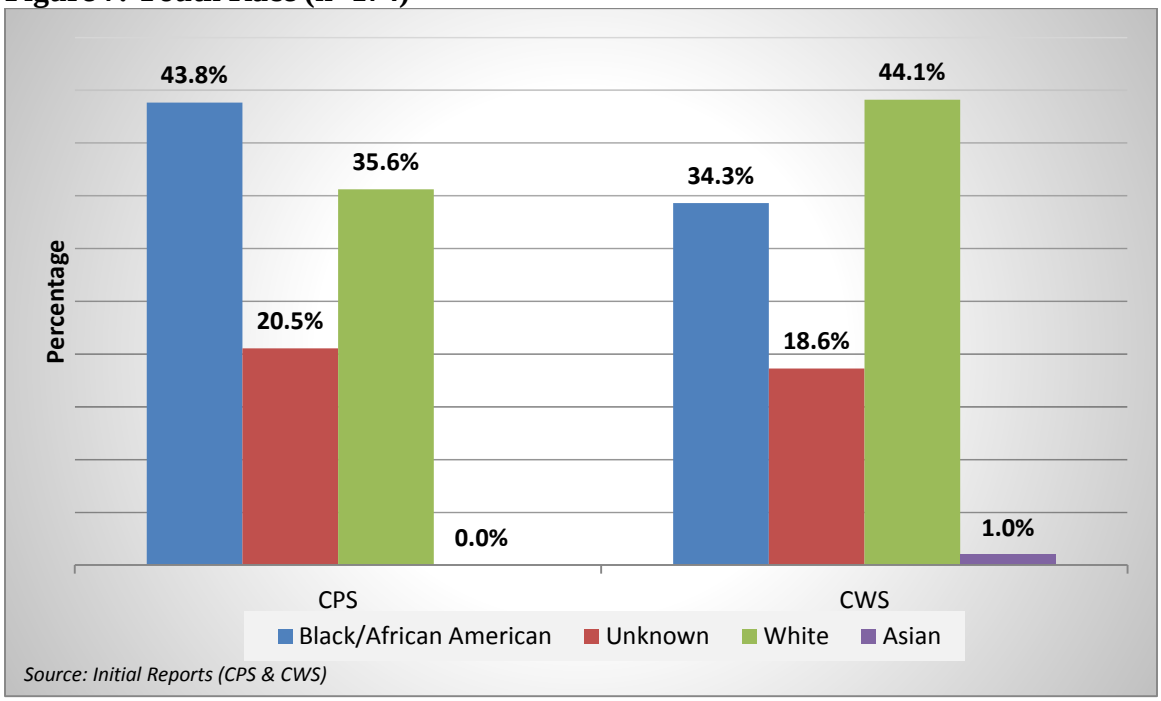
Figure 6. Gender of Youth Reported to CWS (N=102)



[2] Data were missing for one youth

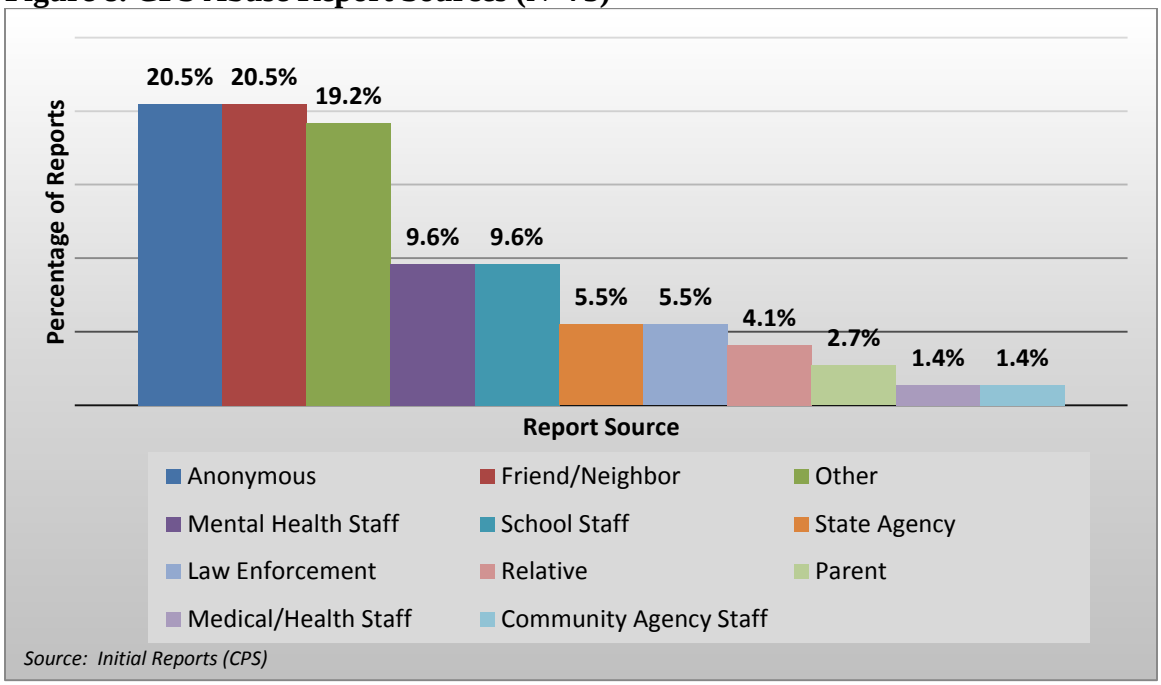
Almost half (43.8%) of youth reported to CPS were identified as Black/African American, 35.6 percent were White, and the race of 20.5% of youth was unknown. In contrast, over 40% of youth reported to CWS (44.1%) were identified as White, 34.3% were identified as Black/African American, and one youth was identified as Asian. The race of the remaining 20.6% of the CWS referrals is unknown. In addition, the average age of the youth referred to CPS for domestic trafficking was 14.7 years of age (data not shown), with age ranging from 7.11 years of age to 17.82 years of age. In contrast, for the CWS referrals for domestic trafficking, the average age of the youth was 14.1 years of age, ranging from 1.25 years to 19.98 years of age. It is important to bear in mind two aspects of CWS cases that are distinct from CPS cases. First, as discussed earlier, CWS cases are not necessarily child-specific and could encompass siblings and family members beyond the focal child. Second, referrals to CWS can be made for youth up to age 26 years.

Figure 7. Youth Race (n=174)



Referral Sources. Figure 8 highlights sources of CPS abuse referrals. The 73 total referrals were generated from a variety of sources. The two most common referral sources were anonymous referrals or a friend/neighbor (both at 20.5%). Other referral sources included mental health staff and school staff (both at 9.6%), a state agency or law enforcement (both 5.5%), a relative (4.1%), parent (2.7%), or medical/health staff or community agency staff (both 1.4%). An additional 19.2% of referrals were listed as "other" and came from a source not listed.

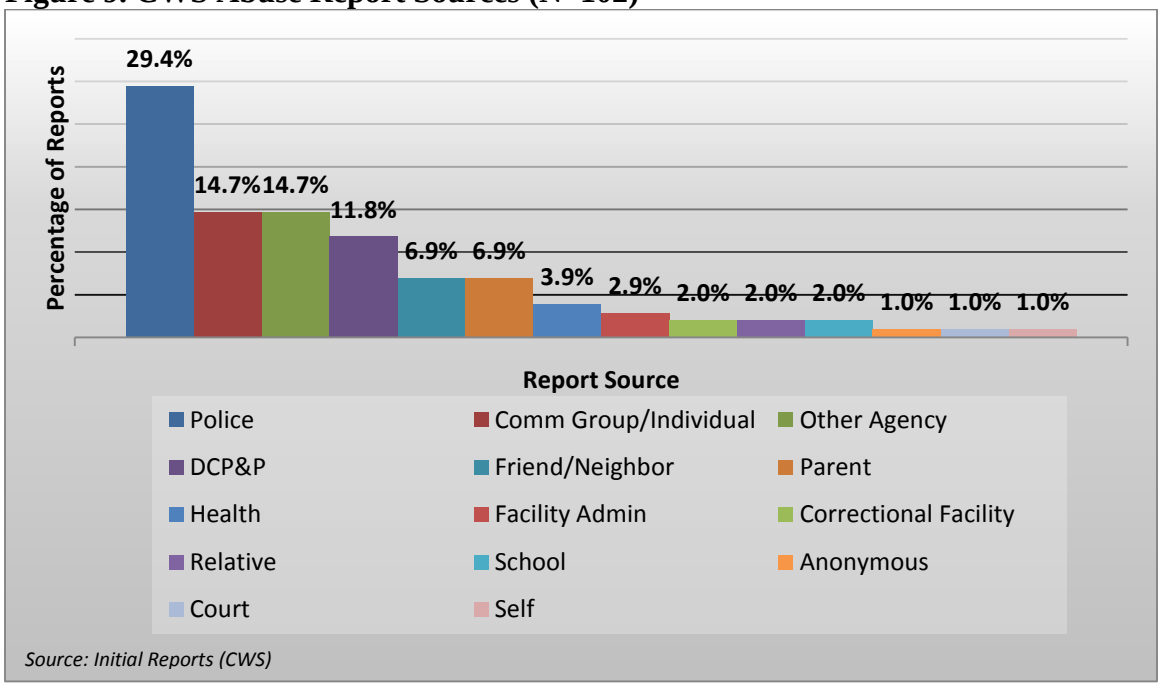
Figure 8. CPS Abuse Report Sources (N=73)



Source: Initial Reports (CPS)

Figure 9 highlights sources of CWS abuse reports. Most frequently, reports came from police (29.4%), followed by other agency and community agency group/individual, which each accounted for 14.7%. Other report sources included DCP&P (11.8%); friends/neighbors and parents (each 6.9%); health (3.9%); facility administration (2.9%); and correctional facilities, relatives, and schools (each 2.0%). Lastly, anonymous, court, and self-reports sources each made one report (1.0%).

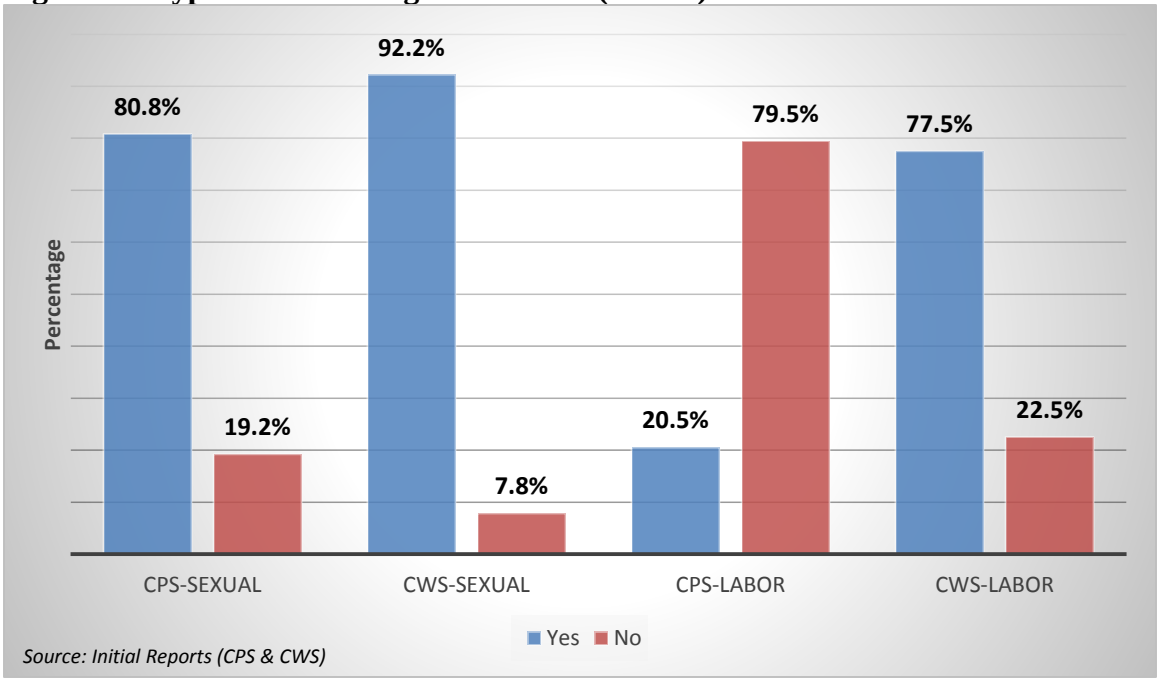
Figure 9. CWS Abuse Report Sources (N=102)



Source: Initial Reports (CWS)

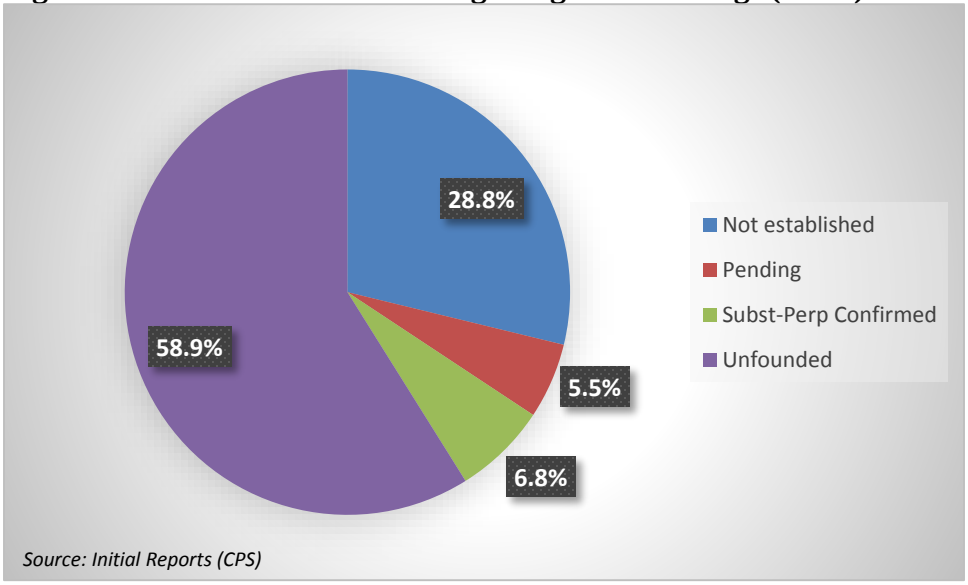
Type of Domestic Trafficking. In total there were 73 domestic trafficking cases reported to CPS during this time period. Of this total, 20.5% of cases reported included concerns of trafficking by means of labor servitude. In contrast, 80.8% of cases reported involved concerns of domestic trafficking by means of sexual exploitation.
Another 102 cases were reported to CWS due to concerns for domestic trafficking. Of that total, 22.5% of cases reported included concerns of trafficking by means of labor servitude. The majority of reported cases (92.2%) involved concerns of trafficking by means of sexual exploitation (see Figure 10).

Figure 10. Type of Trafficking in Referrals (N=175)



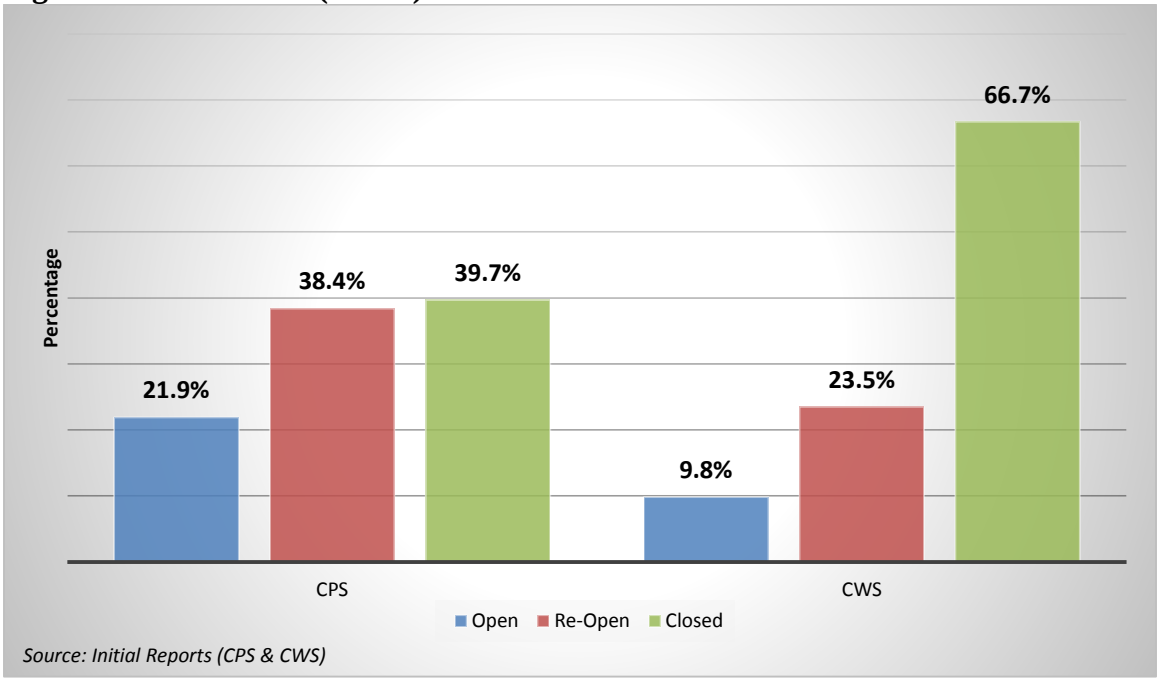
Outcome of CPS referrals. Figure 11 presents domestic trafficking allegation findings for CPS referrals (there is no parallel outcome for CWS allegations). CPS allegations can fall into one of four categories: pending, not established, substantiated – perpetrator confirmed, and unfounded. In regard to the 73 domestic trafficking allegations received by CPS, the majority were unfounded (58.9%). The next most common finding was not established (28.8%). Five allegations were substantiated (6.8%), and four reported allegations were still pending (5.5%). To provide context for how these outcomes are defined, we refer to the language in the New Jersey regulations. According to the 2013 regulations, allegation findings are categorized as: substantiated, established, not established, and unfounded. As specified in the NJ regulations, these are defined as: *substantiated* indicates that DCF has determined that enough evidence from the investigation exists to proclaim that a child IS an abused or neglected child. An allegation finding of *established* indicates that DCF has determined that the case involves abuse or neglect, yet due to aggravating or mitigating factors, the abuse or neglect does not warrant a finding of substantiated. An allegation finding of *not established* DCF has determined that child abuse or neglect did not occur, though a child was harmed or placed at risk of harm. An allegation finding of *unfounded* means that abuse or neglect did not occur and the child was not harmed or placed at risk of harm. In our reported findings, there were no findings of "established."

Figure 11. CPS Human Trafficking Allegation Findings (N=73)



Current Status of Referrals. Figure 12 presents the current case status of CPS reports and CWS reports. For close to 40% of the CPS reports, they are currently closed. An additional approximately 40% (38.4%), the cases have been re-opened, while and just over one-fifth are still opened. In comparison, two-thirds of CWS reports were closed, with 9.8% still open and one-quarter have been re-opened.

Figure 12. Case Status (n=174)



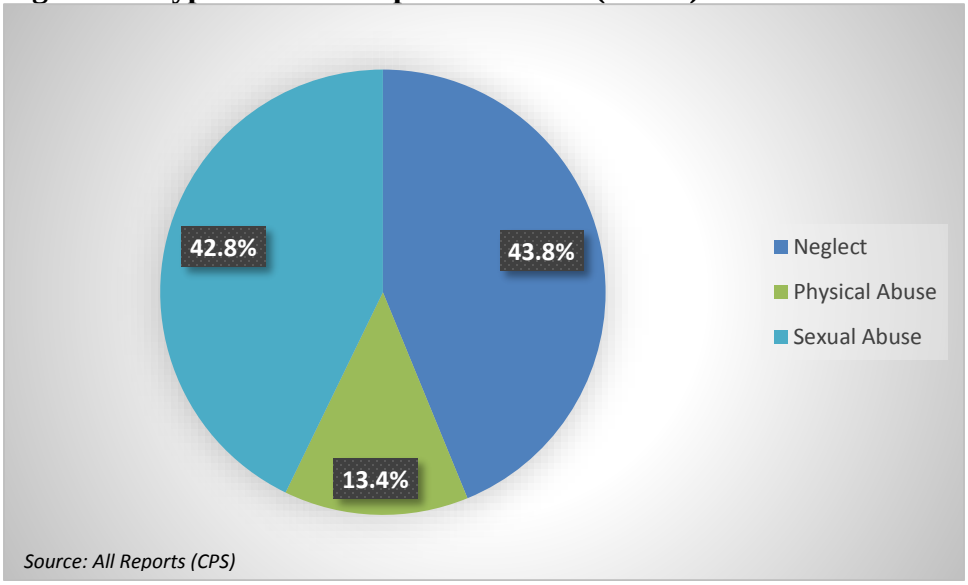
Source: Initial Reports (CPS & CWS)

ALL REPORTS: ***Patterns Associated with the Youth: All Reports to CPS & CWS for Domestic Trafficking Allegations***

In this section, we present the findings for all reports associated with alleged domestic trafficking, on or after the date of the reported domestic trafficking as described in the previous section. In this section we provide data on the maltreatment type associated with the cases, alleged perpetrators, outcomes of the investigations, and information about referrals to CWS.

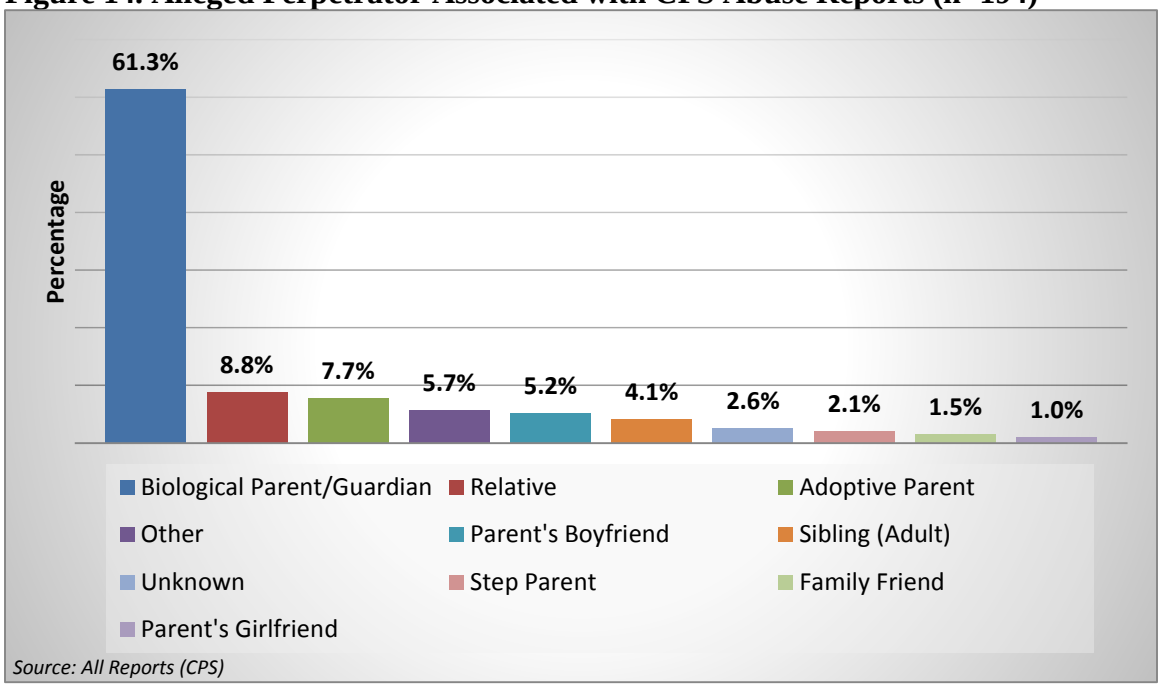
CPS Abuse Allegations. For only the CPS reports, out of 194 incidences of abuse recorded, 43.8% constituted neglect, 42.8% were for sexual abuse, and 13.4% were for physical abuse (see figure 13).

Figure 13. Type of Abuse Reported to CPS (n=194)



Across the CPS referrals related to domestic trafficking, the perpetrators of abuse varied greatly. However, the most common perpetrator was the youth's biological parent/guardian, which accounted for close to two-thirds (61.3%) of alleged perpetrators in these referrals. Other alleged perpetrators of abuse included relatives (8.8%), adoptive parents (7.7%), parent's boyfriend (5.2%), adult siblings (4.1%), step parents (2.1%), family friends (1.5%) or parent's girlfriend (1.0%). In 5.7% of cases the perpetrator was someone other than those listed above and in 2.6% of cases the perpetrator was unknown (see Figure 14).

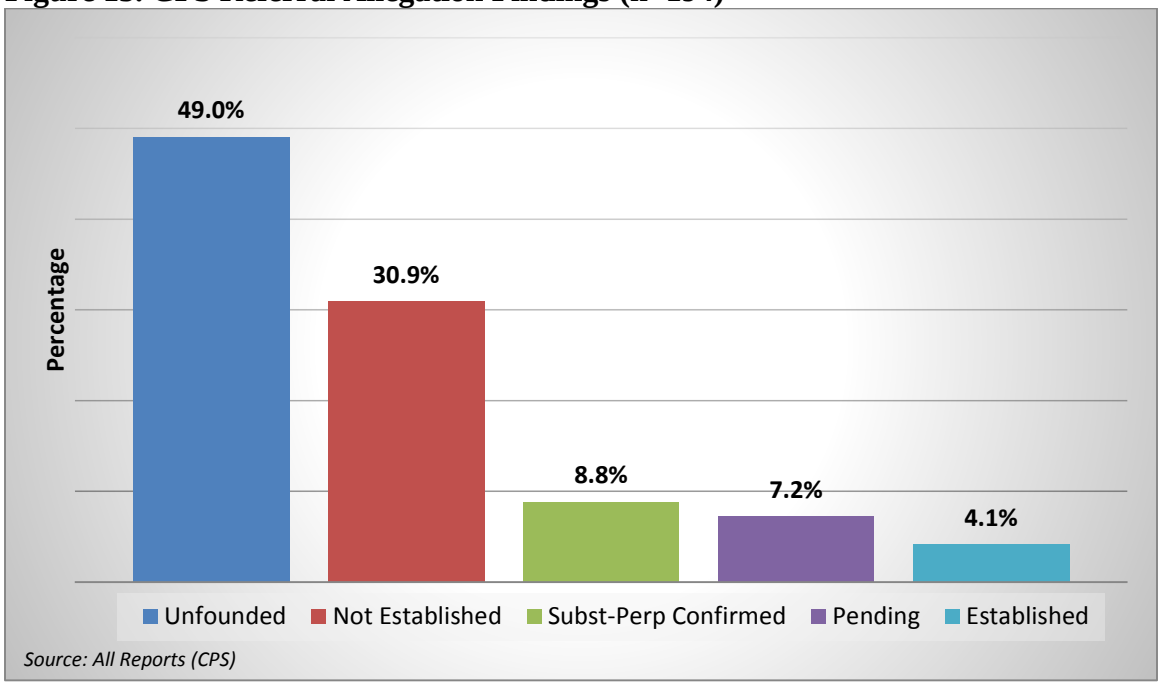
Figure 14. Alleged Perpetrator Associated with CPS Abuse Reports (n=194)



Source: All Reports (CPS)

Figure 15 presents the abuse allegation findings. Findings of an abuse allegation could fall into one of four categories: substantiated, established, not established, or unfounded. With respect to the 194 abuse allegations, almost half (49%) of were unfounded. Thirty percent of cases had a finding of not established, while 8.8% of the allegations were substantiated, and 4.1% were established. Some allegations were still pending.

Figure 15. CPS Referral Allegation Findings (n=194)



CWS Report Type. In Figure 16, we present the nature of the report associated with the intake reports for domestic trafficking. Close to two-thirds (63.2%) were for RI or a situation in which the caller provides additional information about a current service case or active investigation; about one-third (32%) were for child welfare services or assessments; 2.5% were for information and referral to services available outside of DCF; 1.3% were for CPS in addition to CWS; and 1% were for no further action by DCP&P (NAR).

Figure 16. Intake Types for CWS Reports (n=519)

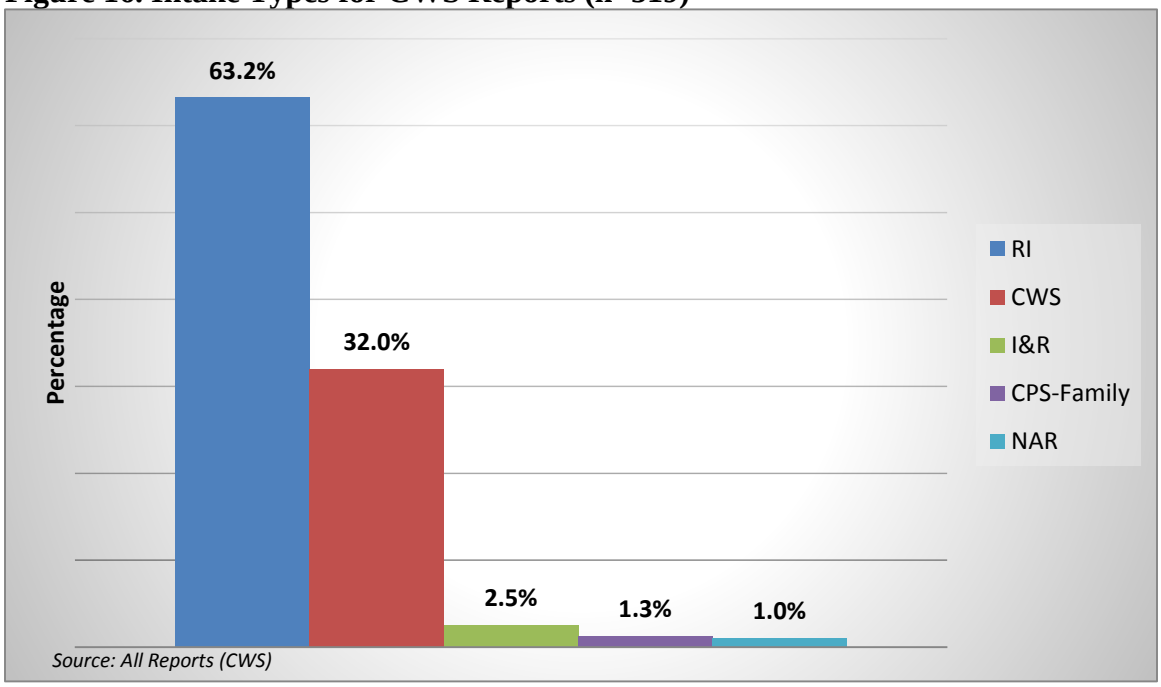
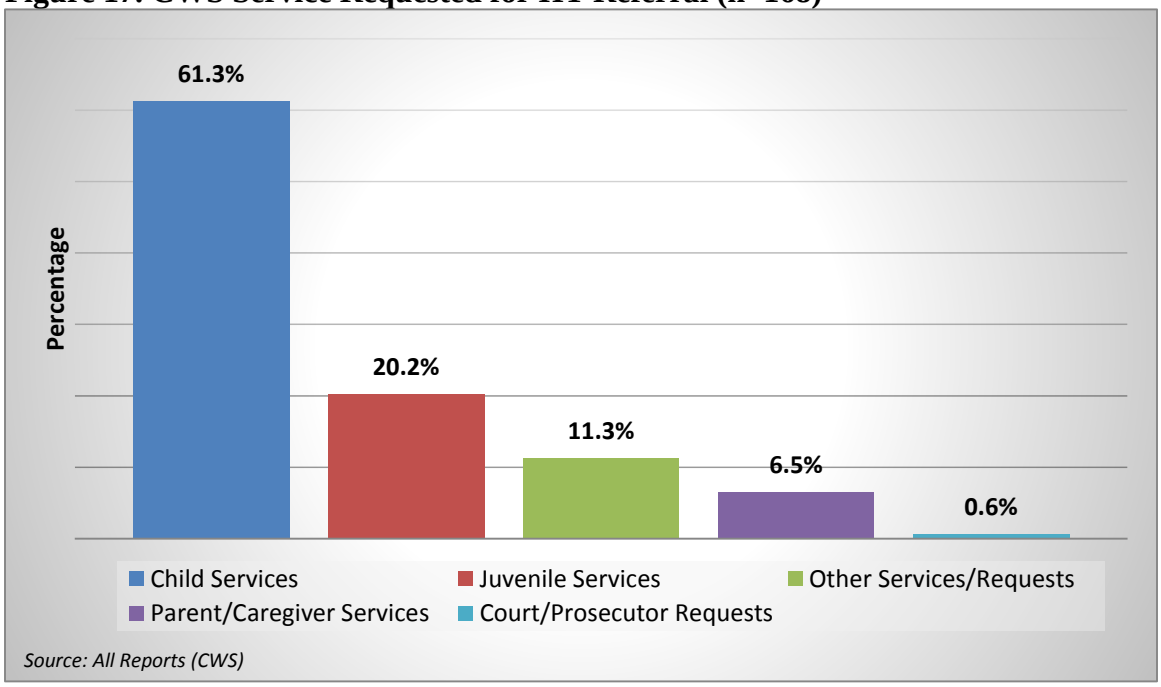


Figure 17 illustrates CWS services requested for domestic trafficking referrals. CWS service types requested consisted of the following services: child services, court/prosecutor requests, juvenile services, other services/requests, and parent/caregiver services. Of these, the vast majority of services requested were child services, which accounted for 61.3% of the requested services, followed by juvenile services 20.2%, other services/requests (11.1%), parent/caregiver services (6.5%), and one court/prosecutor request (.6%).

Figure 17. CWS Service Requested for HT Referral (n=168)



The patterns uncovered in the child welfare data reveal some noteworthy trends. For this time period, three counties had relatively higher number of refers associated with domestic trafficking: Hudson, Essex, and Atlantic counties. For referrals to CPS regarding domestic trafficking, there were increasing number of referrals in the spring and summer of 2014, perhaps due to the heightened interest in domestic trafficking following the Super Bowl in early February of 2014. Following this peak, the remaining months showed a variable pattern of reports and time of year. Some of these peak reporting periods may coincide with the onset of school. For the CWS referrals, there was an initial peak in this same time period of spring 2014, though the number of referrals quickly declined in the late spring. The remaining pattern of referrals is a bit more variable than the CPS referrals, though again some of the peak periods seem to coincide with the school schedule.

Not surprisingly, the gender of the youth associated with both CPS and CWS-related domestic trafficking referrals is predominately female. From these data we can see that most of the reports were for either African American or White youth, for both CPS and CWS referrals. Specifically, for CPS cases, more of the youth were African American, whereas for the CWS cases, White youth accounted for most of the referrals. However, it should be noted that the race of the youth was missing for approximately one-fifth of the reports.

The source of the reports, form of trafficking reported, and service needs identified vary according to CPS or CWS referrals. For the former, the most frequent sources were Anonymous, Friends/Neighbors, and Other, which do not provide much specificity about how these youth are coming to the attention of DCF. For CWS referrals, Police accounted for the most frequent referral source, followed by community individuals and Other. Our data further indicate that Labor-related trafficking is more likely associated with CWS referrals than CPS referrals. For CPS cases, sexual abuse and neglect were the most frequent identified types of alleged maltreatment; moreover, biological parents were the most frequently identified alleged perpetrator. For cases referred to Child Welfare Services, services for youth and children were the most frequently identified need.

Qualitative Analysis of Case Records

Overview

The purpose of the qualitative analysis of case records was to identify risk and protective factors that are potentially associated with youths' vulnerability to involvement in DMST. This component of the research project was completed through the review of case records of eight youth who were recently referred to a residential treatment program for domestically trafficked adolescents.

Methods

Sample: Case files of eight (8) youth were selected by the New Jersey Department of Children & Families (DCF) based on their participation in a residential treatment program for domestically trafficked adolescents. The records spanned the youths' entire involvement with DCF. The sample is comprised of youth who received both in-home and out-of-home services throughout the timeline of their case. Based on review of the case records, there was no consistent way in which the youth were identified as victims. Most frequently, DCF, in collaboration with family members and law enforcement officials, recognized red flags for trafficking; as a result of these indicators, DCF referred the youth to a DCF-funded program that provided out-of-home care for youth involved in DMST.

Data Collection: The case record review was conducted by three Masters and Doctoral level research assistants along with the project coordinator and one of the PI's on the project. Three sources of data were reviewed: 1) Electronic records within the child welfare database for each of the eight youth identified; 2) Paper files with collateral information from the youths' child welfare cases; 3) Electronic records within the Children's System of Care (CSOC) Electronic Youth Record Database for each of the eight youth. The review of child welfare data took place at a DCF facility with a DCF staff member present. The review was conducted over a period of 3 months, between December 2014 and February 2015, with each case requiring an average of 2 days for complete review. Subsequently, one week was set aside at the end of the case review to focus specifically on CSOC Electronic Youth Record notes for each case. Throughout each review research team members took notes (in accordance with DCF privacy policies) based on key pieces of information. Notes included important events in lives of the youth, as well as the lives of their family, family friends, and any other collateral information that was obtained when available and when relating to the research goals.

***Instruments*:** Three tools were initially developed to capture the data found in the case records. These were developed based on key risk factors for domestic minor sex trafficking (DMST) that were identified in the literature, and included assessment tools on: 1) child maltreatment, 2) service provision, and 3) individual and family-level risk and protective factors. Given the expansive amounts of information presented in each case record, the forms were used as a guide when recording notes from the case records.

Data Analysis: Upon completion of the case record review, the notes from each research team member were compiled, organized into and analyzed using four different formats: 1) a timeline

of all notes by month/year, 2) risk factors except abuse, 3) abuse experiences, and 4) systemic failures. For each youth, both child welfare and CSOC Electronic Youth Record records were reviewed, in conjunction with any paper files available; the data collected for each youth, based on the review of the three data sources (i.e. child welfare, CSOC Electronic Youth Record, paper copies), were combined and analyzed together. Ultimately, only the timelines were used for data analysis, as the timelines included all of the information captured in the other three formats (risk factors except abuse, abuse experiences, and systemic failures) plus additional information.

Next, four research team members conducted a comprehensive read-through of the case timelines of two youth. A coding guide was created to assist the research team with identifying recurring concepts within the timelines, such as: 1) key themes, 2) significant life events, and 3) the actions and behaviors of the youth, their families, and the service providers involved with the youth. During the process of examining the timelines several times for the different concepts, the coders also kept a separate document in which they kept record of their process of coding.

The notes compiled during this process were then utilized to generate a codebook representing codes and major themes (merging of codes). A working codebook was developed to use for coding all eight interviews within ATLAS.ti. Utilizing this codebook, three research assistants and the project coordinator coded the remaining cases, taking note of any possible new codes that were not present in the initial codebook and incorporating them into the final codebook document. Codes and themes generated from the analysis emerged from the research team's interpretation of the notes recorded as part of data collection. The most frequently utilized codes were discussed within this report.

Results

Three major themes of risk and protective factors emerged from the case record review data and were framed using an ecological framework. Hence, the themes included risk and protective factors found at: 1) the Structural Level; 2) the Family Level; and 3) the Individual Level. Each theme was comprised of multiple codes and will be described in turn.

During the case record review process, the research team took notes on the case records that DCF provided on each of eight youth in accordance with DCF privacy policies. In order to protect the confidentiality of the youth during the case record review process, all persons and places recorded in the notes were assigned a unique identifier code.

Whenever possible within this report, we included content from the notes taken during the case record review to illustrate themes and codes. We identified cases as "Case #"; however, the order of the cases reviewed was changed within this report to further protect the confidentiality of the youth. Throughout this report some direct quotes from research notes were used; they were not direct quotes from the case records themselves. Direct quotes from the notes were presented in italicized lettering, while codes are presented in quotations.

Structural Level – Risk Factors

Throughout the review, case notes revealed that there were various structural hindrances to success for the youth. These structural barriers were not identified as perpetrated by any one entity but were noted generally as factors contributing to the youth's inability to navigate away from trafficking and other risky situations.

The theme of structural issues reflected larger structural factors outside of a youth's control that may affect his or her development and included lack of permanency, poverty and/or economic stress, poor responses to mental health, and lack of providing emotional outlets to youth. This theme consisted of five codes: 1) lack of permanency; 2) poverty/economic stress; 3) poor responses to mental health; 4) poor medication regulation; and 5) lack of providing emotional outlets for youth.

One of the most frequently utilized codes was "lack of permanency." Reviewers pointed to multiple arenas where change was frequent and at times rapid. Cases highlighted the youth moving between schools, primary housing locations, therapists, identified guardians, and social workers, amongst others.

In Case 4, for example, there is a very clear reason for a change in guardianship. The notes indicated that:

> *Division removed five children from [mother]. All the children had healing burn wounds on their bodies. [One child] also had a swollen lip and black eye. [The mother] was arrested for leaving the kids home alone while she went out to get drugs – she appeared intoxicated. Children unfed, unclean. Children were placed with maternal aunt.* (Case 4)

However, the notes also indicated that over a short period of time, the children, including the trafficked youth, were moved between three caregivers over the course of 3.5 years. While this incident displays very clear and documented instances of abuse which prompted removal and placement, notes in other cases indicated a less clear rationale for some of the shifts as this note from Case 8 indicated, *[One youth] was given to paternal (not entirely clear) [sic] grandmother for custody*.

Throughout the case records, several of the youth had frequent changes in out-of-home placements. The majority of cases showed the youth being in out-of-home placement at least twice throughout the life of their case. Youth were often moved from one placement to another due to the environment not being conducive to the youth's needs (i.e., the youths' safety was compromised). One case in particular had the youth of interest and her sibling being removed from their home and placed in out-of-home care, only to be moved soon after due to men entering their room at night while they slept.

Other examples identified by the research team in their interpretation of the case records included the repeated reopening of cases. Many youth had multiple interactions with DCP&P that spanned over years indicating an ongoing concern with their wellbeing yet an inability to permanently close the case; while in other instances cases appeared to be closed out before they

were ready. For example, in Case 4 the notes stated that the youth was *displaying signs of depression and anger and is acting out in a negative manner. She is being defiant with [her grandmother] and getting into altercations with siblings.* Yet two months later, the notes indicated that the case worker had linked the youth with *all possible services and is requesting to close her case because her behavior has stabilized a great deal.*

Throughout the case notes, structural issues such as poverty and economic stress were also evident, as several families cited receiving public assistance for periods of time in the notes. Some families also found it difficult to secure basic items to meet their needs due to financial constraints. For example, the youth in Case 4 was in need of "clothing, shoes, underwear and hygiene items." In Case 2, it was noted that "Family's economic situation is affecting them – and they feel trapped and unable to move to a better area." These examples highlight how structural issues, such as poverty, impacted the youth.

Codes surrounding mental health were also frequently utilized during analysis. The research team conceptualized the codes "poor system response to mental health issues" and "medication oversight" as structural-level factors because within the notes there was a focus on the diagnosis of mental health issues and the utilization of medications to manage symptoms. As such, the focus of this response was on reducing the presence of symptoms, rather than addressing the underlying trauma triggering behavioral challenges through therapeutic interventions.

The code of "poor system response to mental health issues" referred to the various mental health diagnoses youth were given, the mechanisms in which youth received these diagnoses, and how they were treated. Each of the eight cases reviewed were coded for a mental health diagnosis. Each of the youth received at least one mental health diagnosis and the majority had multiple diagnoses. Notes pointed to frequent diagnoses from multiple providers and inconsistent plans for treatment. The research team interpreted that these diagnoses reflected a belief that mental health issues were a primary factor contributing to what the service providers' perceived as behavioral challenges, thus leaving many diagnosed with adjustment disorder, oppositional defiant disorder, and ADHD.

Similarly, "medication oversight" was also a reoccurring challenge in Cases 4 and 6. For example, in Case 6 a youth began refusing her medications because of weight gain, yet there was no acknowledgement by caseworkers of this being a legitimate concern. Youth also seemed to be placed on various medications and the way in which mental health concerns were treated seemed to vary by case. In some instances the youth would receive frequent psychological evaluations, diagnoses and medications, and yet in other cases it seemed as though not enough was being done to address the youth's mental health needs.

Lastly, the case notes also reflected a "lack of providing emotional outlets" as a challenge experienced by many of the youth. For example, in Case 1 it was noted:

> *[The youth] was hospitalized for mental health reasons. A note indicates that [the youth] she was physically and sexually abused by her brother at a young age. She said her father beats her because she is gay and she feels abandoned and alone. (Case 1)*

In Case 2, the youth had a close friend who committed suicide which greatly impacted the youth and *caused [the youth] to not have anyone to talk to.*

Structural Level – Protective Factors

There were several times throughout the cases in which the systems involved responded in positive ways. These promising responses make up the second theme under structural level factors. This theme consists of three codes: 1) utilization of assessments; 2) utilization of system interventions; and 3) utilization of therapeutic interventions.

Through analysis of positive structural factors present in the case record review, several codes emerged as most prominent within this theme. The first of these codes was "utilization of assessments." At many points, in each case, assessments were used to identify the needs of the youth and evaluate whether the services being provided to the youth were bringing about improvements. When assessments were used effectively, they provided service providers with the information necessary to better meet the needs of the youth.

Another code frequently utilized during the case record review was "utilization of system interventions." A wide array of system interventions were implemented for the youth in this case records review. In fact, during the review, at least 16 different systems were counted as being involved in at least one of the eight cases and when these systems worked together they were able to effectively intervene with the youth. Aside from the New Jersey Department of Children and Families, other frequently involved systems included members of the criminal justice system (law enforcement officials, prosecutors' offices, and the courts) and schools. For example, in Case 4, after police responded to an incident in which a man was abusing the youth, the police contacted DCP&P with concerns that the man involved may actually be the youth's trafficker. After this report was made, it appeared as though there was a greater effort by the youth's family members to keep the youth away from her trafficker.

Lastly, "utilization of therapeutic interventions" was a prevalent code throughout the analysis. There were a number of times that the youth were referred for therapeutic interventions, particularly to help them manage mental health and behavioral challenges. The focus of this code was the utilization of specific types of therapeutic interventions (i.e., trauma-focused cognitive behavioral therapy; individual counseling services).

Family Level – Risk Factors

The second major theme to emerge from the case record review was family level risk factors that impacted the domestically trafficked adolescents in the eight cases reviewed. This theme consists of three codes: 1) drug environment; 2) family factors that hinder healthy youth development; and 3) perpetration of interpersonal violence.

One identifiable risk factor at the family level "exposure to drug environments" relates to any structural influences on a youth's exposure versus a youth's or other actor's individual choice to engage in drug related activities. Most prominent throughout the cases was the selling of marijuana by non-immediate family members or romantic partners of the youth or the youth's

guardian. In other instances, this code referred to the nature of the community that the youth was residing in more generally. For instance, it was noted in Case 2:

> *Mother reports that the neighborhood [the youth] used to live in prior to the shelter is not very safe and there are a lot of drugs and violence in the area.*

Within the case record review, there were also several family factors that may have hindered healthy youth development. Content analysis revealed that the code "relational issues" was the most commonly utilized hindering family factor; it was evident in all eight cases under review. The "relational issues" code comprised a range of family dysfunction, including different forms of abuse in the family, communication issues between family members, and other forms of strife present in the family.

Next, "parenting limitations" and "parallels within the family" were also prevalent codes utilized during content analysis. In regards to parenting limitations, this family factor was present in all eight cases reviewed. Instances of parenting limitations included a lack of parenting skills, a lack of parental guidance, instability of parents/guardians, and an inability to provide support. Case 4 provides an example of a parenting factor interfering with the caregiver's ability to adequately provide for the youth in question:

> *[The grandmother] reports difficulties monitoring and disciplining [the youth]. She [the grandmother] needs assistance to improve supervision skills.* (Case 4)

Parallels within the family were often recognized. This code referred to two or more family members enduring a similar experience, such as teen pregnancy, sibling/family member delinquency, or the direct involvement of family members in sex work (i.e., involved with prostitution or transactional sex). Parallels within the family were observed in the vast majority of cases under review. Frequently, delinquency on the part of one family member was associated with delinquency of another individual in the family. For instance, arrest of a caregiver often coincided with the youth engaging in what the research team interpreted as coping behaviors, which were sometimes viewed as delinquent acts by family members and service providers. Additionally, it was not unusual to observe a younger sibling attempting to mirror the behavior of the youth:

> *In case note [the mother] states that [the youth's sibling] was just trying to act like her sister and that she wouldn't really hurt herself.* (Case 3)

Additional prominent codes included "familial legal issues," "substance use," and "health-related barriers." Recurrently, there was overlap between legal issues and substance use, as charges of possession, distribution, or usage often resulted. Health-related barriers were evidenced in several instances and impacted guardians' ability to effectively care for the youth. In one case, the guardian had severe health issues which impacted her ability to parent.

Other codes elucidated through content analysis of hindering family factors were "resistance to treatment," "lack of social support," and "avoidance/evasion coping mechanisms." Throughout the cases, resistance to treatment commonly took the form of the youth's family declining

services extended by the system, whether the target of those services was the youth or the family. Lack of social support included absentee caregivers, inability to or inefficient effort in supporting the youths' needs, or a general lack of supportive people in the youth's life. "Avoidance/evasion" was a code that conceptualized the youth's family attempting to circumvent a system intervention.

Finally, various forms of interpersonal violence were highlighted as being perpetrated on youth throughout the case record review. Each case featured multiple incidences of abuse and/or neglect. The abuse and neglect reported included physical, emotional, verbal and sexual abuse perpetrated by individuals such as grandparents, parents/caregivers, adults, cousins, siblings, peers, boyfriends/girlfriends. Codes included individual reports or "experiences of abuse or neglect," cycles for the intergenerational "cycle of abuse," and youth experiencing repeating "patterns of abuse" throughout the time featured in their case files. The "patterns of abuse" code referred to a pattern of similar abuse experienced by the youth at various points throughout their lives or abuse perpetrated by the same individual multiple times. In Case 2, there were multiple times in which the mother's intimate partners abused the youth and her siblings, establishing a repeated pattern of victimization experienced by these children:

> *[Youth's mother] has multiple boyfriends in short periods of time, will leave children alone with them after only a short period of time (of knowing the boyfriends), and the boyfriends yell at and fondle the children. (Case 2)*

In addition to the youths' direct experiences with interpersonal violence, the youth were also exposed to violence. Youth's "exposure to violence" was a code utilized to indicate when youth were witnesses to violence and/or exposed to a consequence of violence. Witnessing family violence, whether between caregivers, parents, parent and paramour, cousins, or siblings, was the most frequent type of violence the youth were exposed to.

Family Level – Protective Factors

It is important to note that there were also many family factors within the youth's case records that supported healthy youth development. These positive family factors comprise the second theme of family level factors. This theme consists of five codes: 1) shows concern; 2) attempts at compliance; 3) attempts to show support; 4) strong family bonds despite problems; and 5) attempts to remove youth from situation.

Overall, the most prevalent code was "shows concern," which referred to a display of caring for the youth as evidenced through the actions of a family member. The act of showing concern was identified in seven of the eight cases. Most often, this code was selected to illustrate cases in which a family member expressed concern about the placement of the youth (i.e., wanting the youth to be placed in a residential treatment program so that they receive the services they need). Additionally, it was common to see family members showing concern in regards to the services being offered, or not offered, to the respective youth. For example, there were numerous instances in which family members expressed their concern that a youth's current treatment plan was not effectively meeting the youth's needs. At times, this positive family factor proved the

first step in more adequately helping the youth, so it was critical that family members show concern.

The code "attempts at compliance" was the second most common positive family factor in the case record review. Attempts at compliance referred to any proactive behaviors exhibited by the youths' families, indicative of cooperation with treatment plans, assessments, or other system directives. This code was noted in seven of the eight cases reviewed. Most often, attempts at compliance were evidenced when system actions were perceived to be efficacious to a youth's family. For instance, Case 4 illustrated the youth's grandmother's attempts at compliance with a service that had proved effective for her family in the past:

> *Mobile Response and Stabilization Services (MRSS) offered but [the grandmother] declined and requested Care Management Organization (CMO) services because of positive outcomes in the past with siblings*. (Case 4)

The third code that emerged as prevalent in the case record review was "attempts to show support." Attempts to show support were recorded in six of the eight cases and were evidenced in several ways, including efforts by the youth's family members to bolster the family and/or the youth in whatever way they could. In most cases reviewed, this code presented caregivers as willing to make sacrifices to help the youth in their life circumstances. An attempt to show support appears in Case 1, in which the youth's father, who was initially resistant to his daughter's trans-status, helps her acquire hormones because the father recognizes that his daughter's mental health was suffering without them, *[The father] signed for the hormones because [the youth] was very depressed not taking them.*

"Strong family bonds despite problems" was the fourth code that appeared often throughout the case record review. This positive family factor was most commonly associated with adverse life situations affecting the youth's family that were to some degree countered by a strong connection within the family. Case 2 provided an example of strong family bonds despite problems:

> *[The youth] stated her mother drives her crazy but she loves her. Problem with mom is that she committed a lot of errors when she was young and she is trying to help her children not commit errors.* (Case 2)

Lastly, a positive family factor that emerged through the case record analysis process included attempts to "remove from situation." Attempts to remove from situation entailed any effort exhibited by the youth's family that sought to extricate the youth from a potentially harmful situation. This included voluntary relinquishment of children who were abused and neglected as well as offering information to the police that could help improve circumstances for the youth

Individual Level – Risk Factors

The final theme to emerge from the case record review was risk and protective factors at the individual level. In each of the cases that were reviewed, there were a multitude of individual factors that were viewed as hindering desired outcomes. This theme consists of six codes: 1)

avoidance strategies; 2) perceived antisocial behaviors; 3) aggression; 4) school-related challenges; 5) hypersexuality; and 6) internal challenges with gender or sexual identity.

The most common code present within this theme was "avoidance strategies," which the research team interpreted as the youth's attempts to avoid reality, events, authority figures, or conflict. Avoidance strategies were noted in each of the eight cases. A majority of the strategies used by the youth were substance use (e.g., alcohol, marijuana, ecstasy) and running away. In all of the cases the use of substances was often associated with the youth running away from home.

The second most common hindering individual factor that appeared across all of the cases was conceptualized as perceived "antisocial behaviors," including manipulation, lying, stealing, physical, and emotional harm. Many of the events and instances categorized as an antisocial behaviors overlapped with other frequently used codes such as hypersexuality, aggression, school-related challenges, poor judgment, and behaviors related to psychopathy.

The third individual factor that appeared frequently throughout all of the cases was aggression. Aggression included instances of physical violence, verbal aggression, threats, and defiance of authorities. Within the case records, the youth engaged in a variety of aggressive behaviors; in some cases, the youth were accused of bullying, in other cases the youth's refusal to follow rules was highlighted, and yet in other cases, threats of violence were noted specifically. For example, in Case 4, the youth's aggression was demonstrated through noncooperation with a judge:

> *When the judge requested the youth [to] remove her glasses but [she] refused to remove her hat … The judge then asked the youth again to remove her hat, she refused. The youth began cursing and being disrespectful and defiant…The youth was so out of control that the court ordered her to be taken to PIP (psychiatric intervention program) by the sheriff's officers. (Case 4)*

It should be noted that avoidance strategies, antisocial behaviors, and aggression were commonly discussed along with school-related challenges that each of the youth in the reviewed cases experienced. For example, each case indicated that the youth had been reported as running away or missing, which also caused many of the youth to be absent from school, as noted in the case records. Additionally, aggression and antisocial behavior correlated with suspensions from school. To cite a specific instance, the youth in Case 5 was suspended from school for stealing another student's iPod and suspended at another point in time because she had been fighting other students. Issues with academic achievement were also referenced occasionally within the notes.

Hypersexuality was the fifth recurrent individual factor noted in all of the reviewed cases. Hypersexuality included over sexualized behaviors such as possessing erotic/sexual images, posting photos of themselves in sexual positions or in the nude on social media or other websites, making sexual gestures towards others, and engaging in sexual activity at a very young age (sometimes in exchange for items of value), or dressing in sexually revealing clothing (e.g., tight, low-cut, short). These sexualized behaviors appear in all of the youth's cases at developmentally inappropriate ages. In one case that was reviewed, a youth who was 12 years old at the time stated that:

> *She has had 5 sexual partners, ranging in age from 14 to 16. She says that the most recent partner was the one that gave her chlamydia. At this point, [the youth] became aggravated and stated that she liked all of the boys and wanted to have sex with them. (Case 3)*

Although internal challenges with gender or sexual identity was the sixth and final code that emerged in only two cases, these internal challenges were particularly difficult for the youth experiencing them in Case 4. In this case, the youth was struggling with both gender and sexual identity issues prior to experiencing trafficking. In this case the school social worker attributed the youth's "acting out" to her personal challenges with her identity, which signified an acknowledgement by a service provider of the internal struggles that the youth was having. Yet, the youth was largely unsupported by her family. Though the case workers strived to connect the youth with service providers that work with the LGBT population, the options were limited within the state. As a result, the youth frequently ran away to a neighboring state to seek services and access to hormones.

Individual Level – Protective Factors

In each of the cases that were reviewed, there were several individual factors that were viewed as positive individual factors. The primary codes under this theme included: 1) coping strategies; 2) willingness of the youth to receive services; and 3) school-related improvements.

The most common positive individual factor was "coping strategies"; this code referred to adaptive and healthy coping mechanisms used by the youths that were learned strategies (e.g., breathing techniques), hobbies (e.g., sports, art), support systems, and adaptive qualities. One of the youth showed that being exposed to a combination of coping strategies had helped to offer alternative and healthier responses:

> *Before [the youth] entered [residential program], mother reported nothing worked; youth is now learning positive coping skills and reported that art, reading, writing and going outside to take a breath helps calm her down.* (Case 1)

In a majority of the reviewed cases, a "willingness of the youth to receive services" was present when the youth accepted services outright, respected limitations set by the program, suggested services or negotiated with case worker about what services they believed fit their needs.

The third positive individual factor coded was "school-related improvements." Six of the youth showed improvements in academic activities, school attendance, and participation at school. Cognitive strengths and behavior improvements were also common recurrent positive individual factors.

Other less commonly coded positive individual factors were independence as an attribute of the youth, strong interpersonal skills, having adaptive, safe, and developmentally appropriate interests, good relationships with parents, and sensitivity.

In summary, three major themes of risk and protective factors emerged from the case record review data; the themes included risk and protective factors found at: 1) the Structural Level; 2) the Family Level; and 3) the Individual Level. These themes reflect the research teams' interpretation of the data presented in the case records and were derived from the research teams' notes on the cases, rather than direct quotes from the cases themselves.

Limitations

Although this study provided insight into best practices for working with youth involved with DMST in the State of New Jersey, there are several limitations to the research. First and most significantly, absent from this study are the voices of the youth who were at-risk for or experienced DMST directly. Rather, information regarding youths' experiences with DMST came from service providers, as part of key stakeholder interviews, case records, and administrative data. As a result, the findings represent service providers' perceptions of the youths' needs, rather than responses from the youth themselves. Future research could build on these findings to solicit the voices of youth themselves regarding their experiences in multiple systems of care.

Second, the review of case records required that the research team review the notes of others and in some cases make interpretations based only on the information that was recorded. As such, the case record reviews reflect only the information that the service providers viewed as worth documenting, providing only one of several possible perspectives on these complex case histories.

Third, the nature of this study was exploratory in nature. Although quantitative data was analyzed, the dataset was cross-sectional and did not illustrate changes over time. Future longitudinal research could track youth over time to learn more about factors that affect their entry into and exit from DMST.

Lastly, the data utilized in this study were drawn from youth known to DCF as being either at-risk for DMST or having experienced DMST directly. Therefore, we are unable to determine if the characteristics of these youth are similar or different from those who have not been identified within the system but may still be vulnerable to involvement with DMST. Similarly, given that all the data in this study came from one state, the results of this study may not be applicable to other states with different constellations of risk and protective factors for DMST.

Recommendations

The overall goal of this exploratory study was to identify best practices for working with survivors of domestic minor sex trafficking in NJ. To achieve this goal, the project had four aims: 1) Determine best practices for working with youth involved with DMST; 2) Identify risk and protective factors that may make youth more vulnerable to involvement in DMST; 3) Develop recommendations on best practices for youth involved with DMST based on a review of the literature and findings from primary data collection and analysis; and 4) Identify next steps for practice, policy, and future research. The recommendations presented below emerged from analyses collected from four data sources: 1) a comprehensive review of the literature; 2) interviews with 20 key stakeholders whose work provides them with a unique vantage point on the needs and experiences of survivors of DMST in New Jersey; 3) a quantitative analysis of child welfare data for youth where domestic trafficking (both labor and sexual exploitation) is alleged; and 4) a review of the case records of eight youth selected by the New Jersey Department of Children & Families (DCF) based on their participation in a residential treatment program for domestically trafficked adolescents. The recommendations presented below emerged from the results of analyses from all four data sources collectively.

The recommendations suggested below are for all personnel tasked with working with youth vulnerable to or survivors of DMST, including staff from DCP&P, CSOC, and all DCF affiliates, as well as individuals from the fields of law enforcement, criminal justice, mental health, and education. We classify these personnel from different agencies as "service providers" or "providers." These terms also include reference to staff from DCF.

Recommendation #1: Continue to build on becoming trauma-informed by utilizing a strengths-based, empowerment approach.

While DCF has made concerted efforts to incorporate trauma-informed practices into case management and service provision, it is important that all personnel tasked with working with this population, from DCF staff to contracted agencies and service providers be trained on how to utilize a strengths-based, empowerment approach. Interviews with stakeholders echoed findings in the literature, which recommend ensuring that all levels of an organization – from administration to front-line staff – are trained to provide trauma-informed services in a way that avoids retraumatizing survivors of trafficking. Empowerment approaches include actively soliciting the input of clients, respecting the decision-making capacities of clients, and providing services in a strengths-based and nonjudgmental way. Where possible, service providers should work with youth to identify goals that the youth would like to work toward. The process of goal-setting can be empowering and also allows service providers to have more tangible ways of measuring success, particularly because leaving the life can be a non-linear process.

Additionally, stakeholders emphasized repeatedly the importance of service providers, law enforcement, educators, child protection workers and all other adults who may encounter youth involved in DMST to be knowledgeable and empathic regarding the intense psychosocial traumas that youth involved in DMST have endured. This knowledge includes the nature of complex trauma, common emotional and behavioral reactions to trafficking and best practices

for professional responses, the non-linearity of progress in this population, and cultural sensitivity around using nonjudgmental language.

As part of trauma-informed services, service providers should pay attention to aspects of physical and emotional safety, including the utilization of respectful language, the creation of a comfortable environment (both interior and exterior), and the honesty of service providers. Emotional safety is also an important aspect with special attention given to diagnoses given to these youth. The results indicated at the number of diagnoses that vulnerable youth receive is very high; additionally, there were issues with the effectiveness and side effects of psychotropic medications. Specifically, clinicians should dismiss old diagnoses in exchange for new ones, as to provide more clearly delineated diagnoses (Narendorf, Bertram, & McMillen, 2011).

Finally, organizations should establish proactive rather than reactive responses to youth vulnerable to DMST. While additional research is needed on the factors that contribute to a youths' victimization, a wide array of risk factors are already known. As such, service providers can use these known factors to "flag" youth who are at-risk for trafficking and provide support services and trafficking education.

Recommendation #2: Foster a work environment that supports the professional development and self-care of staff working with youth involved with DMST.

DCF should continue to develop training opportunities and establish protocols which encourage providers to support ongoing professional development and self-care for all staff. Transformational relationships between adults and youth are key to providing effective trauma-informed services. From across the interviews, stakeholders emphasized the vital importance of healthy relationships between adults and youth involved in DMST. The organizational climate that fosters such transformational relationships is one where staff are rigorously vetted, regularly trained, paid appropriately and encouraged to take care of themselves in order to be able to support clients through a difficult journey of recovery.

To encourage such relationships, it is crucial that providers invest in their staff. Professional development opportunities for service providers should be ongoing. Training is needed on professionalism so that providers understand how to interact with and support youth, as well as on topics related to complex trauma, secondary trauma, and self-care. Providers need to genuinely care for youth and provide support. They also need to be competent of particular needs of population and have adequate knowledge and skills to be effective. Hence, it is important to hire providers or staff who are well-vetted and experienced with working with survivors of DMST; should such a pool of staff not be available, then recruit staff who are experienced working with survivors of interpersonal violence.

Additionally, there should be organizational policies that are clearly defined and understood among all staff – particularly surrounding the exchange of confidential information (when appropriate) and how to collectively and appropriately respond in crisis situations (i.e., youth running away). Other policies and protocols are needed to ensure continuity of care as youth move around – especially with regard to psychiatric care.

Administrators and supervisors must also pay attention to the self-care needs of staff, especially for those working directly with youth and/or trauma survivors. Strategies to address these concerns include providing mental health services for staff, continuing education programs, and orientations for new staff. Further, providers should have opportunities to participate in regularly scheduled supervisory sessions in which they are provided with safe, supportive spaces to discuss challenging cases and process the emotional impact of such cases.

Recommendation #3: Recognize and respond to the heterogeneity of the population.

There are multiple routes into sexual exploitation (grooming, peers, internet, gangs). Youth may have diverse experiences based on a number of factors, including ethnicity, gender, and socioeconomic status, as these factors may shape the youths' life experiences, access to resources, and also influence the youths' perceptions of sex work and sexuality. Further, research has found that youth belonging to some ethnic or sexual minority groups may be more vulnerable to experiencing trafficking. For example, some studies have suggested that African American youth may be at higher risk for trafficking due to structural inequalities (Holger-Ambrose et al., 2013; Reid & Piquero, 2014). While results from the analysis of child welfare data were varied, 43.8% of the initial CPS reports were for youth who identified as African American/Black, as were 34.3% of initial CWS reports. As such, service providers working with youth should engage in culturally sensitive practices that are sensitive to the unique needs of each youth. Providers should receive training on cultural competency and oppression to gain a better understanding of how this impacts the youth; staff could also educate youth on these areas, something that GEMS includes in their services to youth. Further, services should encourage reflexivity around attitudes toward adolescent sexuality (Brodie et al., 2011).

Additionally, current service providers for domestically trafficked adolescents in NJ seemed most equipped to serve female victims. Less is known about the identification and assessment of male and transgender youth, as well as their particular needs and experiences moving through systems. For example, in our review of the eight identified cases, one individual was trans-identified. Based on the research teams' interpretation of the case records, it seemed as though neither the youths' family nor service providers were able to meet her particular needs. Additionally, it did not seem like caseworkers were particularly sensitive to her transgender status. As a result, the youth ran away to a neighboring state to gain access to resources unavailable to her in New Jersey. In instances where service providers did try to meet the youths' needs, they encountered barriers due to the limited service options available in New Jersey. Hence, there is a need for more culturally-specific response for male and transgender victims of trafficking**.**

Recommendation #4: Strengthen protective factors for youth

Healthy relationships can serve as an important protective factor for youth. Research has found that family support plays an important role for youth in in the child welfare system, particularly those in care (Collins, Spencer, & Ward, 2010). Collins, Paris, & Ward (2008) reviewed a series of studies on youth transitioning from foster care and found that between 17% and 54% of youth returned home to live with their families after leaving care, which illustrates the important role that familial support plays for vulnerable youth. For this reason, service providers should strive

to strengthen, if not maintain, youths' relationships with family as much possible. However, family members are not the only individuals who can provide support to youth. Relationships with positive adult role models and peers can also play an important role in the lives of youth.

In addition, formal supports also play an important protective function for youth. An important function of formal supports is the modeling of healthy relationships, which is a key element to trauma-informed care. While some of this modeling will be done in formal counseling sessions, it can also be done informally through day-to-day interactions with you. For example, service providers can establish realistic expectations of how they can assist youth and then actively work with youth to meet these expectations. Further, service providers should consistently engage youth with transparency, honesty and reliability. These types of interactions demonstrate that there are adults whom the youth can trust.

Within this study, positive coping strategies emerged as a protective factor for youth. Service providers can help youth develop positive coping strategies through a number of formal and informal interactions. Formal resources, such as counseling sessions and art therapy, provide youth with more structured spaces to learn how to express themselves and cope with their trauma. However, youth can also be encouraged to engage in unstructured activities such as writing poetry or music as mechanisms for emotional expression.

Recommendation #5: Develop a continuum of services for all youth vulnerable to DMST.

In order to best meet the needs of youth vulnerable to DMST, a continuum of services must be available within the State of New Jersey. Included in this continuum would be a system for screening and identifying at-risk youth, as well as having services available for youth who screen positively for being at-risk or currently involved in DMST.

Prevention programs should be in place for youth who are at-risk for DMST. These programs should provide education about trafficking and challenge unhealthy attitudes about the commercial sex industry, educate girls on recruitment tactics, and provide youth with information regarding additional resources that may be available to them.

For youth currently involved in DMST, a wide range of services should be available to meet the youth where they are. Examples of services include a drop-in center, short-term residential treatment for youth in crisis, and long-term residential care for youth who have been out of the life for extended periods of time. Clawson & Goldblatt Grace (2007) developed a research brief that outlines currently known best practices for serving victims of domestic minor sex trafficking in residential treatment facilities. This brief can also serve as a guide in the development of such programs. Because service provision in this field is still relatively new, best practices for service delivery still need to be identified. As such, all services being offered to this population should be evaluated for effectiveness.

Recommendation #6: Ensure collaborations between providers are comprehensive and have established policies and protocols to be successful in working with survivors of DMST.

Stakeholders agreed that the myriad presenting problems of youth involved in DMST are too complex for any one agency to tackle on their own. They agreed that it is crucial for service providers to cultivate good working relationships with organizations that provide services they cannot offer, and then work to maintain those relationships over time with regular communication. A challenge for collaboration is that some key service providers for youth involved in DMST – such as mental health agencies and law enforcement – may have quite different perspectives and approaches to working with this population, which makes the work of cultivating relationships all the more important.

As such, providers must maintain clear channels of communication within and across agencies. Stakeholders emphasized that not only is this necessary for successful collaboration, but it also models honest communication to clients emerging from exploitative relationships grounded in deception. Additionally, those working with these youth must act as a steward to those in other systems that are not as well-versed in trafficking. From our evaluation, we encountered individuals, who may have been more peripheral to DMST, lacked the knowledge of proper terminology. Therefore, it is important that inter-agency interactions and usage of terms is led by agencies working directly with victims and survivors with correct and consistent language included in all documentation and communications.

Recommendation #7: Pursue more research to fully recognize the challenges youth involved with DMST face.

Several areas for further research were identified throughout the evaluation process including research that sheds light on the needs of the DMST population. Specifically, research is needed to explicitly address the issues of gender and ethnicity and further explore the unique experiences of transgendered youth. Exploratory research is also needed on the service needs of youth involved in labor trafficking.

Additional research and attention must also be given to the environments in which these youth reside. Identifying and addressing the positive and negative environmental and family factors might help identify youth at risk of being recruited into trafficking. Prevention efforts could be focused on employment opportunities for youth including job training and further educational opportunities so that at-risk youth are not easily recruited into trafficking. Other efforts could focus on addressing intergenerational abuse within the family with support services available to provide as much permanency as possible for at-risk youth. Further research is needed on how best to identify youth at risk of being trafficked along with what services are needed to prevent youth from being recruited.

Finally, research is needed to determine best practices on providing services for youth, as well as identifying best practices for supporting staff working with this population. This includes conducting program evaluations to identify evidence-based practices that effective when working

with this population. Additional research is also needed on the impact of secondary trauma on staff working in this area.

Recommendation #8: Utilize two risk assessment tools for DMST, with one designed to assess for initial vulnerability and a second for identifying indicators of trafficking.

Due to the complex nature of DMST, two unique risk assessment tools must be utilized in order to effectively assess for varying stages of DMST, particularly 1) initial vulnerability or factors that make youth vulnerable to be recruited into trafficking and 2) indicators of trafficking or when youth are under the control of a trafficker. The tool that was drafted as part of this project (See Appendix A) illustrates particular areas that could be assessed for these stages of risk. While some assessments have been developed to identify indicators of trafficking, to the research teams' knowledge there are no tools that assess for initial vulnerability.

A limitation of the tool developed as part of this project, as well as some of the other tools that have been developed to identify indicators of trafficking, is that they are not validated. As a next step, further research is also needed to validate the risk assessment tool that was developed for youth vulnerable to trafficking; included in that validation should be interviews with youth to learn about their vulnerability to recruitment into DMST.

References

A 21 Campaign. (n.d). *Signs of human trafficking.* Retrieved from https://neutrinodata.s3.amazonaws.com/a21/userimages/SignsofHumanTrafficking-2014.pdf

Altena, A. M., Brilleslijper-Kater, S. N., & Wolf, J. R. (2010). Effective interventions for homeless youth: A systematic review. *American Journal of Preventive Medicine, 38*(6), 637-645.

Anti-Slavery International. (2005). *Protocol for identification and assistance to trafficked persons and training kit.* London, United Kingdom: http://www.antislavery.org/includes/documents/cm_docs/2009/p/protocoltraffickedpersonskit2005.pdf

Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth, 17*(3), 17-21.

Berckmans, I., Velasco, M. L., Tapia, B. P., & Loots, G. (2012). A systematic review: A quest for effective interventions for children and adolescents in street situation. *Children and Youth Services Review*, *34*(7), 1259-1272.

Black, P. J., Woodworth, M., Tremblay, M., & Carpenter, T. (2012). A review of trauma-informed treatment for adolescents. *Canadian Psychology/Psychologie Canadienne*, *53*(3), 192-203.

Bounds, D., Julion, W. A., & Delaney, K. R. (2015). Commercial sexual exploitation of children and state child welfare systems. *Policy, Politics & Nursing Practice, 0*(0), 1-10.

Brodie, I., Melrose, M., Pearce, J. J., & Warrington, C. (2011). Providing safe and supported accommodation for young people who are in the care system and who are at risk of, or experiencing, sexual exploitation or trafficking for sexual exploitation: University of Bedfordshire.

Brunovskis, A. & Surtees, R. (2012). *Out of sight? Approaches and challenges in the identification of trafficked persons.* Norway: Fafo & Nexus Institute. Retrieved from *http://www.fafo.no/pub/rapp/20255/20255.pdf*

Casey Family Programs (n.d.). Traffic stop: A discussion about child welfare and judicial strategies for preventing juvenile sex trafficking and helping its survivors. Retrieved from: http://sharedhope.org/wp-content/uploads/2014/08/Traffic-Stop-FINAL.pdf.

Clawson, H. J. & Dutch, N. (2008). *Identifying victims of human trafficking: Inherent challenges and promising strategies from the field.* Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Retrieved from http://ncfy.acf.hhs.gov/sites/default/files/docs/19726-Identifying_Victims_of_Human_Trafficking.pdf

Clawson, H. J., Dutch, N., Solomon, A., & Goldblatt Grace, L. (2009). *Human trafficking into and within the United States: A review of the literature.* Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Retrieved from http://aspe.hhs.gov/hsp/07/humantrafficking/litrev/

Clawson, H. J., & Goldblatt Grace, L. (2007). Finding a path to recovery: Residential facilities for minor victims of domestic sex trafficking *Human trafficking: Data and documents*, 10.

Clayton, E. W., Krugman, R. D., & Simon, P. (2013). *Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States*: National Academies Press.

Colby, I. (2011). Runaway and throwaway youth: Time for policy changes and public responsibility. *Journal of Applied Research on Children: Informing Policy for Children at Risk, 2*(1), Article 4.

Collins, M. E., Paris, R., & Ward, R. (2008). The permanence of family ties: Implications for youth

transitioning from foster care. *American Journal of Orthopsychiatry, 78*(1), 54-62.
Collins, M. E., Spencer, R., & Ward, R. (2010). Supporting youth in the transition from foster care: Formal and informal connections. *Child Welfare, 89*(1), 125-143.
Cook, A., Spinazzola, P., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., . . . van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390-398.
Countryman-Roswurm, K. & Bolin, B. L. (2014). Domestic minor sex trafficking: Assessing and reducing risk. *Child and Adolescent Social Work Journal, 31*(6), 521-538.
Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training, 41*(4), 412-425.
Covenant House. (2013). *Homelessness, survival sex and human trafficking: As experienced by the youth of Covenant House New York.* New York, NY: Covenant House New York. Retrieved from http:/traffickingresourcecenter.org/sites/default/files/Homelessness%2C%20Survival%20Sex%2C%20and%20Human%20Trafficking%20-%20Covenant%20House%20NY.pdf
Department of Health and Human Services (n.d.). Resources: Identifying and Interacting with Victims of Human Trafficking. Retrieved from Rescue and Restore Victims of Human Trafficking website: http://www.acf.hhs.gov/programs/orr/resource/rescue-restore-campaign-fact-sheets
Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*(4), 461-477.
Estes, R. J. & Weiner, N. A. (2001). *The commercial sexual exploitation of children in the U.S., Canada and Mexico.* Philadelphia, PA: University of Pennsylvania, School of Social Work, Center for the Study of Youth Policy.
GEMS. (2014). Direct Intervention. Retrieved from: http://www.gems-girls.org/about/what-we-do/our-services/intervention
Gillespie, A. A. (2002). Child protection on the internet – challenges for criminal law. *Child and Family Law Quarterly, 14*(4), 411-426.
Hardy, V. L., Compton, K. D., & McPhatter, V. S. (2013). Domestic minor sex trafficking: Practice implications for mental health professionals. *Affilia: Journal of Women and Social Work,* 28(1), 8-18.
Hickle, K. E., & Roe-Sepowitz, D. E. (2014). Putting the Pieces Back Together: A Group Intervention for Sexually Exploited Adolescent Girls. *Social Work with Groups, 37*(2), 99-113.
Hodge, D. R. (2014). Assisting victims of human trafficking: Strategies to facilitate identification, exit from trafficking, and the restoration of wellness. *Social Work, 59*(2), 111-118.
Holger-Ambrose, B., Langmade, C., Edinburgh, L. D., & Saewyc, E. (2013). The illusions and juxtapositions of commercial sexual exploitation among youth: Identifying effective street-outreach strategies. *Journal of Child Sexual Abuse, 22*(3), 326-340.
Hopper, E. (2004). Underidentification of human trafficking victims in the United States. *Journal of Social Work Research and Evaluation, 5*(2), 125-136.
Institute of Medicine & National Research Council of the National Academies (2014). *Confronting commercial sexual exploitation and sex trafficking of minors in the United States: A Guide for Providers of Victim and Sup-port Services.* Washington, DC: National Academies Press. Retrieved from http://www.nap.edu/catalog.php?record_id=18798
Johnson, P., Wistow, G., Rockwell, S and Hardy, B. (2003). Interagency and inter-professional collaboration in community care: the interdependence of structures and values. *Journal of Inter-professional Care, 17*(1), 69-83.

Kagan, R., & Spinazzola, J. (2013). Real Life Heroes in residential treatment: Implementation of an integrated model of trauma and resiliency-focused treatment for children and adolescents with complex PTSD. *Journal of Family Violence, 28*(7), 705-715.
Kalergis, K. I. (2009). A passion practice. *Affilia: Journal of Women and Social Work, 24*(3), 315-324.
Kennedy, A. C., Agbényiga, D. L., Kasiborski, N., & Gladden, J. (2010). Risk chains over the life course among homeless urban adolescent mothers: Altering their trajectories through formal support. *Children and Youth Services Review, 32*(12), 1740-1749.
Kennedy, M. A., Klein, C., Bristowe, J. T., Cooper, B. S., & Yuille, J. C. (2007). Routes of recruitment: Pimps' techniques and other circumstances that lead to street prostitution. *Journal of Aggression, Maltreatment & Trauma*,*15*(2), 1-19.
Kidd, S. A., Miner, S., Walker, D., & Davidson, L. (2007). Stories of working with homeless youth: On being "mind-boggling". *Children and Youth Services Review, 29*(1), 16-34.
Klatt, T., Cavner, D., & Egan, V. (2014). Rationalising predictors of child sexual exploitation and sex-trading. *Child Abuse & Neglect, 38*(2), 252-260.
Lalor, K., & McElvaney, R. (2010). Child sexual abuse, links to later sexual exploitation/high-risk sexual behavior, and prevention/treatment programs. *Trauma, Violence, & Abuse, 11*(4), 159-177.
Lebloch, E. K., & King, S. (2006). Child sexual exploitation: A partnership response and model intervention. *Child abuse review, 15*(5), 362-372.
Macias-Konstantopoulous, W. L., Munroe, D., Purcell, G., Tester, K., Burke, T. F. (2015). The commercial sexual exploitation and sex trafficking of minors in the Boston Metropolitan Area: Experiences and challenges faced by front-line providers and other stakeholders. *Journal of Applied Research on children: Informing Policy for Children at Risk, 6*(1), 1-21.
Macy, R. J., & Johns, N. (2011). Aftercare Services for International Sex Trafficking Survivors: Informing U.S. Service and Program Development in an Emerging Practice Area. *Trauma, Violence & Abuse, 12*(2), 87-98.
Markoff, L. S., Fallot, R. D., Reed, B. G., Elliott, D. E., & Bjelajac, P. (2005). Implementing trauma-informed alcohol and other drug and mental health services for women: Lessons learned in a multisite demonstration project. *American Journal of Orthopsychiatry, 75*(4), 525-539.
Martinez, O. & Kelle, G. (2013). Sex trafficking of LGBT individuals: A call for service provision, research, and act. *International Law News, 42*(4), 21-24.
McClain, N. M. & Garrity, S. E. (2011). Sex trafficking and the exploitation of adolescents. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 40*(2), 243-252.
McIntyre, B. L. (2014). More than just rescue: Thinking beyond exploitation to creating assessment strategies for child survivors of commercial sexual exploitation. *International Social Work, 57*(1), 39-63.
Narendorf, S. C., Betram, J., & McMillen, J. C. (2011). Diagnosis and medication overload? A nurse review of the psychiatric histories of older youth in treatment foster care. *Child Welfare, 90*(3), 27-43.
National Human Trafficking Resource Center & Polaris Project. (2011). *Comprehensive human trafficking assessment tool.* Retrieved from http://traffickingresourcecenter.org/resources/comprehensive-human-trafficking-assessment-tool
Polaris Project. (n.d.). Comprehensive human trafficking assessment. Retrieved from: http://www.polarisproject.org/tools-for-service-providers-and-law-enforcement
Raphael, J. & Myers-Powell, B. (2010). *From victims to victimizers: Interviews with 25 ex-pimps*

in Chicago. Chicago, IL: Schiller DuCanto & Fleck Family Law Center of DePaul University College of Law.
Raphael, J., Reichert, J. A. & Powers, M. (2010) Pimp Control and Violence: Domestic Sex Trafficking of Chicago Women and Girls, *Women & Criminal Justice, 20*(1-2), 89-104
Reid, J. A. & Piquero, A. R. (2014). Age-graded risks for commercial sexual exploitation of male and female youth. *Journal of Interpersonal Violence, 29*(9), 1747-1777.
Robertson, M. A. & Sgoutas, A. (2012). Thinking beyond the category of sexual identity: At the intersection of sexuality and human-trafficking policy. *Politics & Gender, 8*(3), 421-429.
Saewyc, E. M., & Edinburgh, L. D. (2010). Restoring healthy developmental trajectories for sexually exploited young runaway girls: Fostering protective factors and reducing risk behaviors. *Journal of Adolescent Health, 46*(2), 180-188.
Slesnick, N., Dashora, P., Letcher, A., Erdem, G., & Serovich, J. (2009). A review of services and interventions for runaway and homeless youth: Moving forward. *Children and Youth Services Review, 31*(7), 732-742.
Sloper, P. (2004). Facilitators and barriers for co-ordinated multi-agency services. *Child: care, health and development*, *30*(6), 571-580.
Thomson, S., Hirshberg, D., Corbett, A., Valila, N., & Howley, D. (2011). Residential treatment for sexually exploited adolescent girls: Acknowledge, Commit, Transform (ACT). *Children and Youth Services Review, 33*(11), 2290-2296.
Trafficking Victims Protection Act (TVPA) of 2000. Public Law 106-386, 114 Stat. 1464, codified as amended at 21 U.S.C. 22 U.S.C. §7101.
United Nations Office on Drugs and Crimes (2008). *United Nations Global Initiative to Fight Human Trafficking: Human trafficking: An overview*. New York: United Nations. Retrieved from http://www.ungift.org/doc/knowledgehub/resource-centre/GIFT_Human_Trafficking_An_Overview_2008.pdf
van der Kolk, B. A. (2005). Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401-408.
Vera Institute of Justice (2014). *Screening for human trafficking: Guidelines for administering the Trafficking Victim Identification Tool (TVIT).* New York, NY: Vera Institute of Justice. Retrieved from http://www.vera.org/sites/default/files/resources/downloads/human-trafficking-identification-tool-and-user-guidelines.pdf
Watt, T. T., Norton, C. L., & Jones, C. (2013). Designing a campus support program for foster care alumni: Preliminary evidence for a strengths framework. *Children and Youth Services Review, 35*, 1408-1417. doi: http://dx.doi.org/10.1016/j.childyouth.2013.06.002
Zimmerman, G. L., Olsen, C. G., & Bosworth, M. F. (2000). A 'stages of change' approach to helping patients change behavior. *American Family Physician, 61*(5), 1409-1416.

Appendix A: Risk Assessment Tool Draft

Initial Vulnerability

- Push factors
    - Societal / community stressors
        - Poverty
        - Hyper-sexualization of women & girls in the media, community, family
        - Exploited by others (engaged in survival or transactional sex)
    - Organizational stressors
        - Lack of permanency
        - Frequent changes in out-of-home placements
        - Focus on reducing mental health symptoms instead of addressing underlying trauma
        - Frequent and varied mental health diagnoses
        - Frequent and varied psychotropic medication
        - Inconsistent treatment plans
        - Lack of attention to trauma experiences
    - Family stressors
        - Recruited by family member
        - Parental drug addiction or mental health
        - Financial strain
        - Family dysfunction including legal troubles, medical challenges, & homelessness
        - Prior involvement in commercial sex industry or being trafficked
        - Lack of engagement in treatment with youth
    - Individual stressors
        - Experiences with interpersonal violence (dating violence)
        - Witnessing violence (domestic violence in home; community violence)
        - Unhealthy peer relationships / peer pressure
        - History of abuse & neglect
        - Living on the street, kicked out of homes
        - Poor mental health due to trauma or other (i.e. depression, anxiety, PTSD)
        - Feeling powerless
        - Alcohol & drug use
        - Gang involvement
        - History with juvenile justice / delinquent behavior
        - History of interpersonal betrayals & violence at the hands of adults
        - Lack of support based on membership in a sexual minority group (LGBT)

- Pull factors
    - Opportunity to make money
    - Want better relationship with adults

Indicators of Trafficking (under the control of a trafficker)

- Physical signs
    - Bruises from forced intercourse
    - Difficulty sleeping
    - Self-injury
    - Repeated visits to the ER
- Avoidance strategies
    - Answer questions evasively or inconsistently
    - Lack of trust in / avoid adults or authority figures
    - Avoid conflict
    - Running away
    - Truancy
- Poor behaviors such as:
    - Manipulation
    - Lying
    - Stealing
    - Hypersexuality
    - Problems at school, home, community
    - Poor judgment
    - Physical or emotional harm to others; bullying; aggressive
    - Coming & going at odd hours for unexplained reasons
- Seems to be in fear of "other"
- Has cell phone while missing other basic necessities; may also have unexplained keys, money, jewelry, clothing
- Refer to older boyfriend as "daddy" or "pimp"
- Tattoos indicate branding
- Relocated to another community
- Feels exploited for monetary gain

Appendix B: Key Stakeholder Consent Form & Interview Guide

Consent Form for Key Stakeholders

The Center on Violence against Women and Children at the Rutgers, School of Social Work supports the protection of participants in research. This information is provided for you to decide whether you wish to participate in a study about the program for domestically trafficked adolescents (DTAs). You may refuse to sign this form and not participate in this study. If you agree to participate, you are free to withdraw from the study at any time, without penalty. If you do withdraw from this study, it will not affect your relationship with the agency where you work or Rutgers University.

Purpose & Procedures: The purpose of this project, funded by the New Jersey Department of Children and Families, is to identify best practices and create a replicable model of providing residential services for domestically trafficked adolescents (DTAs). We want to learn more about your experiences with the DTA program including 1) the background on how this program was developed; 2) the components currently being implemented; and 3) your thoughts on possible outcome measures to use with the DTAs, their families, the program, and other organizations and systems involved with this program. We would like for you to participate in a face-to-face interview; we anticipate that the interview will take no more than an hour to complete. The information you provide will be confidential. We expect to interview up to 20 key stakeholders such as yourself.

To make sure we gather all of your comments, we will take notes during the interview. The notes will not include your name but instead will have letter and number identifiers; the list that matches the name with the number, along with any notes, will be converted to electronic format and be kept in a secure and password protected file.

Risks: The risks for your participation in this study have been minimized as much as possible. Please know that you may choose to not answer any of these questions if you don't want to describe your experiences.

Benefits: Your responses will help develop better ways in which to reach intervene with DTAs. Such interventions could then be tested with DTAs in other states. Compensation will not be provided since state law prohibits compensation for such activities.

Confidentiality: Once you have completed the interview, a unique identification number will be assigned to the information you provided and, using only that number, the information will be entered into a database. Consequently, your name will be removed from all records. What you answer will not be reported back to the agency from which you received notice of this study. Instead, our findings will be reported on a group summary basis (i.e., "the majority of participants answered…."). Your participation is strictly your choice, thus it is voluntary. We will use the information you provide to make a report to the NJ Department of Children and Families supporting the study about ways they might improve services offered to DTAs. This research is confidential. This means that the research records will include some information about you. I will keep this information confidential by limiting access to the research data and keeping it in a secure location. The research team and the Institutional review Board at Rutgers University are the only parties that will be allowed to see the data, as may be required by law. If a report of this study is published, or the results are presented at a professional conference, only group results will be stated.

Any notes will be converted to electronic format and be kept in a secure and password protected file at Rutgers University. Only the researchers listed below and their assistants will have access to these surveys. Again, once a numerical identifier is issued on your survey, your name will be removed from

the paper copy of the interview instrument. Any notes or data collected for this study will be permanently deleted from the secure electronic file after three years upon completion of the research.

Refusal to Sign Consent and Authorization: Your services provided by the agency from which you learned of this study will not be affected by whether you participate or not. You may decline to answer any questions you choose, and you may stop taking part in this study at any time, without penalty.

Canceling the Consent and Authorization: You also have the right to cancel your permission to use and disclose information collected about you, in writing, at any time, by sending your written request to the researchers listed below. If you cancel permission to use your information, the researchers will stop collecting additional information about you. However, the research team may use and disclose information that was gathered before they received your cancellation, as described above.

PARTICIPANT CERTIFICATION: I have read this Consent and Authorization form. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the study and the use and disclosure of information about me for the study. If you have any questions about the study procedures, you may contact Dr. Postmus at (848) 932-4365. If you have any questions about your rights as a research subject, you may contact the Sponsored Programs Administrator at Rutgers University at:

Rutgers University Institutional review Board for the Protection of Human Subjects
Office of Research and Sponsored Programs
3 Rutgers Plaza
New Brunswick, NJ 08901-8559
Tel: 848-932-0150 Email: humansubjects@orsp.rutgers.edu

I agree to take part in this study as a research participant. I further agree to the uses and disclosures of my information as described above. By my signature I affirm that I am at least 18 years old, and that I have received a copy of this Consent and Authorization form.

SIGNATURE:_____DATE: _____

FORM EXPLAINED & WITNESSED BY _____DATE_____

Researcher Contact Information:

Judy L. Postmus, Investigator
Center on Violence against Women & Children
Rutgers, School of Social Work
536 George Street
New Brunswick, NJ 08901
(848) 932-4365

Semi-Structured Interview Guide

General Questions:

- Identify the agency you work for, your position, and responsibilities in that position.
- How long you have worked in this position? With this agency?
- In what other human service organization have you worked? Please describe your positions.
- What level of education have you achieved?

Questions about their involvement with the DTA program:

- What is your involvement or role with the DTA program?
- How was the program developed?
- Please describe the program including any components used?
    - Discuss the program components as related to…
        - The youth
        - Their families
        - The entire agency
        - Relationship with other agencies or organizations
    - Has the program changed since it began? If so, how and why?
- What are some strengths of the program?
- What are some limitations or challenges faced by the program?
- What suggestions might you have to strengthen this program?

Questions about the evaluation plan:

- This program is to be evaluated to identify best practices when working with domestically trafficked adolescents (DTAs) and to create a replicable model of this program.
- How will you know if this program is successful? What are its outcomes?
    - For the youth
    - For their families
    - For the agency
    - For other program providers?
- What are your thoughts about how to measure those outcomes?
- What other thoughts might you have about evaluating this program?

Do you have any other comments or questions related to the evaluation project?

Thank you for your time and helpful responses to these questions.

Appendix C: Three Case Record Data Collection Instruments

Domestically Trafficked Adolescents Case Record Review Form

Reminder to case record reviewer: All elements of dates in a case record except year are considered protected identifiers. Please only record dates in the format of Month/Year.

CP & P Local Office

Reviewer Name

Date of Review

Gender of the child:

a. Male
b. Female

Child's birthdate (Month/Year):

Race of Child:

a. White
b. Black or African American
c. American Indian/Alaska Native
d. Asian
e. Native Hawaiian/Other Pacific Islander
f. Unable to determine
g. Other (please specify): _____

Child's ethnicity:

a. Non-Hispanic
b. Hispanic
c. Unable to determine

Date CSOC case opened (Month/Year):

What is the date range (Month/Year to Month/Year) reflected in the file (i.e., when did the case open and when did it close, or is it still open)?

What type of placement has the youth been in (from the time the case opened but prior to receiving services for trafficking)?

Type of placement	Length of time in each placement
Non-relative resource/guardian home	
Relative placement	
Biological parent(s)' home	
Home with friends	
Home with relatives	
Shelter	
Own apartment	
College dormitory or other college affiliated housing	
Other	
Unable to determine	

What is the marital status of youth's biological parents, if known?

a. Married
b. Divorced
c. Widowed
d. Cohabiting
e. Civil union
f. Domestic partnership
g. Unmarried partners
h. Unmarried and separated

Is the youth employed?

a. Yes
b. No
c. Unable to determine

What type of job, if any, did the youth hold prior to receiving services for trafficking?

a. Full time (paid)
b. Full time (unpaid)
c. Part time (paid)
d. Part time (unpaid)
e. Unable to determine

What was the nature of the job? _____

What type of school was youth in prior to receiving services for trafficking?

a. Elementary school
b. Middle school
c. High school
d. Alternative high school
e. GED
f. 4 year college
g. 2 year college
h. Vocational training/employment training program
i. Other (please specify): _____

What is the youth's highest level of educational attainment?

a. Some middle school
b. Middle school diploma
c. Some high school
d. High school diploma
e. GED Preparation
f. GED
g. Some college
h. Unable to determine
i. None of the above (please specify):
_____

What was the youth's functional educational attainment/other comments about youth's educational experience? (This is an opportunity to comment on examples such as the youth graduated from high school, but has an 8th grade reading level.)

Is there documentation in the record that the youth was connected to caring adults inside or outside of the family?

a. Yes
b. No
c. Unable to determine

Please identify who the youth is connected to?

a. Biological parent
b. Relative/fictive kin
c. Teacher
d. Mentor
e. Other caring adult (please specify):
   _____

What is the nature of the relationship? (strength of connection, types of support adult is providing to youth—emotional, financial, etc.)

Was the youth placed in out-of-home services by DCP&P prior to receiving services for trafficking?

a. Yes
b. No

Is there any documentation that the youth identifies as GLBTQI?

a. Yes
b. No

Please record any information about GLBTQI-related services that were made available to or used by the youth?

Please record any information documented regarding the financial status of the family (i.e., receiving TANF, SNAP, disability, etc.) or any mention of financial challenges within the family.

Is there any documentation that the youth has mental health symptoms or diagnoses?

a. Yes
b. No
c. Unable to determine

Please record any information about mental health that was documented (diagnosis, any medication).

Is there evidence that the youth has gang involvement?

a. Yes
b. No
c. Unable to determine

Is there documentation that the youth has/had current/past substance abuse?

a. Yes
b. No
c. Unable to determine

Please record any information related to substance use or abuse experienced by the youth (e.g. type of substances, amount used, etc.).

Is there evidence of substance use or abuse by the youth's caregivers?

a. Yes
b. No
c. Unable to determine

Is there documentation that the youth has/had current/past involvement with the criminal/juvenile justice system?

a. Yes
b. No
c. Unable to determine

What type of involvement (e.g., whether current or past involvement, need to expunge a juvenile record, etc.)?

Does the youth have a history of running away?

a. Yes
b. No
c. Unable to determine

Please provide details on the youth's history of running away (including the number of times, date of run (Month/Year) and duration of each run, where the youth may have gone and how DCF responded).

Does the youth have a history of homelessness?

a. Yes
b. No
c. Unable to determine

Please provide details on the youth's history of homelessness (where did they go, date range for homelessness (Month/Year), duration of homelessness, what services did they receive).

Is there evidence that the youth talks to strangers online?

a. Yes
b. No
c. Unable to determine

Is there evidence that the youth associates with individuals whom he or she met online?

a. Yes
b. No
c. Unable to determine

Is there documentation of any of the youth's family members being involved in the commercial sex industry?

a. Yes
b. No
c. Unable to determine

What type of involvement (e.g., which family member, which industry)?

Other comments:

Please record any additional risk factors (not mentioned previously) found in the case records that may make youth more vulnerable to domestic minor sex trafficking.

Please record any additional protective factors (not mentioned previously) found in the case records that may make youth less vulnerable to domestic minor sex trafficking.

Domestically Trafficked Adolescents Case Record Review:
Maltreatment Incident Form

How many reports:

Date of Allegation (Month/Year):

Nature of allegation:

a. Domestic violence (witnessed)
b. Dating violence (victim)
c. Sexual abuse
d. Physical abuse
e. Psychological abuse
f. Neglect
g. Child welfare services
h. Other (please specify): _____

Perpetrator of the allegation:

Please provide a brief overview of incident in space below.

Was report substantiated?

a. Yes
b. No

Domestically Trafficked Adolescents Case Record Review:
Has the youth received the following services?

Type of service needed by youth	**Program or service needed (yes or no)**	**Program or service offered**	**Youth accepted service/program/ intervention**	**Youth received service/program/ intervention**	**Not applicable**
Housing					
Pregnancy/parenting services					
Health care					
Dental care					
Substance abuse treatment					
Mental health services					
DDD services					
Financial services					
Homelessness services					