Annual Report on the Commercial Sexual Exploitation of Children in Florida, 2020

Report No. 20-05

July 2020

OPPAGA

Office of Program Policy Analysis and Government Accountability

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EXECUTIVE SUMMARY

In 2019, 378 children were verified as victims of commercial sexual exploitation (CSE) in Florida. This number has decreased from 2018, when 400 victims were verified. This is the first decrease in verified victims seen across OPPAGA's reports.[1] The number of children who remain in the community following their CSE investigation continues to increase.

The number of safe house beds has increased in the past year, while safe foster home beds have decreased. Providers of CSE specialized services reported having implemented several promising practices, including a variety of evidence-based therapeutic modalities and increased use of survivor mentors.

Our review included interviews with six states regarding their experiences with serving CSE victims. These states' CSE programs are still in development; however, state officials were consistent in reporting placement options, service gaps, and lessons learned.

REPORT SCOPE

Section 409.16791, *Florida Statutes*, directs OPPAGA to conduct an annual study on the commercial sexual exploitation of children in Florida. This review reports on the number of children that the Department of Children and Families identified and tracked as victims of CSE; describes specialized services provided to CSE victims; and presents short- and long-term outcomes for children identified in prior reports.

Our review of CSE youth's Department of Juvenile Justice (DJJ) files found limited evidence of CSE-specific services in juvenile detention centers and residential commitment facilities. Further, several files were missing the CSE alert that notifies facility staff of the youth's exploitation.

As in prior reports, CSE youth do not fare well in a variety of short-term outcomes. Victims identified in our prior reports have high rates of subsequent Department of Children and Families (DCF) and DJJ involvement and low performance in K-12 schools.

DCF is preparing for full implementation of the federal Family First Prevention Services Act. Department staff has drafted a definition for children at risk of human trafficking and licensing standards for a new placement type to serve these victims. Other states are still evaluating characteristics to include in their definitions of at-risk and options for possible placement types.

[1] See OPPAGA reports 15-06, 16-04, 17-09, 18-05, and 19-05.

BACKGROUND

Human trafficking includes two types of exploitation: commercial sexual exploitation (CSE) and forced labor.[2] Florida law defines human trafficking as the exploitation of another human being through fraud, force, or coercion.[3] Florida law does not specify coercion as a condition of the CSE of children but defines it as the use of any person under the age of 18 for sexual purposes in exchange for money, goods, or services or the promise of money, goods, or services.[4] Federal and state law both criminalize human trafficking of adults and children.[5]

Numerous authorities engage in activities to address human trafficking crimes and assist victims, including activities related to prevention, education and outreach, victim identification, investigation and prosecution of offenders, and comprehensive services for victims. Law enforcement agencies involved in the process include the U.S. Department of Homeland Security, Federal Bureau of Investigation, Florida Department of Law Enforcement, and local sheriffs' offices and police departments. Other key entities include the Office of the Attorney General, State Attorneys, and U.S. Attorneys' Offices that pursue convictions against individuals charged with trafficking in Florida.

In addition to investigation and prosecution, federal, state, and local government organizations also seek to identify and serve trafficking victims. At the state level, Florida's Department of Children and Families (DCF) takes the lead in identifying and managing services for CSE victims who are minors. DCF has three regional human trafficking coordinators covering all areas of the state and operates the statewide Florida Abuse Hotline, which receives calls alleging CSE of children. Child protective investigators, through both DCF and sheriffs' offices, investigate the allegations.[6] When investigators identify youth involved in trafficking, the investigator conducts a safety assessment to determine if the child can safely remain in the home. DCF contracts with community-based care lead agencies in all 20 circuits across the state to manage child welfare services, including services for CSE victims.[7]

The Department of Juvenile Justice (DJJ) partners with DCF to identify CSE victims brought into the delinquency system and to divert them to the child welfare system when possible. At delinquency intake, DJJ staff assesses all youth and screens those who demonstrate indicators related to sexual exploitation; some of DJJ's prevention partners, including the Florida Network of Youth and Family Services residential and non-residential program and the PACE Center for Girls, also screen for CSE. When appropriate, DJJ and its partners refer children to DCF.

Since the Legislature established specialized services for CSE children in 2014, DCF has allocated funds to its lead agencies to serve these victims. While this amount has remained the same each year of our reporting, in Fiscal Year 2018-19, DCF increased its annual allocation of funds to serve CSE children from $3 million to $5.1 million. In addition to these funds, the Legislature appropriates funds to individual CSE providers to deliver specialized services. In Fiscal Year 2019-20, the Legislature appropriated nearly $1.7 million to CSE providers serving minor victims. (See Appendices A, B, and C for more information on funding for CSE services.)

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[2] Labor trafficking includes debt, bonded, and forced labor.
[3] Section 787.06, *F.S.*
[4] Section 409.016, *F.S.*
[5] 22 USC 7102 and s. 787.06, *F.S.*
[6] DCF directly employs child protective investigators in all but seven counties in Florida. In Broward, Hillsborough, Manatee, Pasco, Pinellas, Seminole, and Walton counties, sheriffs' offices conduct child welfare investigations.
[7] Lead agency subcontractors provide case management, emergency shelter, foster care, and other services in all 67 counties.

PREVALENCE

The number of verified victims decreased slightly in 2019; youth demographics are consistent with prior years, but the percentage of community children continues to increase

To assess the prevalence of CSE victims identified in Florida during 2019, we analyzed the number of allegations and subsequently verified CSE cases recorded by the Department of Children and Families throughout the year. The following prevalence analysis only includes CSE victims who had a verified CSE finding by DCF for calendar year 2019. Verified means that a preponderance of the evidence supports a conclusion of specific injury, harm, or threatened harm resulting from abuse or neglect.[8] To better identify CSE victims, DCF and the Department of Juvenile Justice (DJJ) use the Human Trafficking Screening Tool; Florida State University's Institute for Child Welfare is in the process of validating the tool.

The number of victims identified in 2019 decreased slightly despite an increase in calls to the hotline; youth with prior victimizations remain vulnerable. Verified cases decreased for the first time in 2019, with 378 children identified by DCF compared to 400 children in 2018.[9] Since 2015, the department has identified 1,527 victims.[10] Although there was a decrease in verified cases, hotline reports increased by 19%, from 2,592 reports in 2018 to 3,088 reports in 2019. Similar to previous years, the counties with the highest numbers of reports to the hotline were Broward (332), Miami-Dade (278), and Hillsborough (234). For almost all counties, law enforcement personnel were the most frequent reporter type. Fifty percent (1,558) of reports resulted in child protective investigations.[11] (See Exhibit 1.)

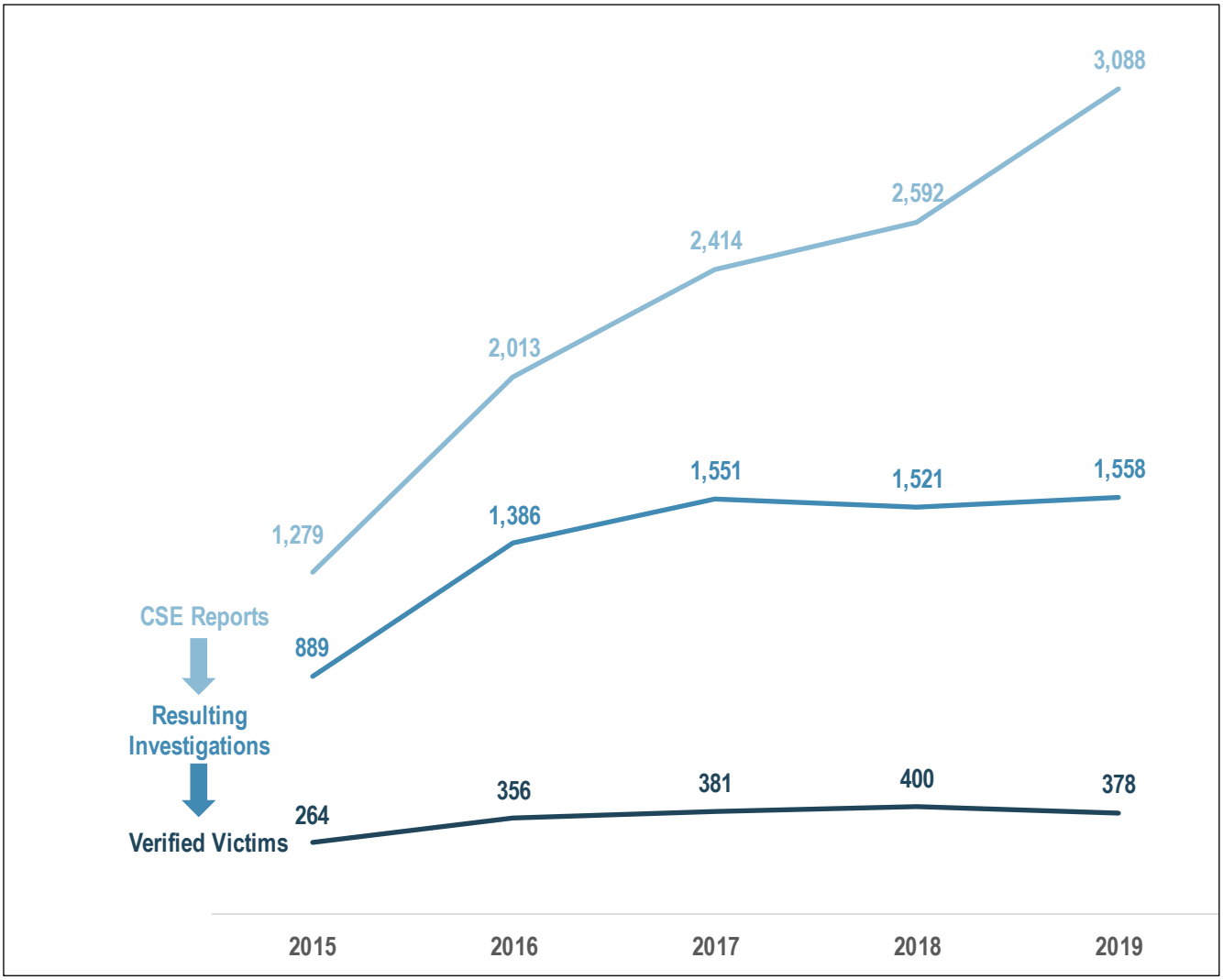
[8] A verified finding is one of three possible investigative outcomes. Other outcomes include no indication, which means no credible evidence was found, and not substantiated, which means credible evidence exists but did not meet the standard of being a preponderance of the evidence.

[9] To estimate the number of allegations and subsequently verified CSE cases, we relied on DCF's Florida Safe Families Network data on hotline intakes and child protective investigations during 2019.

[10] Due to prior issues with DCF maltreatment codes, we do not include comparisons to 2014 in this section. For more information, see OPPAGA Report 15-06.

[11] Five additional reports were screened in under a general human trafficking maltreatment code. These reports were not included in this analysis, as we could not determine which reports were related to CSE, as opposed to labor trafficking.

Exhibit 1
Verified CSE Cases Decreased for the First Time in 2019



Source: OPPAGA analysis of Department of Children and Families data.

DCF hotline staff did not refer cases for investigation if the allegation did not rise to the level of reasonable cause to suspect abuse, neglect, or abandonment based on statutory definitions (81%); there were no means to locate the victim (9%); or the alleged perpetrator was not the child's caregiver (6%).[12] Hotline staff screened out this 6% of cases (83 reports) because the perpetrator was someone other than the child's caregiver, despite department policy to the contrary.[13] The percentage of calls screened out due to not meeting caregiver statutory guidelines is the same as in 2017 and 2018.

In 2019, DCF investigations resulted in verified CSE cases involving 378 child victims, 45 of whom were verified in more than one investigation.[14] Of the 1,558 investigations, 1,161 did not have a verified finding of CSE, though 43% of all investigations closed with families voluntarily accepting service provision or case management services.[15] Counties with the highest prevalence of verified cases were

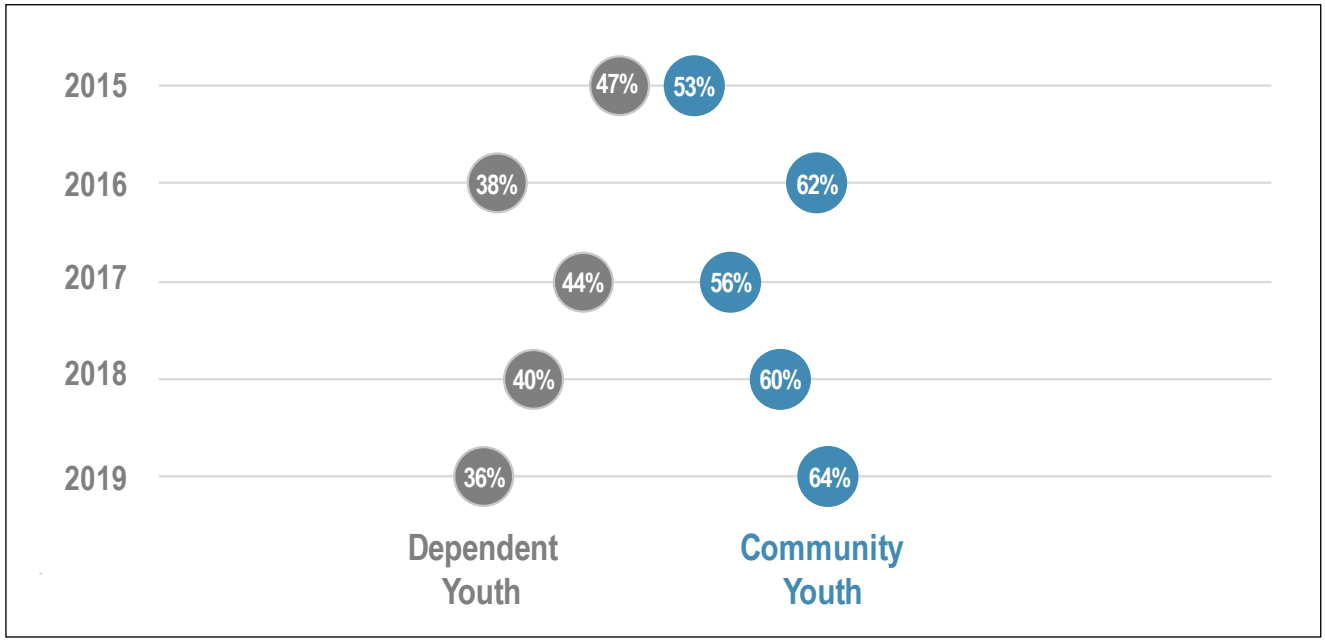
[12] An additional 4% of cases were screened out for other reasons, including that the child lived out of state or did not meet statutory guidelines.
[13] For typical child welfare reports, the caregiver must be the alleged perpetrator for the report to be referred for a child protective investigation; however, DCF policies state that CSE cases warrant investigation regardless of the perpetrator's identity.
[14] Thirty-seven youth had two verifications while eight youth had three or more verifications in 2019.
[15] Investigations may have multiple maltreatment allegations, so the services may not be related to a child's possible CSE.

Broward (48), Miami-Dade (37), Duval (27), and Orange (27). These four counties accounted for 37% of all cases. Similar to rates in prior reports, 18% of CSE victims verified in 2019 had a verified CSE investigation in prior years. Most (54%) of these victims were not receiving in-home or out-of-home services at the time of their 2019 investigation, but some began receiving such services after their 2019 verification (4% receiving in-home and 4% receiving out-of-home services).[16] Forty-six percent of previously verified youth were already receiving in-home or out-of-home services in 2019; of these, most continued with additional placements after their 2019 verification (9% receiving in-home services and 81% receiving out-of-home services). (See Appendix D for verified victims by county.)

Demographics for verified youth in 2019 remain similar to CSE victims in prior reports; the percentage of children who remain in the community continues to increase. As in prior reports, verified victims in 2019 were predominately female, white, and 14 to 17 years of age. The percentage of verified victims who were white increased from 49% in 2018 to 57% in 2019, while the percentage of victims identified as African American decreased from 41% in 2018 to 34% in 2019. The percentage of CSE victims remaining in the community after verification, meaning they remained with their parent or caregiver and did not enter the state's child welfare system, has been increasing since 2017. Concomitantly, the percentage of dependent CSE victims, or those under or entering the care of the state child welfare system within six months of verification, has been decreasing since 2017. Of the 378 verified victims in 2019, nearly two-thirds remained in the community after verification, and 36% were dependent children. Exhibit 2 shows the annual percentages of community and dependent verified CSE victims since 2015.

Exhibit 2

Percentage of CSE Victims Remaining in the Community Has Increased Annually Since 2017



Source: OPPAGA analysis of Department of Children and Families data.

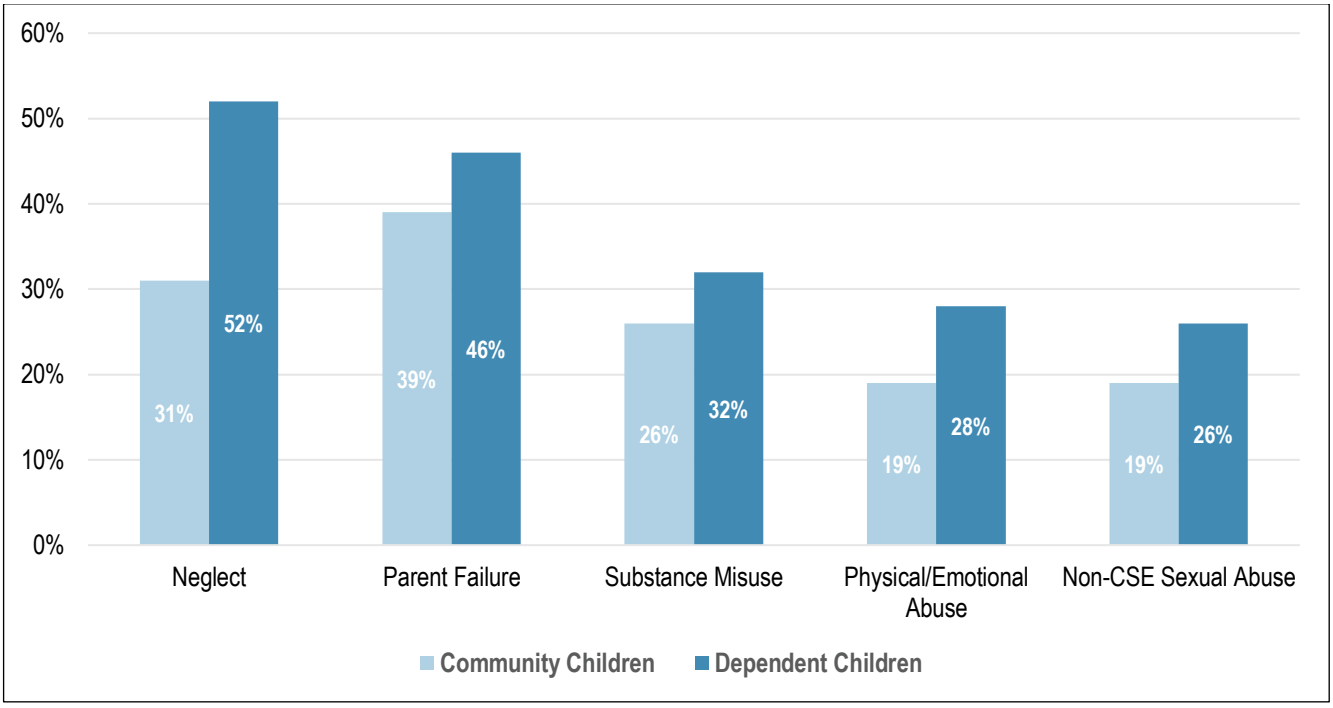
[16] In-home protective and out-of-home care services are mutually exclusive categories, but some youth received both types of services at different times.

Of the 378 verified CSE victims in 2019, 4% were already receiving in-home protective services and 21% were already in out-of-home care at the time of the investigation. Within six months of their CSE investigation, an additional 6% received in-home protective services and 8% entered out-of-home care. Among youth who were receiving out-of-home care services at the time of the CSE investigation, 39% resided in a residential setting, such as group care, residential treatment, or a DJJ facility. Fourteen percent of dependent youth were on runaway status, down from 24% in 2018. The children on runaway status were most often on the run from group homes (77%).

Slightly more than half of verified victims had histories of prior maltreatment, and dependent children continue to have higher incidence of prior maltreatment than community children. In 2019, 52% of youth had at least one verified maltreatment prior to their CSE investigation (a 6% decrease from 2018), the majority of whom (56%) had two or more prior verified maltreatments. Consistent with prior years' reports, dependent children have a higher incidence of prior maltreatment than community children. Eighty percent of dependent children and 36% of community children had prior maltreatments.

Dependent children had higher incidence of prior verifications across most maltreatment types, though community children did have slightly higher rates of alcohol or substance-exposed child, excessive corporal punishment, sexual abuse by a parent/caregiver, and CSE verifications. While community and dependent children both had high rates of neglect, parent failure (which includes findings of failure to protect and family violence), substance misuse, and physical and emotional abuse, the rates were much higher for dependent children. Of the 52% of victims with prior maltreatment verifications, 23% had a prior non-CSE sexual abuse verification; the incidence rate was 19% of community youth and 26% of dependent children, which is the same as the 2018 incidence rates. Exhibit 3 shows the percentages of dependent and community children experiencing certain types of prior verified maltreatments.

Exhibit 3
Dependent Children Have Higher Rates of Prior Maltreatments



Source: OPPAGA analysis of Department of Children and Families data.

Florida State University is in the process of validating the Human Trafficking Screening Tool. To better identify CSE victims, the Department of Children and Families (DCF) and the Department of Juvenile Justice (DJJ) developed and implemented the Human Trafficking Screening Tool (HTST).[17] The tool is used by a variety of field staff and service providers, including child protective investigators, lead agency staff, juvenile probation officers, and DJJ facility staff. Florida State University's Institute for Child Welfare has begun a validation study of the HTST.

The institute is conducting a phased approach to measure the validity and reliability of DCF's use of the HTST. In 2019, they began the first phase and examined responses to items that indicated evidence of trafficking in a sample of completed tools. At the conclusion of this phase, the institute indicated the tool was promising and was capable of measuring exploitation and environmental risk.[18] While the results of the study have not been determined, institute staff reported that the lack of electronic access to the screening tool has created limitations for their study. Additionally, issues of internal consistency were identified and shared with DCF. The second phase will include conducting focus groups with screeners to examine consistency in the utilization of the tool. The institute expects to conclude the validation study by early 2021 and further hopes to conduct an interrater reliability study involving experts in CSE after the conclusion of the study.

PLACEMENTS AND SERVICES

As the percentage of CSE youth going into out-of-home care declines, providers continue to report challenges

The percentage of CSE youth who spend time in out-of-home care continues to decline. Those who went into care are spending more of their time in residential settings, particularly in specialized settings. Florida's CSE providers continue to report challenges in serving this population, including issues with maintaining capacity and need for respite and crisis intervention. (See Appendix E for the percentage of time spent in each placement type in 2019.)

Fewer youth went into out-of-home care in 2019; those that did spent a larger percentage of time in specialized residential settings. The percentage of CSE youth who spent time in out-of-home care during or after their CSE investigation decreased from 35% in 2018 to 29% in 2019. This decrease, combined with a decrease in the number of verified victims, resulted in fewer youth being served in out-of-home care after their CSE investigation, with 138 served in 2018 and 111 in 2019.

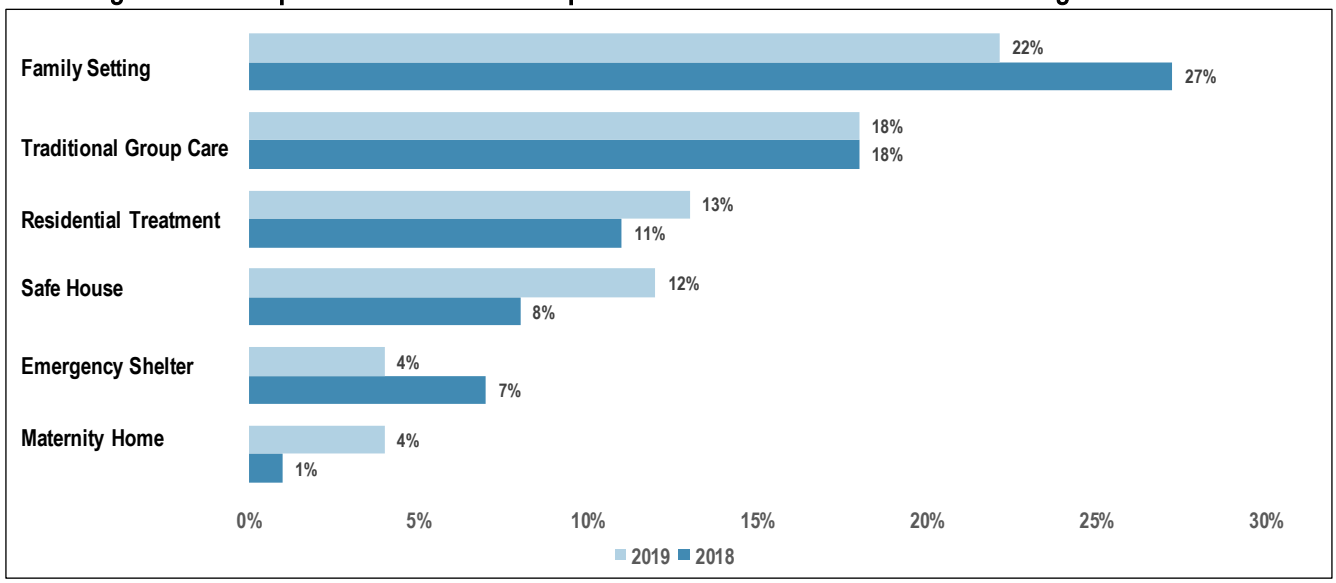
For those who spent time in out-of-home care, the amount of time spent in a residential setting (e.g., group care, residential treatment, safe house, or correctional placement) increased from 52% in 2018 to 61% in 2019. Within residential placements, the bulk of the increases were in specialized placement types. When comparing victims identified in 2018 to those identified in 2019, time spent in residential treatment, safe houses, and maternity homes increased, while time in traditional group care remained relatively stable. In 2018, victims spent 11% of their time in residential treatment placements compared to 13% in 2019. Time in safe houses increased even more, from 8% in 2018 to 12% in 2019, and time in maternity group homes increased from 1% to 4%, respectively. Conversely, time in

[17] While the departments use the same screening tool to identify potential victims, each department has established its own criteria that require their respective staff or providers to screen a child. For more information on the screening criteria, see OPPAGA Report 17-09.

[18] During this phase, the institute identified six factors that predicted higher scores: youth disclosure, a history of four or more runaways or removal incidents, youth being recovered from a runaway episode near a known area of trafficking, youth having allegations of sexual abuse, youth having a current or recent history of inappropriate sexual behaviors, and youth having age inappropriate relationships with older individuals.

emergency shelters decreased from 7% in 2018 to 4% in 2019. Traditional group care remained the same as the prior year at 18%. As time in residential placements increased, time spent in family settings decreased, from 27% in 2018 to 22% in 2019. (See Exhibit 4.)

Exhibit 4
Percentage of Time Dependent CSE Children Spent in Safe House and Treatment Settings Increased in 2019[1]



[1] The chart does not include correctional placements, runaway episodes, and other temporary placements and, therefore, does not sum to 100%.
Source: OPPAGA analysis of Department of Children and Families data.

The number of safe house beds has increased, while safe foster beds have decreased slightly; providers continue to report program challenges. As of May 2020, DCF reported eight safe houses statewide, with 64 licensed beds (an increase of 10 beds from 2018).[19] The department also reported 15 safe foster homes with the capacity for 26 beds (a decrease of 3 beds from 2018). While licensed beds have increased, safe house providers continue to accept and serve fewer CSE youth than their licenses allow, primarily due to staffing and facility limitations. Safe house providers also reported that some lead agencies have started paying for placements for community children.[20] In addition to lead agency placements, community youth are referred to a variety of voluntary community-based services, including those provided by child advocacy centers and local Sexual Abuse Treatment Programs. These services often include case management, individual and family counseling, and substance abuse services.[21]

CSE providers reported challenges with their programs and identified additional supports that could benefit CSE youth. Two providers reported issues with maintaining program capacity. The state's only safe house for males reported that they have received a limited number of referrals since opening in 2017, and the Open Doors Outreach Network reported a reduction in its service area due to decreased funding in Fiscal Year 2019-20.[22,23] Other providers expressed a need for additional supports related

[19] A ninth safe house was scheduled to open in March 2020 in Northwest Florida; however, the opening was delayed by COVID-19 preventative measures. This new home is licensed for five beds for female victims.
[20] As of March 2020, there were 162 CSE-verified youth in out-of-home care who might benefit from CSE-specific placements. DCF's Florida Safe Families Network does not track placement information for community children, so it is unclear how many received lead agency-funded CSE-specific residential services.
[21] For more information on services available to community CSE children, see OPPAGA Report 17-09.
[22] At the time of our review, safe house staff reported having two residents, despite having the capacity for five.
[23] Open Doors Outreach Network reported that due to the funding decrease, the program lost a contracted provider and has subsequently reduced its service area from 32 to 20 counties. Program staff reported that they are in the process of finding a new provider to resume services in these 12 counties. For more information on this program, see OPPAGA Report 19-05.

to crisis intervention and respite care placements. They explained that without these temporary placements, their only option when a youth's behavior escalates is to have the youth involuntarily committed or discharge the youth from the program.[24] These additional supports could include CSE providers working with a pool of additional foster parents or creating an additional setting where youth could de-escalate.[25] One residential treatment facility that serves CSE youth reported having separate space available for children in need of de-escalation and would like to open beds for this purpose if additional funding for necessary staffing were available.

Promising treatment and placement practices for trauma victims exist, but information on efficacy for the CSE population is lacking; Florida providers have used many of these practices for CSE youth

Peer-reviewed literature, consistent with practices recommended by the U.S. Department of Health and Human Services, recommends approaches for CSE victims that are survivor centered, trauma informed, multidisciplinary, and interagency. While many of these and other treatment options used in the field are considered evidence based for similar populations, such as victims of sexual assault, childhood trauma, or domestic violence, the literature continues to lack evidence-based practices specific to victims of CSE. Several of Florida's CSE providers reported implementing many of these promising practices. (See Appendix F for a bibliography of studies we reviewed.)

While promising treatment and placement practices for CSE victims exist, they are often based on evidence from other trauma populations and lack information on the efficacy of practices for the CSE population. In 2009, the U.S. Department of Health and Human Services reported on components of promising clinical practices for CSE victims, which included safety planning, collaboration across multiple agencies, provider-victim relationship building, culturally appropriate service provision, trauma-informed programming, and offering a full continuum of care.[26] Other practices and approaches are repeatedly noted in the literature. Commonly recommended therapeutic modalities include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Stages of Change, and motivational interviewing.[27,28,29] In particular, studies report that TF-CBT can alleviate symptoms of posttraumatic stress, depression, anxiety, and externalizing behavior problems and can improve adaptive functioning in youth with complex trauma. Several additional modalities are emerging in the literature, including body-oriented interventions, such as yoga and dance; drama therapy; music therapy; art therapy; dialectical behavior therapy (DBT); multisystemic therapy; and Eye Movement Desensitization and Reprocessing (EMDR) therapy.[30,31]

[24] Four of the state's safe house providers reported having involuntarily committed youth in their care.

[25] Staff of one program expressed interest in developing a foster care respite program modeled off Washington's Mockingbird Family Model. In this program, 6 to 10 families (foster, kinship, foster-to-adopt, and/or birth families) live in close proximity to a central, licensed foster or respite care family (referred to as the hub home), whose role is to provide support. The support provided through the hub home includes assistance in navigating systems, peer support for children and parents, impromptu and regularly scheduled social activities, planned respite nearly 24 hours a day/7 days a week, and crisis respite as needed.

[26] Clawson, H., N. Dutch, A. Solomon, and L.G. Grace. 2009. *Human Trafficking Within and Into the United States: A Review of the Literature.* U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[27] TF-CBT is an evidence-based treatment for traumatized children ages 3 to 18 and their non-offending parents or caregivers that uses cognitive-behavioral principles and exposure techniques to prevent and treat posttraumatic stress, depression, and behavioral problems.

[28] The Stages of Change model views changes in an individual's behavior as a spiral model of progression, rather than a linear one, through five distinct stages; individuals at different stages benefit from different types of interventions tailored specifically to their stage of change.

[29] Motivational interviewing is a brief, client-centered, directive method for enhancing intrinsic motivation for change, which often complements existing treatment approaches.

[30] DBT involves learning skills of distress tolerance, mindfulness, and emotion regulation.

[31] EMDR consists of engaging in imaginal exposure to trauma while concurrently performing saccadic eye movements.

These existing treatment options may be considered evidence-based practices for other similar trauma populations; however, because they have not been validated for use with CSE victims specifically, it is unknown whether these practices can adequately address the complex needs of the CSE population. Limited information on the efficacy of these practices for CSE victims could result in allocation of resources to ineffective programs. Evidence-based practices for housing CSE youth are similarly lacking due to insufficient data on the efficacy of placement options. However, a national study of residential programs for exploited youth in the child welfare system reports promising practices to improve placements, such as extensive CSE training for all staff (with recurrent in-service trainings), multidisciplinary teams, comprehensive case management, trauma supports, and policies to address running behaviors.

Florida providers reported implementing a variety of evidence-based therapeutic modalities and promising practices to improve service provision for CSE youth, avert running behavior, and help with stepping down from specialized placements. Several providers reported using evidence-based practices in their programs, including TF-CBT, DBT, EMDR, and motivational interviewing; one provider reported that they are currently seeking grant funding to become an evidence-based program. Providers also reported that increasing training for their staff in trauma and human trafficking has been an effective practice in serving youth. Other useful strategies discussed include reducing the number of children in a home (for both foster and safe homes), allowing greater flexibility in safe foster home settings (e.g., allowing couples to care for youth as opposed to the former single foster mother requirement), and more frequent updates among staff regarding youth's progress.

CSE providers reported adopting practices to keep children safe when they run away and avert running behaviors when possible. It is widely acknowledged by Florida's providers that running away is a typical behavior of youth who have been commercially sexually exploited. To prevent disruptions to a child's life and treatment progress and address the dangers caused by running away, most providers reported having adopted practices to reduce the frequency and risk of running. One provider reported that a component of their program includes developing a safety plan with the youth and their mentor so the youth knows how to reestablish contact when they are ready to reengage. In the event of a runaway episode, staff of one safe house reported developing a running protocol, whereby staff members follow the child and local law enforcement assists in recovery efforts. Another provider uses applied behavior analysis to develop a behavior plan to address elopement. Staff of two safe houses reported they work with runners in therapy sessions to determine what needs the child feels they are meeting by running away and get to the root cause of their running behavior. Another provider's staff calls local law enforcement immediately and works with the lead agency's missing persons specialist to have the child declared endangered due to their CSE status and trigger an immediate response from DCF.[32]

In prior years, providers have reported challenges in youth stepping down from CSE specialized placements to more general child welfare settings or in returning to the community. To address this, providers contacted for this year's review reported implementing transition assistance services tailored to the youth's individual situation, whether it be a subsequent placement, reunification, or aging out of the dependency system. Providers described participating in multidisciplinary team (MDT) staffings to discuss next steps with the lead agency for children in care and connecting

[32] Under typical circumstances, teenagers need to be missing for 24 hours before authorities begin a search. A child needs to be missing for only four hours to be declared endangered, and the search can begin immediately.

community children to necessary services.[33] They described using family counseling to work with parents on realistic expectations when a child is to be reunified with family and making sure supports are in place for the youth in the community. Some safe house providers reported it is also common to maintain contact with youth and/or their next provider to facilitate continued support. For youth aging out of care, providers reported working with youth on life skills and planning for future training, education, and employment. A few providers reported that they continue to offer housing and/or community services to youth beyond the age of 18.

Survivor mentors are often noted as a promising practice in the literature, and Florida providers reported increased use of this service. An additional promising practice that has increased in prevalence among experts and CSE providers is the use of survivor mentors. Field experts report improved outcomes for CSE victims when survivor mentors are utilized. These mentors serve as advocates, role models, and peer leaders and may be better poised to engage survivors at different points and encourage participation in treatment. Peer support is often used in other fields, such as addiction medicine, with positive results.

Florida safe houses and safe foster homes are required to provide mentoring by a survivor of commercial sexual exploitation, if available and appropriate for the child.[34,35] Use of survivor mentors has been limited in the past due to concerns about mentor availability and adequate screening. However, providers are now reporting more frequent use of survivor mentors and greater interest in utilizing this service in their programs. The Open Doors Outreach Network relies heavily on survivor mentors as part of their outreach teams who work with CSE youth. Open Doors staff described survivor mentors as key to their success with this population due to a survivor's ability to connect with a victim and build a relationship more quickly than clinicians or other staff. One residential treatment provider did not report using survivors but reported using group therapy to develop mentor relationships between youth who have been in the program longer and those who have more recently begun treatment. Two providers reported a desire to increase their use of survivor mentors; however, they also communicated difficulty in finding mentors who are able to work with children due to funding constraints or mentors' disqualifying criminal histories.

OTHER STATES

States are still developing service networks for trafficked youth; they share commonalities in placement options, service gaps, and lessons learned

As part of this review, OPPAGA interviewed six states about their experiences serving CSE youth, including information on specialized placements.[36,37] We spoke with representatives from California, Minnesota, Nevada, New York, Pennsylvania, and Texas. We identified states using data from the National Human Trafficking Hotline as well as a report by a national human trafficking organization

[33] An MDT staffing must be convened for all CSE investigations to determine possible placements and necessary services. These staffings must include, at a minimum, a representative from the local lead agency, Children's Legal Services, DJJ staff, and knowledgeable victim advocates.
[34] The 2014 Legislature established services that must be provided (or arranged for) by safe houses and safe foster homes.
[35] Section 409.1678, *F.S.*
[36] We contacted two additional states but did not receive responses.
[37] We also interviewed these states about their plans for implementing provisions of the federal Family First Prevention Services Act. See the Family First Prevention Services Act section for more information.

that classifies states according to their statutory response to human trafficking.[38] We included the three states (California, Texas, and New York) with the highest prevalence of sex trafficking (not including Florida). Three states (California, Minnesota, and Nevada) in the analysis have full decriminalization of CSE for minors, while the other three (New York, Pennsylvania, and Texas) have partial decriminalization and provide specialized services through diversion.[39,40] State-level human trafficking programs in these states are still in development; available services and associated challenges are consistent with those reported by Florida providers.

Several state human trafficking programs are still in development; five of the six states we reviewed have specific appropriations for serving victims. Since 2010, the states reviewed have either decriminalized CSE for minors or have begun diverting these youth from their delinquency systems and have subsequently changed their responses to these youth at the state, regional, and local levels. Across states reviewed, specialized service provision began at the earliest in 2013 and in some states is still in development. States reviewed utilize traditional child welfare funding, and a majority have state funding specifically appropriated for human trafficking services. In states with specific appropriations, funding was provided initially to support administrative functions, such as protocol development, and has since been appropriated for direct services, including housing and supportive services.[41] To develop a CSE service network, states contracted with new and existing child welfare providers to create additional specialized services.

Specialized housing options remain limited due to a variety of factors. All states reviewed utilize their full array of child welfare placement settings to serve CSE youth, though one state reported intentionally limiting their use of residential settings for this population. Four of the six states reported having CSE-specific placement options, including group homes, residential treatment, and transitional housing. The states that have created CSE-specific placements reported having 10 or fewer of these placements, with one having similar bed capacities to Florida; only one state currently utilizes specialized foster care. Most states identified limited bed capacity as a service gap. States identified consistent barriers in establishing these specialty programs, including a limited number of providers and insufficient funding. States noted that while there appear to be sufficient networks of community providers in some regions, they lack large-scale access across states. Most states identified rural counties as underserved areas with limited CSE-specific providers. Limited training and staff turnover further exacerbate consistent access. All states in our review plan to continue expanding their continuum of care.

States identified coordination among stakeholders as an integral piece to successful service delivery. All states included in our review have developed statewide guidance for CSE service provision, ranging from individual provider bulletins to established state protocols.[42] All of the states reported using a multidisciplinary team approach to service provision for youth exploited through trafficking. Similar to Florida, stakeholders include human service agencies, juvenile justice agencies, health care agencies, and organized networks such as child advocacy centers. States reported that this has led to successful collaboration and communication to meet youth's needs. Similar to Florida's Open

[38] Shared Hope International, *Protected Innocence Challenge: Toolkit 2019*.
[39] While three of the states have not fully decriminalized CSE, our review indicated these states choose to divert youth from the delinquency system and connect them to services in a similar manner as states with full decriminalization.
[40] Chapter 2016-24, *Laws of Florida*, protects children from being arrested and prosecuted for prostitution.
[41] Three states (California, Minnesota, and New York) have specialized CSE funding in their state budgets for service provision; five states (California, Minnesota, New York, Nevada, and Texas) have funding for administrative purposes.
[42] All but one of the states had an aspect of county administration, with four fully county operated and one bifurcated system.

Doors Outreach Network, two states have also developed specialized service teams that can respond across jurisdictions and coordinate services for youth.

States reviewed serve both dependent and community youth; however, unlike Florida, some states' child welfare agencies only have jurisdiction over familial cases of exploitation. These states reported collaborating with stakeholders to coordinate care for CSE youth, requiring these states to have multiple pathways to services. Some states have developed a streamlined path through established statewide programs where, regardless of who identifies a youth, protocol requires referrals to the statewide program.[43]

States reported success with interventions that engage youth, are victim centered, and are trauma responsive; however, best practices for residential placements are still in development. Treatment modalities and interventions supported by states are in line with the literature. Reported best practices include TF-CBT, motivational interviewing, Stages of Change, and mentorship. States acknowledged that youth in this population have service interruptions, often requiring years of investment in services. States reported having implemented individualized approaches that are survivor informed to respond to youth's extensive service needs and plan to improve upon the inclusivity of these supportive services in the coming years. To reduce the risk of runaway, these states have developed a variety of approaches, including harm reduction, staff-secure placements, respite options, and CSE-specific advocates.[44] These methods aim to prevent occurrences while simultaneously reducing risk. Best practices are still in development for capacity, staffing composition, and levels of lockdown; states shared that they often look to each other to adapt successful models.

DJJ CASE FILE REVIEW

Files reviewed showed minimal CSE-specific service provision for verified youth; several youth had missing or delayed CSE alerts

CSE victims continue to have high rates of involvement with the delinquency system in the years following their initial CSE verifications. There may be unique opportunities to provide CSE-specific services to these youth while they are placed in secure DJJ facilities. To assess what CSE-specific services youth may be receiving while in these placements, we reviewed DJJ files of 28 CSE-verified youth from their time in juvenile detention centers (JDCs) and residential commitment facilities from January 2017 through December 2019. While DJJ may refer youth for CSE-specific services in the community, our review was limited to youth in secure facilities and therefore did not include records pertaining to intake centers, community placements, or probation. Some files we received did, however, contain this documentation, and any CSE services seen in probation or community services documents are included in the analysis.

Our review included a random sample of both dependent and community CSE youth. Twenty-seven youth had stays in secure detention facilities during our review period, while 19 also had stays in either secure or non-secure residential commitment programs. Over the three-year review period, the youth averaged more than five of these placements per year.[45] While JDCs maintain youth's files electronically, residential commitment programs maintain paper files, which, depending on the size and timespan of the file, are often stored in multiple locations. Reviewing youth's DJJ files from commitment placements required juvenile probation officers and facility staff to collect documents

[43] One additional state reported plans to develop a more streamlined approach to serving CSE youth.
[44] Harm reduction is a safety plan approach to help youth reduce risky behavior over time. A staff-secure approach evaluates staff-to-youth ratios.
[45] For definitions of these placement types, see s. 985.03, *F.S.*

from various locations and scan paper documents. OPPAGA requested 35 files; 7 of the files received were reported by DJJ to be incomplete. Further, many of the files that were reported to be complete also appeared to be missing documents.

Youth in the files reviewed had high rates of behavioral health issues and histories involving both the dependency and delinquency systems. As with prior file reviews, nearly all children reviewed had evidence of behavioral health issues, including multiple mental health diagnoses and substance abuse issues. The most frequent mental health diagnoses reported in the files were Attention-Deficit/Hyperactivity Disorder, Conduct Disorder, Bipolar Disorder, Depressive Disorder, and Posttraumatic Stress Disorder. Youth reported using a variety of substances, including cannabis, alcohol, opioids (prescription and illicit), and stimulants (including cocaine and methamphetamine). Nearly all youth had histories of involuntary commitments.

Evidence of common risk factors for trafficking were noted in the files, including prior runaway episodes, sexual abuse, and histories of DCF involvement. Additionally, several youth were either parents or pregnant during their DJJ placements. All but three youth had DJJ involvement prior to the review period, most of which was extensive. The majority of youth began their DJJ involvement at a young age; the average age of first offense for youth in the sample was 13.

Several youth did not have information in their file alerting facility staff to their CSE verification. When youth who are verified or suspected victims of CSE are in DJJ custody, DJJ policy stipulates that the youth's file have either a Possible or Verified Commercial Sexual Exploitation of Children (CSEC) alert; however, several files included in our review were missing alerts for the child's CSE status, indicating that facility staff may not be aware of the child's exploitation. (See Appendix G for more information on DJJ's policies regarding suspected victims of CSE.)

Our review found that seven youth did not have alerts pertaining to their CSE (verified or possible), and, for the youth that did have CSEC alerts, the alerts were often added several months after their CSE investigation began. For the youth with CSEC alerts, the alerts were added to their files an average of 253 days after DCF began their investigation. DJJ staff reported that a delayed or missing CSEC alert may occur if a child's exploitation is discovered by DCF, not DJJ, particularly if the exploitation is verified prior to the youth's DJJ involvement.[46] However, both agencies reported that DCF provides DJJ with quarterly reports containing information related to each youth's DCF involvement (including CSE verifications). Despite receiving these reports, DJJ staff reported that youth's CSE verification may not be entered into alerts reports (and thus communicated to field staff) as systematically as other foster care information is entered. In addition to providing quarterly reports, DCF staff reported that DJJ field staff are invited to all MDT staffings involving suspected CSE victims.

Case files contained little evidence of youth receiving CSE-specific services. While youth in our sample received varying types and frequencies of mental health and substance abuse services, especially depending on whether they were in detention or residential commitment facilities, our review found little evidence of services tailored to address the youth's CSE.

Upon entry into a juvenile detention center or residential commitment facility, all youth receive a variety of assessments regarding their history and behavioral health; however, the assessments appear to be used to assess the youth's safety in the facility and not to determine needed services. Depending on the results of initial assessments, facility staff may make referrals for mental health and/or substance abuse services or additional evaluations. According to DJJ policy, staff is required to submit mental health referrals for youth with suspected or verified CSE involvement containing any known details of the youth's exploitation. While our file review found evidence of frequent mental

[46] Because our review only covered a three-year period and did not contain files from juvenile assessment centers, it was often unclear who administered the Human Trafficking Screening Tool that resulted in a child's first verified CSE investigation.

health referrals, often for further assessment of suicide risk or medication management, none of the referrals reviewed referenced CSE.

As part of intake into a JDC, youth are made aware of available mental health and substance abuse services. Policy dictates that parents or guardians must provide consent for mental health services and psychotropic medications, and youth are responsible for providing consent for substance abuse services. While the majority of youth whose files we reviewed received some form of behavioral treatment during at least one JDC placement, many youth did not consistently agree to receive these services. Those who did consent to services usually received counseling sessions or medication management for psychotropic medications. Reasons for accessing behavioral health services varied by youth and were often used to address acute issues (e.g., relations with peers or preparation for upcoming court dates). Some children requested services but were moved from the facility before they could receive them.

In the residential commitment records reviewed, the types and frequencies of behavioral health services in these programs appeared to be the same for all youth, with little individualization in treatment beyond a youth's specific treatment goals.[47] Youth who had placements in residential commitment programs were scheduled to receive daily group counseling, weekly individual counseling, and monthly family counseling (for non-dependent youth and those under 18 years of age); those who were prescribed psychotropic medication were scheduled to receive medication management with a psychiatrist or psychiatric Advanced Registered Nurse Practitioner at least once per month.[48] The services reviewed were the same regardless of the level of restrictiveness (e.g., non-secure, high-risk, and maximum-risk residential).[49] Therapeutic notes generally showed a focus on behaviors that led to their offenses as opposed to the child's trauma.

Department staff reported that they provide evidence-based treatments for youth impacted by trauma. Our review found services addressing trauma or sexual abuse in general and services that utilized therapeutic modalities that have been identified as promising practices for CSE treatment (e.g., TF-CBT, DBT, and motivational interviewing); however, very few therapeutic notes mentioned the child's exploitation specifically.[50] Two children reviewed had mentors from an outside CSE provider with whom they maintained contact during their stays in detention and commitment programs. A few children were referred to community CSE providers at program discharge or as part of probation services. Our review found no other evidence of community providers working with children while in DJJ facilities.

This lack of specialized programming within DJJ facilities was supported by community CSE providers that make mentors available to youth in DJJ facilities as part of their service continuum. These providers reported that, to their knowledge, CSE youth in DJJ facilities do not receive services specific to their exploitation, with the exception of children who have mentors through community providers. They reported that they have been able to provide mentors to existing clients in JDCs but that these facilities are not conducive to providing therapeutic services. In residential facilities, they have found that there are more therapeutic services, but their providers have not seen a difference between what CSE-identified youth and the general population receive. They noted that services in DJJ facilities are focused on behavioral issues. While DJJ requires staff to attend human trafficking training courses,

[47] Chapter 63N-1, *F.A.C.*, requires individual treatment plans and goals to be developed for a youth requiring ongoing mental health or substance abuse treatment.

[48] Four files were missing service information for the youth's time in residential commitment facilities.

[49] Some similarities across programming and treatment plans can be expected because many components of treatment are mandated for all youth by contract and Standardized Program Evaluation Protocol requirements.

[50] Department staff reported that several types of group therapy sessions are offered in various DJJ residential commitment programs to address trauma, including Coping with Stress: A CBT Guide for Teens with Trauma; Girls Trauma Recovery and Improvement Model; Male Trauma Recovery and Improvement Model; Seeking Safety; and Trauma Focused Coping.

providers reported that CSE training is a consistent need for staff in DJJ facilities, which some providers have previously conducted. They have found that high rates of facility staff turnover lead to a cyclical need for training; however, resources for comprehensive trainings are limited. DJJ staff reported that for Fiscal Year 2020-21, the department has added additional human trafficking training requirements for DJJ and DJJ-contracted staff, thereby strengthening existing requirements.

OUTCOMES (2013 THROUGH 2018)

CSE victims continue to have high rates of involvement with DCF and DJJ in the years following their verification; rates of K-12 school attendance remain low

This section includes youth identified in our prior reports, from 2013 through 2018. We examined children's short-term outcomes in three areas: (1) child welfare, (2) juvenile justice, and (3) education. For these measures, we looked at the short-term outcomes of a subset of all CSE-verified children for whom data were available for at least one year following their initial CSE verification and prior to turning 18.[51,52] We also include comparisons for certain measures where children could be tracked for at least three years prior to turning 18.[53,54] For many of the measures, the children we could track for the different time periods did not make significant progress. In addition to examining outcome measures for CSE victims who are still minors, we also conducted analyses of outcomes for CSE victims who have turned 18 years of age. (See Appendix H for more information.)

Outcomes at both one and three years after CSE verification show high rates of subsequent involvement with DCF. More than half (55%) of the CSE victims in our outcome population who could be tracked for at least a year had a subsequent DCF investigation within that year; of those, 43% had verified findings in at least one of their subsequent investigations. During this time, dependent CSE victims spent the largest amounts of time in group care and foster homes (24% and 16%, respectively).[55] The remainder of their time was spent in placements such as emergency shelters, residential treatment, and with relative and non-relative caregivers.

In the first year following their CSE verification or entry into out-of-home care, using a bridged calculation, victims averaged 7.7 formal placement changes.[56] When considering unbridged placements, and including interruptions due to runaway episodes, victims' placement changes increased to 11.2 changes in one year. The majority (60%) of those in out-of-home care ran away from care at least once during the year, a decrease from the prior year's outcomes population (67%).

[51] The total outcomes population includes 1,388 youth; however, because not all youth can be tracked for one- and three-year intervals, the number of children included for each measure varies.
[52] DCF and DJJ one-year measures include data on 1,027 youth. The education measures included data on 1,240 youth. These numbers may further vary across individual measures.
[53] The three-year outcomes measures include the following numbers of youth: 177 for DJJ measures, 196 for DCF measures, and 264 for education measures. These numbers may further vary across individual measures.
[54] Because of the need to track outcomes for at least three years before the child turned 18, the outcomes reported for these measures tend to include children who were younger when they were identified in the first three years of our reports.
[55] For these measures, group care includes group homes and emergency shelters but does not include safe houses.
[56] Bridged placement calculations do not include temporary placement changes due to a child running away, being hospitalized, having visitations, etc. For example, if a child runs away from a placement and then returns to the same placement, a bridged calculation would only count that as one placement and not a placement change.

Runaway rates were highest for children in group care; while group care made up 19% of the placement records, these placements accounted for 42% of runaway episodes.

In addition to the frequent changes in children's placements, many children remained in out-of-home care for at least a year.[57] For those who entered out-of-home care following their first CSE verification, on average, 80% were still in out-of-home care after one year.

For children who could be tracked for three years (a subset of those who could be tracked for one year) following their first CSE verification, the rates of involvement with DCF increased. Nearly three-quarters (72%) of the victims we could track over this time had a subsequent DCF investigation; of those, 58% had verified findings for at least one investigation. During this time, dependent CSE victims spent 26% of their time in group care and 31% of their time in family settings.

When examining placement changes for children who could be tracked for three years, it appears that children's placements are more stable. Using a bridged calculation, over three years, these children averaged 6.3 formal placement changes per year. Using an unbridged calculation, they averaged 9.4 changes per year. While the number of placement changes is slightly lower for this group, the percentage of children who had a runaway episode is higher. Seventy-two percent ran away from at least one placement over three years, with children most frequently running from group homes (44%).

The majority of the children who were in out-of-home care after their CSE verifications and could be tracked for three years remained in out-of-home care until they turned 18 years of age. That is, 69% of those who were 15 or older when they entered out-of-home care following their CSE verification (or who were already in out-of-home care) aged out of care by the end of the three years. The remainder were reunified with their families (23%), living with a guardian (4%), adopted (3%), or emancipated (1%).

When including all the children in our outcome population, 22% had at least one subsequent verification of CSE, 47% of whom were community children.[58] Almost half (44%) of children with a subsequent CSE verification spent some time in out-of-home care between their first and second CSE verification. This is a slight decrease from the outcome population in our 2019 report, where 47% spent some time in out-of-home care between their first and second verifications. These children spent the largest amounts of time in group homes or on runaway status (26% and 23%, respectively). Children with at least one subsequent verification averaged 293 days between their first and second CSE verifications.

CSE victims continue to have high rates of involvement with the delinquency system in the years following their initial CSE verifications. We reviewed DJJ data to determine the extent of these children's subsequent involvement with the juvenile justice system. Of those who could be tracked for at least a year, 43% had an arrest within the year following their first CSE verification. The majority (68%) of those children were arrested more than once within that year. The primary charges for these arrests were assault and/or battery (18%), aggravated assault and/or battery (15%), and violation of

[57] According to federal and state law, a permanency hearing must be held no later than 12 months after the date the child is considered to have entered foster care. The hearing determines the permanency plan for the child that includes whether, and if applicable when, the child will be returned to the parent; placed for adoption and the state will file a petition for termination of parental rights; referred for legal guardianship; or, in the case of a child who has attained 16 years of age, placed in another planned permanent living arrangement. A permanency hearing must be held at least every 12 months for any child who continues to be supervised by the department or awaits adoption.

[58] To provide the full number of children who had subsequent verifications, the measures related to re-victimization are not constrained to those who could be tracked for at least one year and instead include the entire outcome population.

probation (14%).[59] Nearly half (43%) of these victims received at least one DJJ service within the year, including detention (34%), probation (22%), residential commitment (11%), and diversion (9%) programs. However, when looking at the year in which the child was identified, this DJJ involvement appears to be decreasing over time (46% in 2014 v. 39% in 2018), primarily due to decreases in rates of subsequent detention and probation.

Of those individuals who could be tracked for three years, 52% were arrested by DJJ in the three years following their first CSE verification; 79% of those children were arrested more than once. Thirty-four percent of the primary charges were for aggravated assault and/or battery. Among these victims, 53% received at least one DJJ service in the three-year period, including detention (46%), probation (33%), residential commitment (15%), and diversion (13%) programs.

In the years after verification, the majority of CSE victims were enrolled in school; however, they had low attendance records and were in lower-than-expected grade levels. We examined educational outcomes for CSE victims who we could track for the full calendar year following their first CSE verification using Department of Education data on K-12 school enrollment, grade level, and attendance. In the school year following their CSE verification, 84% of CSE victims had a K-12 enrollment in a Florida public school.[60] However, 59% of those enrolled the next school year were in a lower-than-expected grade level based on their age, 42% of whom were two or more years behind. Additionally, 45% of those enrolled attended for less than half the school year.

For those individuals that we could track for three years in the K-12 system, 92% were enrolled at some point during this time. Two-thirds (66%) of those that were enrolled were in a lower grade level than expected based on their age. Of those that were enrolled, 53% attended school for less than half the year.

FAMILY FIRST PREVENTION SERVICES ACT

Florida and other states are preparing for child welfare system changes related to the Family First Prevention Services Act

The Family First Prevention Services Act of 2018 (FFPSA) made federal changes to child welfare financing to encourage states to transition to a prevention-focused model for their child welfare systems and increase the use of family foster homes for out-of-home care placements. Under FFPSA, federal funding is limited for group care settings, with the exception of certain specialized settings, including those serving children who are victims or are at risk of becoming victims of CSE.[61] To qualify for this exemption, states must develop definitions of who will be considered at risk of human trafficking and develop criteria for placement options for this population. While states are allowed to

[59] Children may have been charged with multiple offenses during these arrests; however, for the purposes of these calculations, we only include the most serious charge associated with each child for the follow-up year.

[60] Children may be enrolled in school but not appear in the data for several reasons. First, the identifying information for the children in the outcome population may be inconsistent between DCF and Florida Department of Education data. Second, enrollment records are not available for children who attended school out of state or attended private or home school. As a result, the counts of enrollments, attendance, and highest grade completed may be low. Further, some children may not be enrolled at all, particularly those whose age during this academic year exempted them from K-12 enrollment.

[61] FFPSA limits the use of federal Title IV-E funding for group care settings beyond two weeks, with the exception of the following settings: placements serving children who are victims or are at risk of becoming victims of human trafficking; maternity homes; qualified residential treatment programs; and supervised independent living settings for youth 18 years of age and older. Most of the states we interviewed, including Florida, have delayed implementation of this provision until 2021.

delay certain provisions of the act, all funding changes required under FFPSA must be implemented by October 1, 2021. Florida and other states are at various stages of the planning process.

DCF is preparing for implementation of the group care provisions of the federal Family First Prevention Services Act. While FFPSA allows for the use of federal funds to serve children who are at risk of human trafficking, states must develop their own definitions for who is included in this population as well as criteria around their placement options. DCF has drafted a definition for children who will be considered at risk of human trafficking and licensing standards for a new placement type to serve these children. The department is preparing to submit these drafts for federal approval.

The department's draft definition includes common risk factors for CSE, including history of runaway episodes, sexual abuse or sexually inappropriate behavior, and out-of-home placement instability. The draft also includes additional risk factors, such as inappropriate interpersonal or social media boundaries and family history of exposure to human trafficking. DCF plans to establish a new group placement type to serve children deemed at-risk. In addition to standard licensure requirements, providers will have to meet additional requirements for supervision and staffing ratios, staff training related to human trafficking, specific client-based services, and treatment plan requirements.[62] The department's proposed training requirements include specialized pre-service training on human trafficking and human trafficking prevention education as well as 40 hours of annual in-service training, 8 hours of which must be focused on human trafficking.

Other states are still drafting their definition of who will be considered at risk of sex trafficking under FFPSA. States have evaluated their current CSE-related definitions and have sought feedback from stakeholders, survivors, national experts, and other states to develop a new definition of at risk of human trafficking. Four states have a current definition of at risk for trafficking established for identification purposes and are evaluating those existing definitions to establish a separate definition for service provision. Throughout the drafting process, states are discussing how to narrow this definition to guard against unnecessary labeling for vulnerable youth. Broader than Florida's draft, one state plans for all children and youth in out-of-home placement settings to be classified as at-risk. Some of the states reviewed reported that they are still educating the public and providers on the distinctions among trafficking, exploitation, and abuse, and they are concerned with how a new definition will fit into existing classifications.

Many states are considering qualified residential treatment programs as the primary placement option under FFPSA. While states are granted discretion in developing a new placement type for at-risk children, states expressed mixed interest in creating new placements and overall viewed development of this type of placement as a long-term goal. Anticipating a diminished use of group home placements under FFPSA, states are adjusting their current structure to leverage the use of foster care, specialized placements, and treatment programs to accommodate CSE youth and comply with federal requirements.

States expressed consistent interest in utilizing qualified residential treatment programs and expanded foster home availability for CSE-identified and at-risk youth.[63] While these are Title IV-E-eligible placements under FFPSA, qualified residential treatment programs have extensive requirements under federal law (including restrictions on who can be placed in these programs), and

[62] At-risk homes must meet the same training requirements as foster parents of safe foster homes and staff of safe houses, outlined in Ch. 65C-43.004, *F.A.C.*

[63] A qualified residential treatment program is a newly defined type of non-foster family setting required to meet detailed assessment, case planning, documentation, judicial determination, and ongoing review and permanency hearing requirements for a child to be placed in and continue to receive Title IV-E foster care maintenance payments for the placements.

recruiting foster parents for this population requires extensive training and resources. Similar to Florida, one state has drafted enhanced practice standards for certification of providers serving at-risk youth and is considering creating a specialized track within existing settings. Some states shared concerns about creating specialized placements for at-risk youth, with concerns similar to those around creating an at-risk definition. Overall, states are still evaluating the associated costs, provider readiness to transition, and how licensing standards will change to comply with federal requirements for specialized treatment in qualified settings.

RECOMMENDATIONS

To address the lack of CSE-specific services, file organization issues, and lack of CSE alerts that we found in our case file review of CSE youth who resided in Department of Juvenile Justice facilities, we recommend that the department increase CSE-specific programming for youth that receive department services. In addition, the department should enhance its file management activities and improve data sharing with providers to ensure that youth receive appropriate services based on their CSE status.

We recommend that DJJ require its providers to develop and implement CSE-specific programming in facilities and consider electronic file maintenance. Our review of CSE youth's DJJ files found little evidence that these youth receive services to address their exploitation. CSE-specific services that are received are generally mentoring services provided by external community providers, though these were still not provided to the majority of youth in our file review. Since these youth are in secure placements, often for extended periods, we recommend that the department implement CSE-specific programming in detention and commitment facilities. Recommended services include a human trafficking prevention curriculum to be provided as part of group counseling as well as a requirement for a CSE-specific individualized treatment goal for all verified CSE youth. Additionally, we recommend that DJJ residential providers strengthen their partnerships with child welfare community providers that offer survivor-mentor services to more consistently provide these services while youth are in custody.

Further, DJJ should improve its maintenance of children's files and consider requiring residential commitment facilities to maintain electronic records. Youth's residential commitment files are primarily kept as paper files and may be stored in multiple locations (e.g., part of a file may reside with the youth's probation officer, with other components kept at facilities or in storage). Due to the frequency with which these children move in and out of facilities, having electronic records would make it easier for therapeutic staff to review children's records and evaluate needed services and past progress. Additionally, juvenile detention centers maintain a document summarizing each youth's mental health services across facilities throughout their history with the department. A similar document could be helpful to staff of residential commitment facilities to easily review residents' treatment services.

We recommend that DJJ improve data sharing with its providers regarding a child's CSE verification. Our file review revealed that several files were missing the alert that notifies facility staff that a child is a suspected or verified CSE victim. Additionally, the majority of youth who had these alerts in their files had the alerts added several months after the child's DCF investigation began. DCF provides CSE investigation findings and other foster care information to DJJ on a quarterly basis. However, department staff reported that youth's CSE verification might not be entered into alerts reports provided to the field as systematically as other foster care information. We recommend that

DJJ improve its data sharing with its residential providers and include youth's CSE investigation data in reports with other protective services information. Further, while DJJ policy requires staff attend multidisciplinary team staffings for youth with active CSE investigations and determine the outcomes of these investigations, the policy does not require staff to enter a Possible CSEC alert unless DJJ staff administered a Human Trafficking Screening Tool. We recommend that DJJ modify its policies to ensure that alerts are added each time DJJ staff members participate in MDT staffings for youth with suspected CSE involvement.

APPENDIX A

Department of Children and Families Has Increased Allocations to Lead Agencies to Serve CSE Victims

For Fiscal Year 2018-19, the Department of Children and Families allocated $5.1 million to lead agencies to serve CSE victims, which was $2.1 million higher than the amount allocated for Fiscal Year 2017-18. In prior years, lead agencies consistently exceeded their annual CSE allocations to serve victims, but in Fiscal Year 2018-19, lead agencies expended 86% of their DCF allocation, or $4.4 million, for CSE victim services. However, as shown in prior years' reports, the percentage of funds expended by each lead agency varies widely, ranging from 0% to 181%. (See Exhibit A-1.)

Exhibit A-1
Lead Agencies Expended 86% of Their Budget Allocation for Fiscal Year 2018-19

Lead Agency	Counties Served[1]	DCF CSE Allocation[2]	Total Expenditures of Fiscal Year 2018-19 Funds[3]	Percentage of Funds Expended[4]
Big Bend Community-Based Care	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Wakulla, Washington	$200,419	-	0%
Brevard Family Partnership	Brevard	156,027	131,500	84%
ChildNet	Broward	446,517	742,839	166%
ChildNet	Palm Beach	256,334	392,567	153%
Children's Network of Southwest Florida	Charlotte, Collier, Glades, Hendry, Lee	266,222	251,532	94%
Citrus Family Care Network	Miami-Dade, Monroe	594,841	346,273	58%
Communities Connected for Kids (formerly Devereux)	Indian River, Martin, Okeechobee, St. Lucie	176,374	155,438	88%
Community Partnership for Children	Flagler, Putnam, Volusia	205,530	100,259	49%
Eckerd Community Alternatives	Hillsborough	445,358	-	0%
Eckerd Community Alternatives	Pasco, Pinellas	360,026	21,641	6%
Embrace Families (formerly Community-Based Care of Central Florida)	Orange, Osceola, Seminole	441,420	530,513	120%
Family Support Services of North Florida	Duval, Nassau	284,260	269,741	95%
Heartland for Children	Hardee, Highlands, Polk	265,335	278,596	105%
Kids Central	Citrus, Hernando, Lake, Marion, Sumter	312,524	564,862	181%
Kids First of Florida	Clay	53,162	-	0%
Lakeview Center, Families First Network	Escambia, Okaloosa, Santa Rosa, Walton	276,896	487,230	176%
Partnership for Strong Families	Alachua, Baker, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Madison, Suwannee, Union, Taylor	181,719	63,728	35%
Safe Children Coalition	DeSoto, Manatee, Sarasota	172,906	80,102	46%
St. Johns County Board of County Commissioners	St. Johns	34,003	12,512	37%
Total		**$5,129,873**	**$4,429,333**	**86%**

[1] Not all counties in a lead agency's service area have verified CSE victims.
[2] Based on Department of Children and Families Budget Ledger System.
[3] Based on Fiscal Year 2018-19 Community-Based Care Lead Agency Monthly Actual Expenditure Reports, including use of carry forward funds.
[4] According to DCF, lead agencies may use any core services funding for CSE victims. Section 409.991, *F.S.*, defines all funds allocated to lead agencies as core services funds, with the exception of maintenance adoption subsidies, independent living, child protective services training, designated children's mental health wraparound services funds, and designated special projects.
Source: Department of Children and Families data.

APPENDIX B

Lead Agencies Paid an Average of Nearly $14,000 per Child for CSE-Specific Services in Fiscal Year 2018-19

In Fiscal Year 2018-19, lead agencies allocated $5.1 million to providers to serve CSE youth. This allocation funded services for 221 youth, with lead agencies spending approximately $4.4 million; this is a decrease from Fiscal Year 2017-18, when lead agencies expended $5.2 million to serve 264 children.[64]

Exhibit B-1 shows the payments made to CSE providers who received 65% of the payments to serve CSE children at an average cost of nearly $14,000 per child; this is a decrease from the prior year's average of nearly $18,000 per child. Safe house providers accounted for 83% of payments to CSE-specific placements at a cost of approximately $36,000 per child. The remaining 35% of payments not shown in the table went to non-CSE providers, including residential treatment centers not identified as having CSE-specific programming, residential group care (other than safe houses), and foster parents.

Exhibit B-1
CSE Providers Received 65% of the Funding for Services to CSE Victims in Fiscal Year 2018-19

Provider	Type of Provider	Total Payment Amount	Percentage of Total Payments Statewide	Average Payment per Child Served
Vision Quest/Sanctuary Ranch	Safe House	$845,129	**20%**	$46,952
U.S. Institute Against Human Trafficking	Safe House	410,770	**10%**	82,154
Citrus Behavioral Health	Various[1]	334,746	**8%**	2,536
One More Child	Safe House	278,400	**7%**	19,886
Bridging Freedom	Safe House	250,500	**6%**	41,750
Images of Glory	Safe House	246,800	**6%**	20,567
Wings of Shelter	Safe House	240,300	**6%**	30,038
Devereux Delta Program	Residential Treatment	120,650	**3%**	120,650
Aspire	Residential Treatment	15,082	**0%**	2,154
Total		**$2,742,377**	**65%**	**$13,509**

[1] Citrus Behavioral Health provides multiple types of services to CSE victims, including specialized therapeutic foster homes, inpatient psychiatric services, and wraparound services.
Source: OPPAGA analysis of Department of Children and Families data.

[64] These figures include payments from lead agencies to providers under the CSEC cost accumulator and do not include any appropriations to specific providers described in Appendix C. In addition to these funds, lead agencies may use additional funds to serve CSE youth.

APPENDIX C

Appropriations and Expenditures for CSE Programs

In Fiscal Year 2019-20, the Legislature appropriated $1.7 million in general revenue to four providers to serve and develop or expand services to CSE children.[65] In addition to the appropriated funds, providers may apply for grant funding under the federal Victims of Crime Act (VOCA); these funds are administered through the Florida Office of the Attorney General. Of the Fiscal Year 2019-20 funds, providers have spent $1.8 million to date. (See Exhibit C-1.)

Exhibit C-1
In Fiscal Year 2019-20, CSE Providers Spent $1.8 Million on Programs and Services for CSE Children

Provider	Funds Appropriated/ VOCA Award	Funds Expended	Source of Funds
Fiscal Year 2013-14			
Oasis	$300,000	$270,000	General Revenue
Fiscal Year 2014-15			
Devereux	825,027	796,880	General Revenue
Kristi House Drop-In Center	300,000	295,250	General Revenue
Fiscal Year 2015-16			
Bridging Freedom	1,000,000	977,094	General Revenue
Devereux	359,000	359,000	General Revenue
Kristi House Drop-In Center	250,000	249,407	General Revenue
	300,000	299,343	Federal Grants Trust Fund (DCF)
Porch Light	50,000	49,998	General Revenue
Fiscal Year 2016-17			
Bridging Freedom	700,000[1]	-	General Revenue
Devereux	359,000	359,000	General Revenue
Dream Center[2]	250,000	250,000	Federal Grants Trust Fund (DCF)
Kristi House Drop-In Center	200,000	198,500	General Revenue
Place of Hope	200,000	200,000	General Revenue
Voices for Florida – Open Doors	500,000	299,881	General Revenue
	1,123,996	95,299	VOCA
Fiscal Year 2017-18			
Bridging Freedom	700,000	81,002	General Revenue
	39,287	21,113	VOCA
	700,000	590,080	Reallocation of FY 2016-17 Funds
Devereux	700,000	700,000	General Revenue
Porch Light	200,000	200,000	General Revenue
Voices for Florida – Open Doors	1,956,283	1,556,960	VOCA
	1,140,000	980,999	General Revenue
Fiscal Year 2018-19[3]			
Bridging Freedom	700,000	571,328	General Revenue
Citrus Behavioral Health	400,000	134,161	General Revenue
Devereux	500,000	500,000	General Revenue
One More Child[3]	200,000	200,000	General Revenue
Redefining Refuge	500,000	500,000	General Revenue
Voices for Florida – Open Doors	1,800,000	1,496,856	General Revenue
	3,581,797	2,670,357	VOCA

[65] The Legislature appropriated additional funds to providers serving adult CSE victims.

Provider	Funds Appropriated/ VOCA Award	Funds Expended	Source of Funds
Fiscal Year 2019-20[4]			
Bridging Freedom	700,000	324,201	General Revenue
Nancy J. Cotterman Center	100,000	30,240	General Revenue
One More Child	100,000	91,667	General Revenue
Voices for Florida – Open Doors	750,000	554,505	General Revenue
	4,350,579	830,716	VOCA
Seven-Year Funding Total	**$25,134,969**	**$16,733,836**	**-**

[1] Bridging Freedom did not sign a contract to receive this funding; the funding was reallocated in Fiscal Year 2017-18. The Fiscal Year 2016-17 appropriation is not included in the total.

[2] Dream Center is now doing business as U.S. Institute Against Human Trafficking.

[3] Porch Light is now doing business as One More Child.

[4] At the time of this review, payments were still being made/reimbursements submitted for Fiscal Year 2019-20 grants and appropriations.

Source: Florida Accountability Contract Tracking System and Department of Legal Affairs data as of June 2020.

APPENDIX D

County-Level Prevalence Data

OPPAGA's analysis identified 378 victims of commercial sexual exploitation verified by DCF in 2019. Broward, Miami-Dade, Duval, and Orange counties had the highest numbers of victims. (See Exhibits D-1 and D-2.)

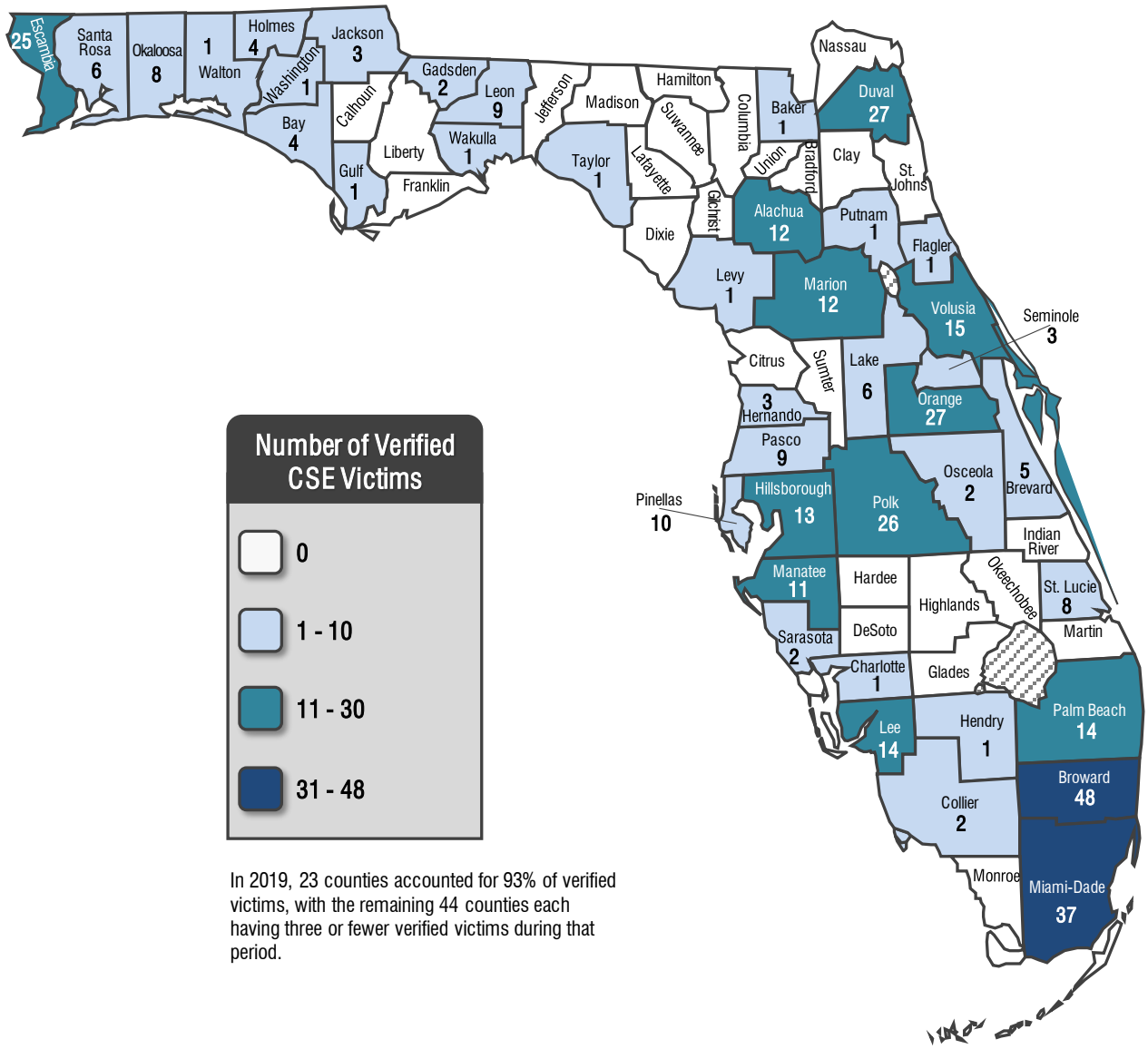
Exhibit D-1
Number of Verified CSE Victims by County

Community-Based Care Lead Agency	County[1]	Verified CSE Victims	Percentage of Verified CSE Victims
Big Bend Community-Based Care, Inc.	Bay	4	1.1%
	Gadsden	2	0.5%
	Gulf	1	0.3%
	Holmes	4	1.1%
	Jackson	3	0.8%
	Leon	9	2.4%
	Wakulla	1	0.3%
	Washington	1	0.3%
Brevard Family Partnership	Brevard	5	1.3%
ChildNet, Inc.	Broward	48	12.7%
	Palm Beach	14	3.7%
Children's Network of Southwest Florida	Charlotte	1	0.3%
	Collier	2	0.5%
	Hendry	1	0.3%
	Lee	14	3.7%
Citrus Family Care Network	Miami-Dade	37	9.8%
Communities Connected for Kids	St. Lucie	8	2.1%
Community Partnership for Children	Flagler	1	0.3%
	Putnam	1	0.3%
	Volusia	15	4.0%
Eckerd Community Alternatives	Hillsborough	13	3.4%
	Pasco	9	2.4%
	Pinellas	10	2.6%
Embrace Families	Orange	27	7.1%
	Osceola	2	0.5%
	Seminole	3	0.8%
Family Support Services of North Florida, Inc.	Duval	27	7.1%
Heartland for Children	Polk	26	6.9%
Kids Central, Inc.	Hernando	3	0.8%
	Lake	6	1.6%
	Marion	12	3.2%
Lakeview Center, Families First Network	Escambia	25	6.6%
	Okaloosa	8	2.1%
	Santa Rosa	6	1.6%
	Walton	1	0.3%
Partnership for Strong Families	Alachua	12	3.2%
	Baker	1	0.3%
	Levy	1	0.3%
	Taylor	1	0.3%
Safe Children Coalition	Manatee	11	2.9%
	Sarasota	2	0.5%
State Total		**378**	**100%**

[1] Counties not listed did not have any verified victims during the study timeframe (though they may have had investigations). Counties presented above were the counties of CSE victims' initial intake.

Source: OPPAGA analysis of Department of Children and Families data.

Exhibit D-2
Number of Verified CSE Victims by County in 2019



In 2019, 23 counties accounted for 93% of verified victims, with the remaining 44 counties each having three or fewer verified victims during that period.

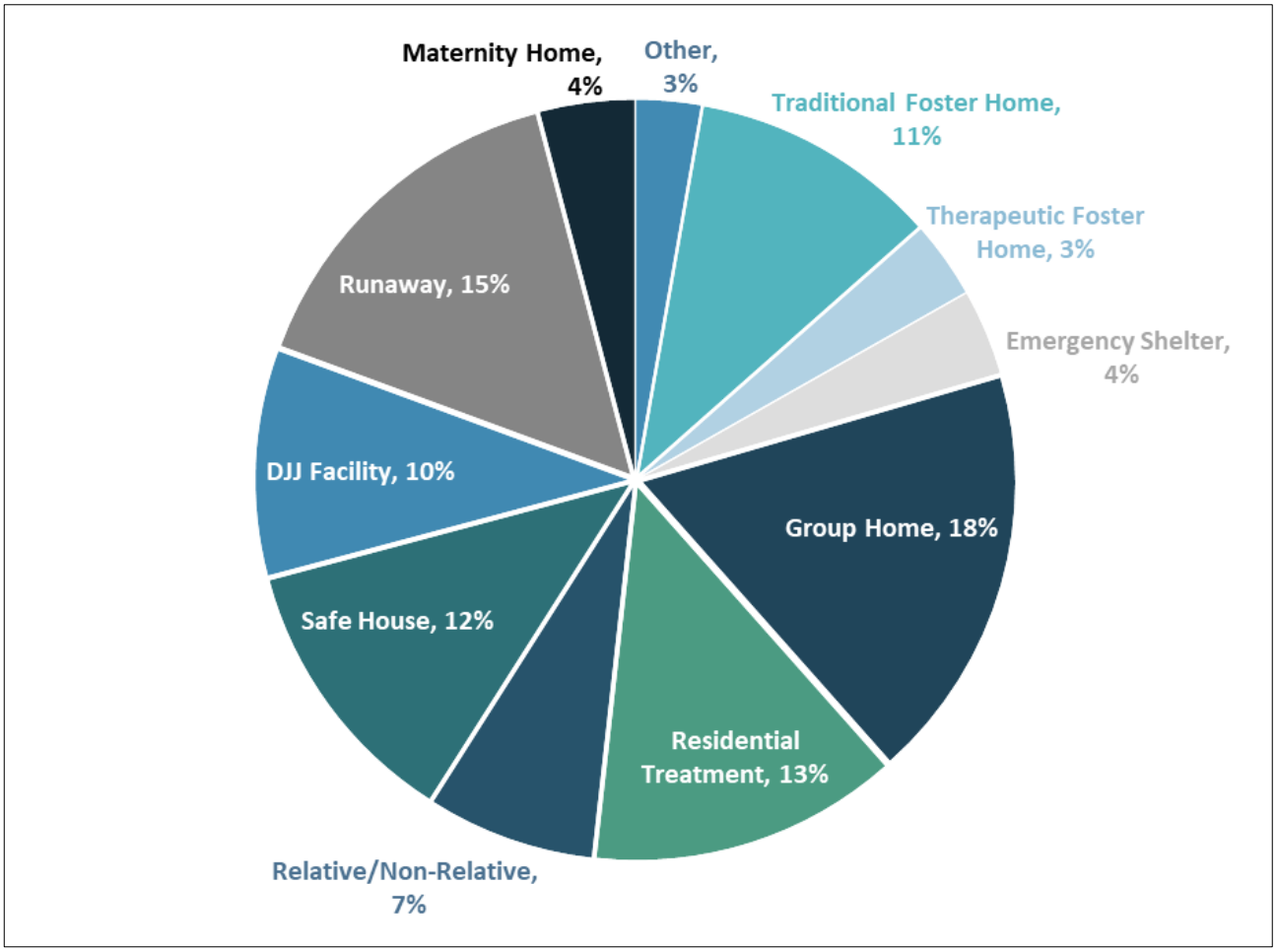
Source: OPPAGA analysis of Department of Children and Families data.

APPENDIX E

Percentage of Time in Out-of-Home Care Placements for 2019 CSE Victims

In 2019, 111 of the 378 verified CSE victims spent some time in out-of-home care following their CSE investigation. These children spent the majority of their time in out-of-home care in traditional group homes (18%), on runaway status (15%), in residential treatment centers (13%), or in safe houses (12%). (See Exhibit E-1.)

Exhibit E-1
CSE Victims in 2019 Spent the Largest Percentage of Their Time in Traditional Group Care Settings[1]



[1] Other includes temporary placements such as hospitals and visitation.

Source: OPPAGA analysis of Department of Children and Families data.

APPENDIX F

Academic Literature on Placement and Treatment Practices for Victims of Trauma

OPPAGA conducted a literature review to assess the most promising treatment and placement practices for CSE youth. Many of the promising treatment practices cited in the literature are considered evidence based for other similar trauma populations, such as victims of sexual assault, childhood trauma, or domestic violence. While several such practices are cited in the literature as promising practices for the treatment of CSE victims, they have not yet been validated for use with this population. (See Exhibit F-1.)

Exhibit F-1
Bibliography of Academic Literature on Placement and Treatment Practices for Victims of Trauma

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APPENDIX G

Department of Juvenile Justice Policies for Suspected CSE Victims

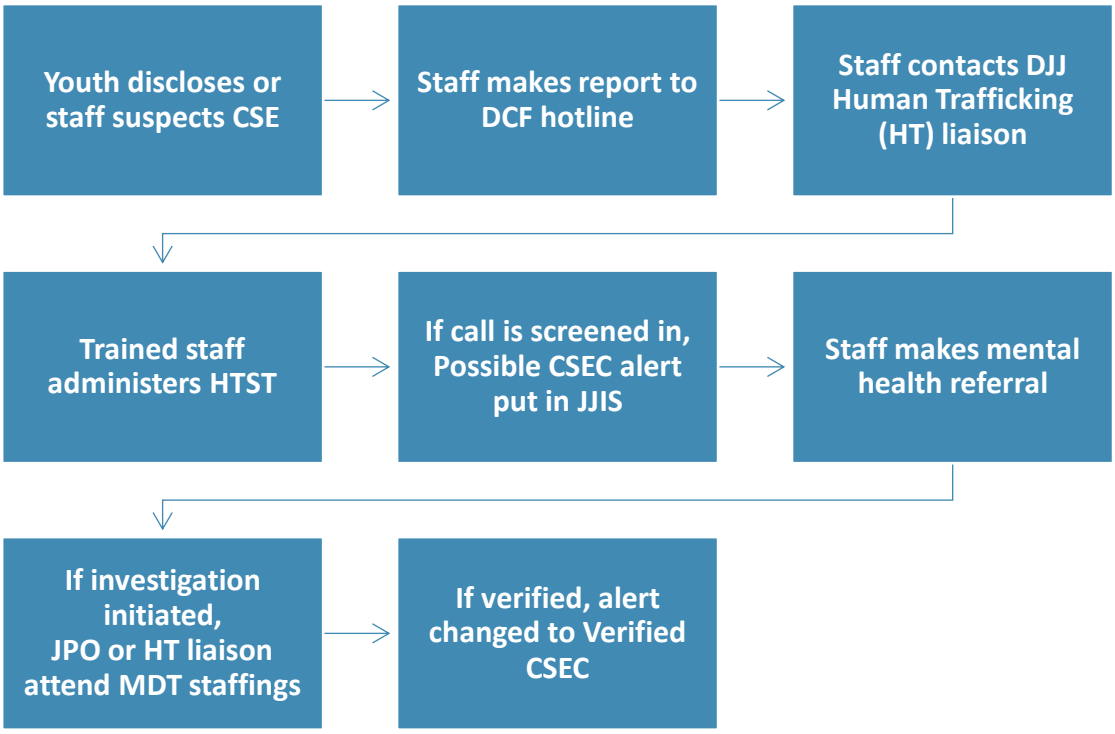
The Department of Juvenile Justice's Human Trafficking Procedures outline requirements for staff when youth are suspected of being victims of CSE, with separate requirements for those going through the intake process and those already involved in the delinquency system.

According to DJJ policy, if a youth entering an intake facility meets certain criteria, facility staff must administer the Human Trafficking Screening Tool (HTST).[66,67,68] Depending on the results of the tool, a call will be placed to the Florida Abuse Hotline. If the call is screened in by hotline staff, DJJ staff is required to enter a Possible CSEC alert into the Juvenile Justice Information System (JJIS). If the youth discloses or staff suspects CSE involvement outside of the intake process (e.g., in a DJJ facility), DJJ staff is required to call the abuse hotline. After calling the hotline, the staff member must contact their circuit's human trafficking liaison regarding the outcome of the call.[69] The human trafficking liaison must ensure that a trained department employee administers the HTST within 48 hours. Again, if the call is screened in by hotline staff, DJJ staff must enter the Possible CSEC alert into JJIS.[70] If a mental health referral has not already been completed, one must be completed immediately and must include details from the youth's disclosure or the indicators of potential trafficking.

If a human trafficking investigation is initiated for a DJJ-involved youth, the youth's juvenile probation officer (JPO) or the circuit's human trafficking liaison is required to attend all MDT staffings involving the youth to strategize appropriate placement and services.[71] DCF staff confirmed that DJJ staff are invited to all human trafficking MDT staffings. DJJ's human trafficking liaisons are responsible for determining the outcome of each abuse case within their circuit that was called into the abuse hotline. If the investigation was not verified, no further action is required. If the investigation is verified, the human trafficking liaison must change the Possible CSEC alert to the Verified CSEC alert. If a youth with a Possible CSEC or Verified CSEC alert is going to a juvenile detention center or residential facility, staff must complete and submit a mental health referral immediately. (See Exhibit G-1 for the process of identifying CSE in DJJ-involved youth.)

[66] DJJ policy defines intake facility as "a facility primarily used for the intake of a youth upon arrest for screening and processing purposes, including Juvenile Assessment Centers."
[67] Florida Department of Juvenile Justice Human Trafficking Procedures, FDJJ – 1925.
[68] DJJ staff must administer the HTST if a youth meets any of the following criteria: history of running away or getting kicked out of the home four or more times, including times when the youth did not voluntarily return within 24 hours and incidents not reported by or to law enforcement; history of sexual abuse; current incident or history of sexual abuse; current incident or history of sex offense, including prostitution; youth's acknowledgement of being trafficked; and/or report of human trafficking by parent/guardian, law enforcement, medical or service provider, teacher, youth protective services, and/or DJJ staff.
[69] Each DJJ circuit and detention center must have an assigned human trafficking liaison.
[70] The policy states that the alert should not be entered into the system until the tool has been administered.
[71] Regardless of the youth's delinquency status, all abuse investigations are conducted through DCF by child protective investigators.

Exhibit G-1
Process for DJJ-Involved Youth Who Are Suspected CSE Victims



Source: OPPAGA analysis of Florida Department of Juvenile Justice Human Trafficking Procedures.

APPENDIX H

Outcomes of Previously Identified CSE Victims Who Are Now Adults

In addition to examining outcome measures focused on CSE victims who are still minors, we included a few age-specific measures for those who have turned 18 years of age, including data on Florida Department of Law Enforcement (FDLE) arrests and charges, continuing education enrollments, public benefit usage, and employment.

Young adults previously verified as CSE victims continue to have involvement with law enforcement. Twenty-nine percent of young adults who could be tracked for a year after turning 18 were arrested by FDLE within that year. The most common charges were for violation of probation, failure to appear, and battery; less than 1% were arrested for prostitution. In looking at the three years following their 18th birthday, 45% of those who could be tracked were arrested by FDLE. The most common charges were for failure to appear, violation of probation, and battery; 3% had an arrest for prostitution.

While CSE victims continued to have low rates of high school completion, rates of continuing education appeared to be higher than in the past; many received public assistance and/or worked in an unemployment insurance-covered job at some point. Twenty percent of those who could be tracked for a year after turning 18 received a high school diploma, GED, or certificate by the end of the year (59% of which were GEDs). Twenty-six percent had at least one continuing education record within the year, 13% greater than observed in our 2019 report; 12% were enrolled in high school or remedial continuing education courses, 10% in a post-secondary institution, 3% in dual enrollment, and 1% in a certificate or trade program.[72]

In examining rates of public assistance and employment, 56% received benefits through the Supplemental Nutrition Assistance Program (SNAP) at some point in the year after turning 18; 40% of these young adults received SNAP for all four quarters. Only 3% received benefits through the Temporary Assistance for Needy Families (TANF) program, most of whom only received benefits for one quarter. Forty-four percent of the young adults we could track had an unemployment insurance-covered job at some point during the year following their CSE verification; the most commonly held job was in food service.

An additional 20% of the young adults we could track for a full three years received a high school diploma, GED, or certificate. Twenty-nine percent had at least one continuing education record: 15% were enrolled in high school or remedial continuing education courses; 10% in a post-secondary institution; 3% in a certificate or trade program, and 1% in dual enrollment. Seventy-two percent received SNAP at some point during this time, and 67% received TANF, generally for two years or less. Sixty-two percent of the young adults we could track had an unemployment insurance-covered job at some point during these three years (with 36% to 45% having a job in any given year); again, the most common job was in food service.

[72] In our 2019 report, this measure included 351 youth over 18, while this year's report includes 647.

AGENCY RESPONSE

FLORIDA DEPARTMENT OF JUVENILE JUSTICE

July 23, 2020

Mr. R. Philip Twogood
Office of Program Policy Analysis and Government Accountability (OPPAGA)
111 West Madison Street
Room 312, Claude Pepper Building
Tallahassee, Florida 32399-1475

Dear Mr. Twogood:

The Department of Juvenile Justice (DJJ) has received and reviewed the preliminary findings and recommendations of OPPAGA's "Annual Report on the Commercial Sexual Exploitation (CSE) of Children in Florida, 2020." This letter is DJJ's official response to the preliminary report in accordance with subsection 11.51(2), Florida Statutes.

DJJ has already implemented process improvements related to opportunities noted and recommendations made in the report and has planned additional improvements. In June 2020, DJJ updated the Human Trafficking Screening Tool (HTST) which will result in updates to DJJ policy and procedure, including items related to data sharing and alerts maintenance. Specifically, DJJ collaborated with the Department of Children and Families (DCF) to modify data sharing protocols to increase the frequency with which DCF sends human trafficking-related abuse investigation data to DJJ from quarterly to monthly. This will help ensure that DJJ has up-to-date information on CSE youth in the juvenile justice system. In addition, upcoming policy changes will require human trafficking alerts for potential trafficking victimization to be added to a youth's file as soon as DJJ staff are made aware of related child abuse investigations. This practice exists in the field but will be codified into policy. Such alerts were not previously required to be added unless DJJ staff conducted an HTST.

For FY 2020-21, the Legislature approved three additional clinical staff to work within DJJ's Office of Health Services to improve clinical treatment services in residential facilities and to provide increased oversight. The additional clinical staff will also provide training and guidance to ensure the youth who have suffered CSE are provided with the most effective and targeted clinical trauma treatment services. Administrative rule changes expected to be implemented in early FY 2020-21 will strengthen and increase human trafficking training requirements for DJJ and DJJ-contracted staff working directly with youth in detention, residential, and probation settings. DJJ also is in the process of implementing a human trafficking prevention and education curriculum for youth in residential commitment programs. Further, DJJ has been working to improve and digitize file management for residential commitment programs.

In addition to data capture and recordkeeping recommendations, the report also recommends that DJJ require its facility-based providers to develop and implement treatment services specifically for CSE youth. However, as the report also correctly points out, there are currently no evidence-based treatment services specific to the treatment of youth who have experienced CSE. Thus, DJJ, like the other entities serving these youth, employs the treatment modalities most frequently identified as promising practices in the report, including Trauma-Focused Cognitive Behavioral Therapy, Stages of Change, and Motivational Interviewing. Many residential commitment programs also provide additional specialized and individualized trauma treatment.

As the report shows, most CSE youth in Florida are served in a variety of settings outside of the juvenile justice system. Therefore, DJJ believes that to be effective, any effort to develop CSE-specific evidence-based programming must study data and outcomes for CSE youth in all settings, not just in DJJ facilities. Florida boasts several world-class research universities that could take on such an effort, elevating the state's national leadership in the fight against human trafficking.

Thank you for the opportunity to review and submit this response to the preliminary findings and report.

Respectfully,

Simone Marstiller
Secretary

State of Florida
Department of Children and Families

Ron DeSantis
Governor

Chad Poppell
Secretary

July 24, 2020

R. Phillip Twogood, Coordinator
OPPAGA
111 West Madison Street, Room 312
Tallahassee, FL 32399-1475

Dear Coordinator Twogood:

This letter is in response to the preliminary findings issued by the Office of Program and Policy Analysis & Government Accountability (OPPAGA) to the Department of Children and Families (DCF) on July 1 related to the commercial sexual exploitation of children. DCF remains strongly committed to preventing human trafficking, identifying victims, and providing effective services to victims of commercial sexual exploitation (CSE) in our state. We appreciate the acknowledgement of the progress that has been made in Florida and the complexity of the nature of the work related to CSE.

During OPPAGA's review period, DCF continued its efforts to address the commercial sexual exploitation of children through identification and service provision. Additional details related to the findings in the report are provided below.

Section 1: Prevalence
The number of verified victims decreased slightly in 2019; youth demographics are consistent with prior years, but the percentage of community children continues to increase.

Response: On-going DCF outreach training, which focuses on new research and emerging trends, has enabled the department to broaden the spectrum and better leverage community organizations and businesses in identifying and reporting CSE of a minor. DCF continues to conduct extensive trainings on issues related to CSE to individuals who are on the frontlines (child protective investigators, first responders, etc.). These trainings are often done in partnership with local task forces, other state agencies, and community stakeholders. These efforts, combined with targeted screening and identification measures, likely contribute to the increased number of calls to the Florida Abuse Hotline.

The identified need for continued training of hotline employees has been addressed by the department and more trainings will be routinely scheduled.

The slight decrease in verified victims indicates that community prevention efforts and rehabilitative services will continue to reduce the number of trafficked children in Florida. The increasing number of verified victims remaining in the community rather than entering the state's child welfare system, likely reflects the growing number of qualified service providers available to deliver appropriate treatment and wrap-around services to children who can be stabilized and safely remain at home.

Section 2: Placement and Services
As the percentage of CSE youth entering out-of-home care declines, providers continue to report challenges.

Response: As DCF continues the practice of six-month follow-up on all verified CSE cases, providers have reported in-home services challenges associated with a youths' unwillingness to participate in treatment and limited availability of CSE services in some areas. However, DCF will continue to identify and partner with agencies capable of providing necessary services throughout Florida. The use of survivor mentors has proved helpful in engaging youth and sustaining their engagement.

DCF is focused on establishing and maintaining a comprehensive system of care capable of meeting the unique needs of CSE victims in both the community and dependency systems. Over the course of the review period, DCF held regular meetings with CSE residential services providers to discuss concerns, successes, and promising practices. The department is currently working on developing training and informational sessions for prospective adoptive parents who are considering adopting a child who has been commercially sexually exploited. Additionally, starting in July 2020, DCF implemented quarterly listening sessions with each region's frontline staff, service providers, and safe homes staff. These sessions are designed to streamline communications and to provide better opportunities for direct feedback on current and prospective policies and procedures.

DCF continues to partner with state and federal research institutions to evaluate existing and emerging practices in treating CSE youth. The department is currently working with the U.S Department of Health and Human Services Administration for Children and Families on a national research project on the prevalence of human trafficking among youth transitioning from foster care; the risk and protective factors associated with increased or decreased risk of trafficking victimization, and the context surrounding victimization among youth in foster care. This important research will provide much needed insights into the most effective treatment modalities for CSE youth and for addressing gaps in providing services.

Section 3: Other States
States are still developing service networks for trafficked youth; they share commonalities in placement options, service gaps, and lessons learned

Response: DCF staff involved in combating CSE of minors work closely with their counterparts around the country as well as participating in nation-wide trainings and symposia relevant to human trafficking of minors. Some of Florida's service providers became certified

in CSE specific treatment curricula developed by other states. DCF also works closely with the National Human Trafficking Hotline and the National Center for Missing and Exploited Children to ensure timely reporting, recovery, transportation to home state, and service delivery to youth from Florida and other states around the country.

The Human Trafficking Unit at DCF is currently conducting a nation-wide search for evidence-based interventions aimed at incorporating a two-generation approach in working with children victimized by CSE as well as with their families. Once the best intervention has been identified, a pilot program will be implemented in select Florida counties. The overarching goal of this project is to better educate parents and caregivers about the dynamics of human trafficking victimization, to improve communications within the family, to decrease any conflicts arising in the home, and ultimately to prevent any future runaway episodes and the risk of youth returning to commercial sexual exploitation.

Section 4: DJJ Case File Review
Files reviewed showed minimal CSE-specific service provision for verified youth; several youths had missing or delayed CSE alerts

Response: DCF remains strongly committed to working in close partnership with DJJ in identifying trafficked youth and providing appropriate services. To assist DJJ in providing CSE-specific services to verified youth, DCF changed the frequency of its data sharing on crossover youth from a quarterly to a monthly basis effective July 2020.

In July 2020, DCF and DJJ Human Trafficking staff decided to create a joint workgroup to better address service planning and delivery. One of the first projects discussed was a cooperation in creating and implementing family-based interventions for verified CSE youth both in home and in substitute care.

Another promising practice of enhancing service delivery efforts to crossover youth is participation and creation of Human Trafficking Courts for youth involved in both dependency and juvenile justice systems. The first such court in Florida, called G.R.A.C.E. (Growth Renewed through Acceptance, Change and Empowerment) court, was launched in the Eleventh Judicial Circuit in 2016. It is a specialized court devoted to the needs of children who have been identified as victims of commercial sexual exploitation and labor trafficking. In October 2019, the Juvenile Crossover Division of the Unified Family Courts in Hillsborough County implemented a very promising problem-solving court called O.P.T.I.O.N. (Offering Potentially Trafficked Individuals Options Now). This innovative court style allows for the delinquent and dependent service providers for the identified crossover youth, including human trafficking specialized providers, to discuss and identify the best "options" for that youth based on that youth's history and create a comprehensive response plan to present to the child, if appropriate, during the hearing. A similar court model also exists in Broward County. Additionally, even outside of such specialized courts, more juvenile delinquency judges are willing to consider placements in therapeutic residential programs designed for survivors of CSE instead of traditional DJJ commitment programs.

Section 5: Outcomes

CSE victims continue to have high rates of involvement with DCF and DJJ in the years following their verification; rates of K-12 school attendance remain low.

Response: It is important to note that most CSE victims have experienced extreme and severe complex trauma, and need comprehensive long-term therapeutic engagement, often far beyond short or intermediate time frames of staying at a residential treatment facility. Many survivors explain that sometimes it takes decades for healing to become palpable.

The department will continue to coordinate with our partner agencies to create a system of care that ensures the best outcomes and meets the complex, long-term needs of CSE survivors. Specifically, DCF has contracts with select Safe Houses to provide residential care for verified victims past their 18th birthday as part of the extended foster care program. This is especially important for those children who have been recovered in their late teen years and who need more time to catch up academically. It also allows the children to acquire professional skills that will enable them to transition to independent living. DCF has also contracted with an adult residential facility to accept youth aging out of DCF care and to provide them with wrap-around services. An additional way DCF assists verified CSE victims is through partnering with agencies that offer life-long support services through mentorship, advocacy, job training, and peer support.

All children placed in Safe Houses for long-term residential programs are enrolled in school upon their admittance to the program. Many Safe Houses utilize virtual schooling options with certified teachers present to assist children with their educational goals. Some Safe Houses allow youth to go to traditional local schools when safe and appropriate. Many survivors of CSE are significantly behind in their academic process upon their recovery and require extensive long-term one-on-one tutoring to reach their appropriate grade level. Some children chose not to pursue a traditional high school diploma and opt for a GED instead. This option, if chosen by the youth, is supported by their caregivers and assistance is provided in obtaining the necessary study material, tutoring, and preparing for the test.

Unfortunately, the educational process is interrupted with every runaway episode and youth ultimately falls behind academically. Efforts to prevent runaway episodes have a direct impact on the academic success of CSE survivors and such efforts are integrated in all treatment modalities used with CSE youth.

Section 6: Family First Prevention Services Act
Florida and other states are preparing for child welfare system changes related to the Family First Prevention Services Act

Response: DCF staff have drafted a definition for children considered to be at risk of human trafficking, as well as licensing criteria, and treatment plan requirements. The draft is in the final stages of development and will soon be submitted for federal review and approval. At the next stage of implementation, DCF will conduct necessary trainings for its staff and partners to ensure comprehensive understanding of new requirements, policies, and procedures, and to ensure compliance.

If you have any questions please contact James Weaver, Director of Protective and Supportive Services, at 850-717-4686 or James.Weaver@myflfamilies.com.

Sincerely,

Chad Poppell
Secretary

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OPPAGA

Office of Program Policy Analysis and Government Accountability

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