Annual Report on the Commercial Sexual Exploitation of Children in Florida, 2021

Report No. 21-06

July 2021

OPPAGA

Office of Program Policy Analysis and Government Accountability

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EXECUTIVE SUMMARY

In 2020, 383 children were verified as victims of commercial sexual exploitation (CSE) in Florida. This number has increased slightly from 2019, when 378 victims were verified. During this review period, the number of children missing from care increased significantly.

Among all dependent children, the amount of time spent in safe houses is increasing; however, placements among re-victimized children vary widely from those first verified in 2020, with less time spent in group homes, safe houses, and with relative/non-relative caregivers and more time spent in residential treatment, foster homes, and missing from care. The majority of lead agencies reported placing community CSE victims in safe houses or residential treatment.

Survivor mentors identified areas of progress in serving CSE youth and identified additional service needs as well as a need for improvement in training and how stakeholders interact with youth. While there are still no evidence-based practices nationally for serving CSE youth, one Florida provider has undergone evaluations over the past eight years as part of its effort to become an evidence-based program.

States are still working toward full implementation of the federal Family First Prevention Services Act (FFPSA). Florida is finalizing policies to serve CSE youth and youth at risk for CSE under FFPSA; licensing for federally qualifying Title IV-E placements will begin in the summer of 2021. The department has identified 132 existing providers interested in going through the new licensing process for at-risk homes.

As in prior reports, CSE youth do not fare well on a variety of short-term outcomes. Victims identified in prior reports have high rates of subsequent involvement with the Department of Children and Families and Department of Juvenile Justice; the majority had at least one involuntary examination following their initial verification. While our reviews have found these victims to have low performance in K-12 schools, this outcome appears to be improving.

State agencies and CSE providers encountered several challenges in serving youth during the COVID-19 pandemic. While some agency initiatives were delayed, efforts to better identify CSE victims and collaboration among agencies improved.

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.

BACKGROUND

Human trafficking includes two types of exploitation: commercial sexual exploitation (CSE) and forced labor.[1] Florida law defines human trafficking as the exploitation of another human being through fraud, force, or coercion.[2] 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.[3] Federal and state law both criminalize human trafficking of adults and children.[4]

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 (FDLE), 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.[5] 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.[6]

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; DJJ providers also screen youth who exhibit certain characteristics indicative of CSE. When appropriate, DJJ and its providers 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 victims of CSE. While our 2020 report noted an increase in these state allocations in Fiscal Year 2018-19 (from $3 million to $5.1 million), the allocations in Fiscal Year 2019-20 returned to their prior level. For this year's review, we analyzed DCF data on all payments made by lead agencies to serve CSE-verified youth. Our analysis found that in Fiscal Year 2019-20, lead agencies spent nearly $11 million to serve these youth. In addition to the funds allocated to lead agencies, the Legislature appropriates funds to individual CSE providers to deliver specialized services. In Fiscal Year 2020-21, the Legislature appropriated $2.8 million to CSE providers serving minor victims, which includes residential programs, prevention education, and other community services.[7] (See Appendices A and B for more information on funding for CSE services.)

[1] Labor trafficking includes debt, bonded, and forced labor.
[2] Section 787.06, *F.S.*
[3] Section 409.016, *F.S.*
[4] 22 USC 7102 and s. 787.06, *F.S.*
[5] 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.
[6] Lead agency subcontractors provide case management, emergency shelter, foster care, and other services in all 67 counties.
[7] Some of the appropriations included in this amount are to organizations that also serve adult human trafficking victims or provide an array of services, including those to treat sexual assault, abuse, and child abuse.

PREVALENCE

The number of verified victims increased slightly in 2020; the percentage of children missing from care during investigations has increased

In 2020, the number of children verified as victims of CSE by the Department of Children and Families increased slightly.[8,9] While the overall number of victims increased, the numbers of victims with multiple verifications, or who had been verified in prior years, decreased. As in prior years, the majority of verified victims remained in the community in the six months following their investigations; however, there was a substantial increase in the number of children who were missing during their investigation. In addition to the data collected by DCF, hospitals have implemented new diagnostic codes to better identify and provide for victims of human trafficking; however, these codes do not appear to be widely used.

The number of victims identified in 2020 increased slightly; fewer youth had prior or multiple verifications. In 2020, reports to the Florida Abuse Hotline alleging the CSE of minors increased by 3%, from 3,088 reports in 2019 to 3,181 reports in 2020. Five counties accounted for more than one-third of all reports: Orange (272), Broward (237), Duval (236), Miami-Dade (228), and Hillsborough (203). Of the 3,181 reports, 47% were screened in and referred for child protective investigations. Of the reports referred for investigation, the two most frequent reporter types were DJJ/Department of Corrections/criminal justice personnel (18%) and law enforcement (17%).

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 (84%); there were no means to locate the victim (7%); or the alleged perpetrator was not the child's caregiver (5%).[10] Hotline staff screened out this 5% of cases (88 reports) because the perpetrator was someone other than the child's caregiver, despite department policy to the contrary.[11] The percentage of calls screened out due to not meeting caregiver statutory guidelines decreased slightly this year.

These investigations resulted in the verification of 383 CSE victims, a slight increase from 378 victims identified in 2019. (See Exhibit 1.) While the overall number of victims increased, the numbers of victims with multiple verifications, or who had been verified in prior years, decreased. In 2020, 32 youth were verified in more than one investigation (a decrease from 45 youth in 2019) and 51 had a prior CSE verification (a decrease from 69 youth in 2019). Counties with the highest prevalence of verified cases were Broward (47), Escambia (31), Miami-Dade (31), and Duval (28). These four

[8] To assess the prevalence of CSE victims identified in Florida, we relied on DCF's Florida Safe Families Network (FSFN) hotline intake and child protective investigation data. The prevalence analysis only includes CSE victims who had a verified CSE finding by DCF in 2020.

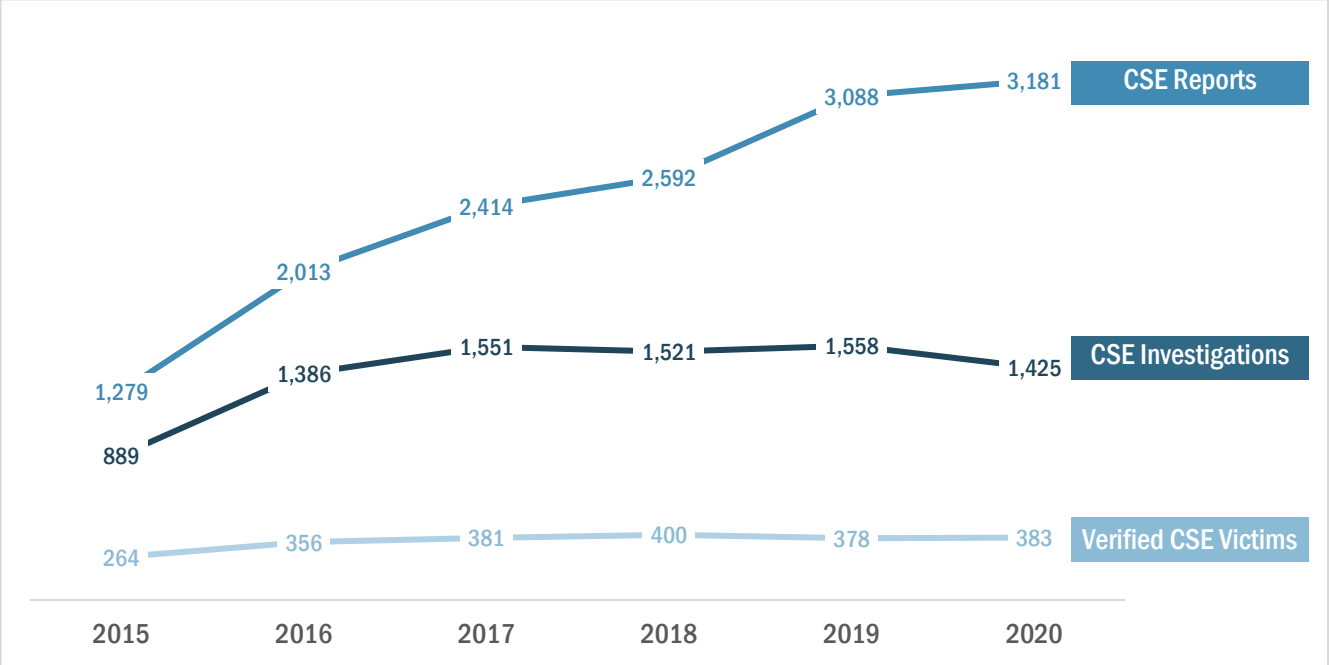
[9] There are three possible investigative outcomes: (1) verified: a preponderance of the evidence supports a conclusion of specific injury, harm, or threatened harm resulting from abuse or neglect; (2) not substantiated: credible evidence exists but did not meet the standard of being a preponderance of the evidence; and (3) no indication: no credible evidence was found.

[10] 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.

[11] 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. This has been a persistent issue throughout our reports, with 5-10% of reports screened out each year for this reason.

counties accounted for 36% of all cases. Since 2015, DCF has verified 1,857 victims.[12] (See Appendix C for the numbers of verified victims in each county.)

Exhibit 1
DCF Verified 383 Child Victims of CSE in 2020



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

Demographics for verified youth in 2020 remain similar to prior reports; the percentage of dependent children missing from care during their CSE investigation has more than doubled. As in prior reports, verified victims in 2020 were predominately female, white, and 14 to 17 years of age. Similar to prior years, the majority (61%) of CSE victims remained in the community in the six months following their 2020 verification, while 39% of CSE victims were in or entered the dependency system within six months of their CSE investigation. Of the 383 CSE victims verified in 2020, 28% were already in the dependency system at the time of their investigation (4% were receiving in-home protective services and 24% were in out-of-home care).[13] Of these youth, 32% were in a residential setting (e.g., a group home, residential treatment center, or correctional placement) and 31% were missing from care (an increase from 14% in 2019).[14,15,16] Within six months of their CSE investigation, an additional 5% received in-home protective services and 8% entered out-of-home care.

[12] 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.
[13] In-home protective and out-of-home care services are mutually exclusive categories, but some youth received both types of services at different times.
[14] While prior OPPAGA reports described children who were categorized as missing from care in FSFN as being on a runaway episode, this does not encompass all instances in which a child may be missing. This year's report uses the phrase "missing from care" to describe youth who may have run away or are otherwise missing from DCF care.
[15] According to DCF policy, a missing child is a person who is under the age of 18, whose location has not been determined, and who is in the custody of the department or designee or for whom a there is (or is a petition for) a Take Into Custody or Pickup Order requiring the delivery of the person into the custody of the department or designee upon their recovery. The policy specifies that a child's child welfare professional enter a missing child report into FSFN within 24 hours of determining that a child is missing. (DCF CF Operating Procedure No. 170-3)
[16] Nearly 60% of the missing children were missing from residential settings, including safe houses. OPPAGA staff were unable to determine the cause of this increase in missing children.

Slightly more than half of verified victims had histories of prior maltreatment, and dependent children continue to have higher incidence of prior maltreatment than do community children. In 2020, 52% of youth had at least one verified maltreatment prior to their CSE investigation, the majority of whom (55%) had two or more prior verified maltreatments. The most frequent prior verified maltreatment was neglect (46%), followed by parental failure (44%). Additionally, 20% of CSE victims with prior verified maltreatments had a verified non-CSE sexual abuse maltreatment. Consistent with prior years' reports, dependent children have a higher incidence of prior maltreatment than do community children (76% and 37%, respectively). Dependent children experienced higher incidences of abandonment (25% of dependent children vs. 3% of community children) and neglect (54% of dependent children vs. 35% of community youth).

Florida hospital staff identified 16 children as confirmed or suspected victims of sexual exploitation from October 2018 through December 2020. In addition to data collected by DCF, hospitals have begun collecting data on patients identified as confirmed or suspected victims of human trafficking.[17] Guidance from the American Hospital Association states that hospitals and health systems should educate necessary individuals, including physicians, nurses, other health care providers, and coding professionals, of the importance of collecting data on forced labor or sexual exploitation of individuals. In June 2018, the International Classification of Diseases coding system was updated to include codes for adult and child forced labor and sexual exploitation (either confirmed or suspected). These new diagnostic codes are designed to allow hospitals to better track victim needs and identify solutions to improve community health; however, data show that the codes have not been widely used. From October 2018 through December 2020, hospital staff in Florida identified 16 minors as confirmed or suspected victims of sexual exploitation (11 inpatient and 5 emergency department visits).

PLACEMENTS AND SERVICES

While the percentage of time children spend in safe houses is increasing, placements vary for re-victimized youth; most lead agencies reported placing CSE community children in safe houses in 2020

As of April 2021, there were nine safe houses statewide, with 54 licensed beds (an increase of one home and a decrease of 10 beds from 2019). The Department of Children and Families also reported 20 safe foster homes with the capacity for 33 beds (an increase of 5 homes and 7 beds from 2019).[18] While the amount of time dependent children spend in safe houses is increasing, so is the amount of time these children are missing from care. Further, time spent in placements in 2020 varied considerably for children with prior CSE verifications as opposed to those who were first verified in 2020, including more time spent in residential treatment centers and missing from care. In addition to

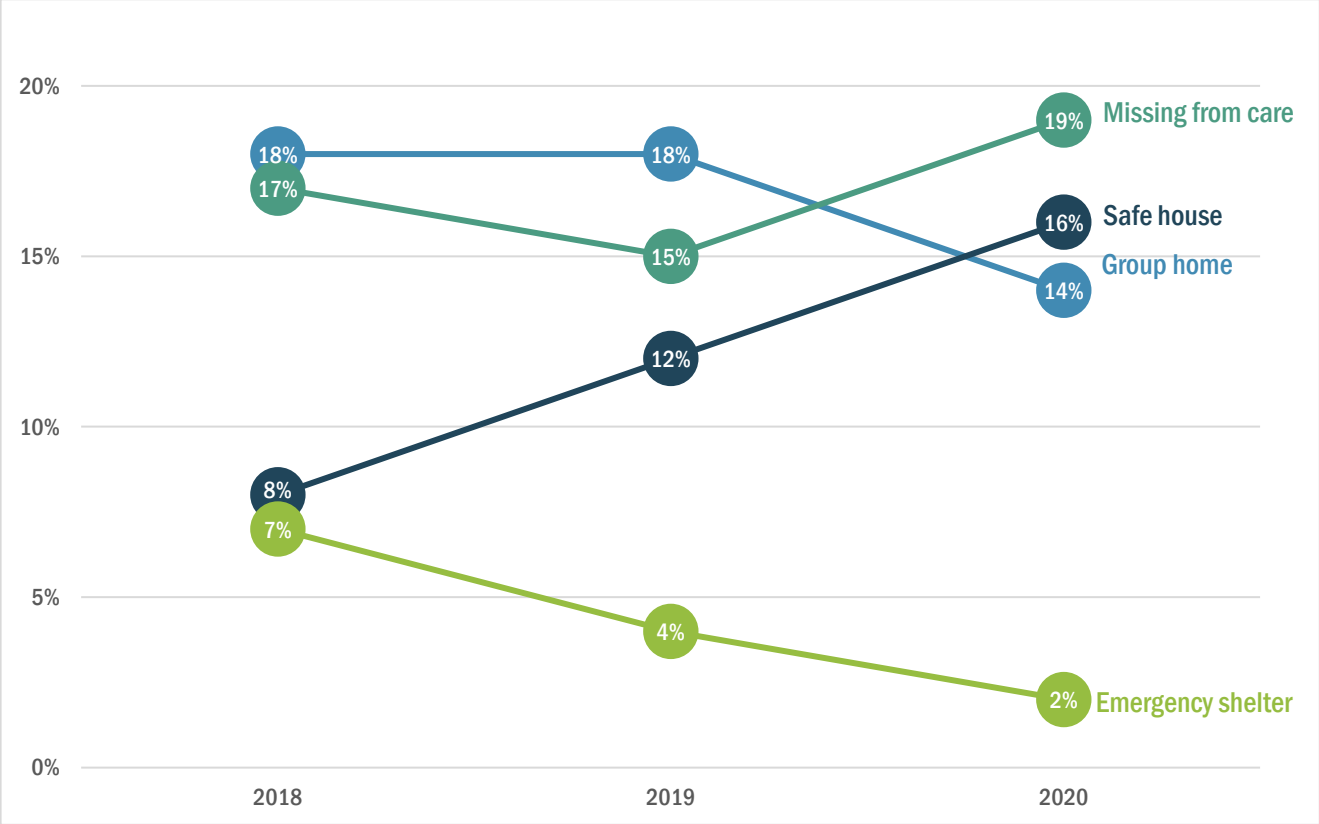
[17] While hospitals collect this information separately from DCF, any person who has knowledge or reasonable suspicion of child abuse or neglect is considered a mandatory reporter under Florida law and is required to report this information to DCF's Florida Abuse Hotline. (s. 39.201, *F.S.*)

[18] As of February 2021, there were 189 CSE-verified youth in out-of-home care who might benefit from CSE-specific placements. This does not include verified youth living in the community who may benefit from placement.

dependent children's placements, most lead agencies reported placing community children in safe houses or residential treatment centers.

For dependent children placed in out-of-home care, the amount of time spent in safe houses is increasing. Over the past three years, the percentages of time children in out-of-home care spent in different placements has changed, with an increase in safe house usage and decreases in placements such as group homes and emergency shelters. From 2018 to 2020, the percentage of time children spent in safe houses doubled, from 8% in 2018 to 16% in 2020. Concurrently, the amount of time spent in group homes and emergency shelters decreased by 3% and 4%, respectively. While the change over time is smaller, the amount of time children in out-of-home care spend missing from care increased from 17% to 19%; this was also the largest percentage of CSE victims' time in care.[19] (See Exhibit 2.) (See Appendix D for percentage of time spent in each placement in 2020.)

Exhibit 2
The Percentage of Time Children in Out-of-Home Care Spend in Safe Houses Has Doubled Over the Past Three Years[1]



[1] This exhibit does not include placements for which there was not a significant change over time. These include residential treatment centers, DJJ facilities, maternity homes, therapeutic foster homes, traditional foster homes, and relative/non-relative caregivers.
Source: OPPAGA analysis of Department of Children and Families data.

Re-victimized children spent more time in certain placements and spent almost double the amount of time missing from care than children who were first verified in 2020. Of the verified CSE children in 2020, 51 had CSE verifications in prior years (referred to as re-victimized children). Consistent with findings presented in our 2019 report, re-victimized children tend to have different characteristics than newly verified children. Time in placements in 2020 for re-victimized children

[19] There were not significant changes over time in the usage of residential treatment centers, DJJ facilities, maternity homes, therapeutic foster homes, traditional foster homes, and relative/non-relative caregivers.

widely differed from victims who were first verified in 2020. Re-victimized children spent less time in group homes, relative/non-relative care, and safe houses and spent more time in residential treatment, traditional foster homes, and missing from care. (See Exhibit 3.)

Exhibit 3
Placements for Children with Prior CSE Verifications Vary Widely From Newly Verified Children[1]

Placement Type	Percentage of Time in Each Placement Type	
	Re-Victimized Children	Newly Verified Children
Group homes	9%	18%
Missing from care	30%	16%
Relative/non-relative care	3%	12%
Residential treatment	17%	7%
Safe houses	8%	18%
Traditional foster homes	19%	12%

[1] This exhibit does not include placements for which there was not a significant difference between the two groups. These include emergency shelters, DJJ facilities, and therapeutic foster homes.
Source: OPPAGA analysis of Department of Children and Families data.

Fourteen lead agencies reported placing CSE community children in residential placements in 2020. While some children with verified CSE investigations are found to be safe to remain in their homes, there are instances where a lead agency, the caregiver(s), and the child may agree that it is in the child's best interest to reside in a residential placement on a voluntary basis.[20] In our 2020 report, we reported that lead agencies were funding safe house placements for some community children. For this year's review, we requested data from the 19 lead agencies regarding placements for CSE community children in 2020; 14 lead agencies reported having placed community children in safe houses (21 children), residential treatment centers (3 children), and a maternity home (1 child). These placements made up a total of 2,571 bed days. Of the 21 children placed in safe houses, the average stay was 92 days (ranging from 6 to 264 days). These placements made up at least 9% of all available safe house bed days.[21]

OPPAGA staff interviewed four of the lead agencies that have placed CSE community children.[22] They reported placing community children in residential placements when other community services have not been effective as a means of preventing youth from entering the dependency system. They have found that parents in these cases are often unaware of available services, are unable to pay for them (safe houses do not accept private insurance or Medicaid), or are otherwise unable to care for their children. Despite lead agencies reporting these placements as being a preventative option for community children, two lead agencies reported that these children often end up entering the dependency system despite this intervention. Lead agencies reported several barriers to placing community children, including a lack of CSE providers, the expense of CSE providers, and children either running away or being kicked out of these placements. Staff of one lead agency reported that they have had more success providing services in the community to both the child and their family.

[20] In instances where a lead agency helps to place a community child in a residential placement, this is done on a voluntary basis. The child only remains in the placement as long as the child and parent agree that it is beneficial to the child. These placements are not recorded in the FSFN placement data; however, they are included in the payment data presented in Appendix A.
[21] These placements may have made up a higher percentage of bed days due to the closure of one safe house and reduced capacity of another due to the COVID-19 pandemic. As OPPAGA staff did not have exact dates for these changes, the calculation is based on all certified safe houses operating at full capacity.
[22] OPPAGA staff interviewed the three lead agencies that had placed at least three community children in 2020 as well as one lead agency that had placed community children in prior years and reported having an increased need for safe house placements.

Survivor mentors identified improvements in serving CSE youth but reported that progress is still needed in service provision and attitudes towards youth

The use of survivor mentors in the treatment of CSE victims is often noted as a promising practice in the literature. They serve as advocates, role models, and peer leaders and may be better poised to engage victims at different points and encourage participation in treatment. Field experts report improved outcomes for CSE victims when survivor mentors are utilized. Florida safe houses and safe foster homes are required to provide mentoring by a survivor of CSE, if available and appropriate for the child.[23]

OPPAGA's 2020 report found increased use of this service among providers, and consistent with that report, Florida providers continue to face challenges finding mentors who are able to work with children due to their disqualifying criminal histories. We identified four providers with a total of 12 survivor mentors across the state. OPPAGA staff interviewed five survivor mentors who work with a variety of human trafficking service providers across the state to learn their perspectives on placements and services for CSE youth. Mentors identified beneficial services as well as gaps in services and supports. They also reported that collaboration among stakeholders has improved, but improvements are still needed in stakeholder attitudes towards CSE youth. Several of the issues reported by survivor mentors were consistent with issues reported by lead agencies and safe house providers as well as findings from the literature.

Survivor mentors perform a variety of roles to help CSE youth and, due to their personal experience, can play a critical role in a youth's recovery. Survivor mentors with whom we spoke had an average of four years of experience in their roles, and all had prior paid and unpaid experiences with similar roles and populations. They reported that it is common to provide support to 13 to 20 youth at a time and that the frequency of contact and meetings is determined by the mentees' individual needs. Survivor mentors often work as part of a community response team with clinical staff and are available to youth 24 hours a day, helping youth to identify and meet their needs and set and achieve goals. They meet with youth in a variety of settings, including DCF placements, DJJ facilities, mental health facilities, and shelters. Because of their lived experience, mentors have the unique ability to identify with youth, quickly establish bonds, and provide consistent support. They reported that the most important aspects of their role include being a consistent source of support, developing relationships, being nonjudgmental, and demonstrating that there is life after trafficking.

Survivor mentors identified beneficial services as well as gaps in services and supports. Most survivor mentors identified therapy and mentoring as the most beneficial services for CSE victims; other critical services included housing, resources to meet basic needs, education, and substance abuse treatment. Only one mentor reported that resources in their area were sufficient to meet the need for services such as mentoring, education, and therapy. All mentors identified housing as a service gap, both in terms of stable, appropriate placements for minors as well as housing for youth aging out of care and those with criminal histories, consistent with what lead agencies reported. According to the literature, a lack of housing options results in inappropriate placements, which can undermine a youth's recovery. Many other gaps were identified, including employment, child care, trauma-informed

[23] Section 409.1678, *F.S.*

housing where youth can receive substance abuse treatment, additional funding and resources for community CSE youth, funding to provide incentives for progress and engagement in normalcy activities, and services and supports for the child's family. While many of these service needs are typical of any youth in DCF care, CSE youth are especially at risk for poor outcomes when service needs are not met. If basic necessities, such as housing, cannot be met through service providers, CSE youth are likely to return to trafficking to fulfill those needs. Additionally, victims are often unable to engage meaningfully in therapeutic services until these basic needs are addressed. Mentors also identified gaps in services and resources between community and dependent CSE youth; those in the dependency system often have access to more funding, which helps with placements and services. Similarly, lead agency staff also reported limited funding for community youth.

Most mentors reported that they had served youth in DJJ facilities. One mentor reported that the DJJ system allows for opportunities to provide services to youth in conjunction with other organizations and that they had seen an increase in referrals for mentor services from DJJ facilities. However, most mentors reported multiple challenges with these placements, including a lack of trauma-informed care, lack of privacy during sessions, difficulty obtaining entry into facilities, and limited communication with DJJ staff. Consistent with findings from our 2020 report, most mentors stated that there were insufficient services and supports for CSE youth in DJJ facilities. Mentors reported the need for increased human trafficking education and training for DJJ staff at all levels as well as the need for increases in victim-centered and trauma-informed care and resources to address trauma. Additionally, mentors reported that safe harbor and foster home placements also lack trauma-informed training, treatment, and services. Lead agencies and safe house providers also reported a need for more training, specifically for staff in safe harbor and foster placement settings.

While collaboration among stakeholders that work with CSE youth has improved, some challenges remain. Most mentors reported that collaboration has improved among the relevant stakeholders, including agencies, law enforcement, and service providers. This has resulted in strengthened partnerships, increased awareness of commercial sexual exploitation of minors, and increased funding for services, including a recent housing grant. Mentors also reported several challenges in this area, including a lack of communication with some safe harbor placements, particularly during the COVID-19 pandemic; DCF personnel being dismissive of mentors' input during staffings; and some law enforcement officers' limited understanding of how trafficking procedures work in the state. Lead agency staff reported difficulties communicating with safe house placements as well, stating a more formalized process is needed to share information on a youth's progress and the efficacy of clinical interventions being used to better plan for the youth's discharge from a safe house. In addition, one safe house provider reported difficulties communicating with their lead agency and a lack of support from the state.

In addition, while some mentors noted improvement in attitudes toward youth, all mentors reported that further progress is needed regarding stakeholder attitudes, communication, and interaction with this population, including DJJ and safe house staff, law enforcement, and the public. In particular, they expressed concerns that DJJ facility staff and safe harbor provider staff often do not interact with youth in a trauma-informed manner, even when staff is trained in trauma-informed care. For example, mentors reported interactions with youth that lacked empathy and continued use of the term prostitution, which they have found to re-traumatize youth. This is consistent with the literature, which highlights the importance of trauma-informed interactions, empathy, and nonjudgmental attitudes to reduce the risk of re-traumatization, which is high for CSE victims and can result in youth either remaining with or returning to their traffickers.

There are still no evidence-based practices for serving CSE youth; research in this area is ongoing, but challenges persist

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 (e.g., victims of sexual assault, childhood trauma, or domestic violence), the literature continues to lack evidence-based practices specific to victims of CSE. In Florida, Citrus Health Network has partnered with the University of South Florida to evaluate the Citrus Helping Adolescents Negatively Impacted by Commercial Exploitation (CHANCE) program to assess the appropriateness and effectiveness of treatment interventions to meet the needs of CSE youth in efforts to establish CHANCE as an evidence-based program.[24]

Although promising approaches and best practices have been reported in the literature, there are currently no evidence-based practices specific to this population. Research has identified a trauma-informed approach as the most effective and a best practice for serving trafficking victims. Consistent with literature reviewed for our 2020 report, recent literature continues to recommend approaches that are multidisciplinary and survivor centered as well as those that employ peer support, trauma-focused cognitive behavior therapy, dialectical behavior therapy, and motivational interviewing.[25,26,27] Additional recommendations include strengths-based service provision and treating victims with empathy and without judgment.[28] Both survivor mentors and available literature find that victims leaving their traffickers have a range of immediate, short- and long-term needs that must be addressed to promote resiliency and allow for psychological healing. These needs include safety, medical care, food, shelter, clothing, counseling, education, employment, and social support. Meeting certain basic needs, such as housing, is a necessary first step to support exploited youth. However, one of the significant challenges victims encounter when seeking services is underfunded or ill-equipped programs that are unable to handle the high demands for services.

CHANCE program evaluations have established adequate adherence to program design, and assessment of treatment intervention efficacy is ongoing; establishing the program as an evidence-based practice remains challenging. While there are no evidence-based practices for serving CSE victims, Florida's CHANCE program has been and continues to be evaluated as part of its efforts to establish an evidence-based model. The Louis de la Parte Florida Mental Health Institute at the University of South Florida has released nine evaluations of the CHANCE program since its implementation in 2013, with the most recent report released in February 2021. The program model uses a wraparound services approach with a range of specialized services.[29] Analyses of the program have centered on establishing adherence to program design (fidelity) and outcomes of youth who

[24] The CHANCE program is a pilot program developed by Citrus Health Network through a partnership with DCF and Our Kids of Miami-Dade/Monroe, with research by the University of South Florida. Each child in the CHANCE program is assigned an individual therapist, a family therapist, a targeted case manager, and a life coach; certified behavioral analyst services are provided when applicable.

[25] Trauma-focused cognitive behavior therapy 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.

[26] Dialectical behavior therapy involves learning skills of distress tolerance, mindfulness, and emotion regulation.

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

[28] Strengths-based services identify and draw upon the strengths of children, families, and communities.

[29] Specialized services include trauma-focused cognitive behavior therapy, family therapy, functional behavioral analysis, parenting training, 24-hour crisis intervention and support/advocacy, psychiatric services, targeted case management, mentoring, and group therapy.

received services through at least one of the program's three tracks: State Inpatient Psychiatric Program (SIPP), specialized therapeutic foster care (STFC), or in-home community response team (CRT).

The fidelity assessment examined what services youth received and whether services were provided as intended based on the CHANCE program model. Youth and therapists completed questionnaires from 2017 through 2019, rating the assessment and treatment planning processes, types of CHANCE services provided to the youth, and the extent to which services met the youth's needs. For those placed in STFC, youth and therapists also answered questions regarding the skills and practices used by foster parents. Overall program fidelity scores were determined by summing the scores of all questionnaire items. Total scores were categorized as either low, moderate, or high fidelity. Youth's scores fell into the moderate to high range, while therapists' scores fell into the high range; average scores increased among youth and therapists over time. Both youth and therapists reported a high degree of fidelity demonstrated by STFC foster parents. Overall, findings suggest adequate program fidelity has been achieved and maintained over time.

Outcomes analyses evaluate changes in youth outcomes over time and compare changes in outcomes among the different CHANCE program tracks. There are six outcomes of interest, which were measured at baseline and every three months until youth were discharged from the program.[30] Results show that youth in all treatment conditions demonstrated improvement, but the amount of change varied by treatment track. Youth placed in the SIPP track demonstrated the most improvement, but they also had higher needs at baseline. Youth placed in the STFC track demonstrated much more improvement during 6-month and 12-month assessments than youth in the CRT track even though their baseline needs were similar.

To become an evidence-based program, CHANCE youth outcomes must be compared to outcomes of youth in other programs. Researchers have experienced difficulty finding a comparison group as well as grant funding. However, one aspect of the CHANCE program that could be incorporated into other safe harbor placements is structuring them into a more normalized family environment. Although the STFC track demonstrates more improvement than the CRT track, and research recommends a family environment, stakeholders reported that there were not enough of these placements available. There are many barriers to establishing and maintaining therapeutic foster care placements, including a need for public education to overcome stigma and misperceptions about CSE youth, recruitment of STFC families, funding, and preventing burnout for existing STFC families.

FAMILY FIRST PREVENTION SERVICES ACT

States are in the process of complying with FFPSA standards

For this year's review, OPPAGA staff obtained updated information on Family First Prevention Services Act (FFPSA) implementation from the six states included in our 2020 report.[31,32] The relevant departments in the states reviewed have worked with stakeholders and providers in the past year to

[30] The six outcome variables were life functioning, education, individual strengths, relational strengths, mental health needs, and risk behaviors.

[31] The Family First Prevention Services Act of 2018 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. 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 human trafficking; maternity homes; qualified residential treatment programs; and supervised independent living settings for youth 18 years of age and older.

[32] The states reviewed include California, Minnesota, Nevada, New York, Pennsylvania, and Texas.

determine how they will define youth who are at risk of sex trafficking and provider readiness to transition to federally qualifying Title IV-E placements. The states reviewed are preparing for full FFPSA implementation by October 1, 2021.

Most dependent youth are considered vulnerable to trafficking in the states reviewed. All states have drafted definitions regarding which youth will be considered at risk for human trafficking. States utilized a combination of known risk factors, current human trafficking definitions, stakeholders, and research to determine their definitions. A majority of state definitions identified that youth with unstable housing and a history of running away are considered at risk for human trafficking. Most identified prior dependency or juvenile justice system involvement and known association or exposure to trafficking as risk factors. States differed in primary and secondary factors, though they utilized commonly recognized indicators of potential trafficking; other factors included age, behaviors that put children in a vulnerable position, common signs of trafficking, and a prior history of maltreatment. States we reviewed have not determined how many youth will screen in as at risk for trafficking and therefore have not determined whether they will have sufficient providers to meet this need. States did report plans to monitor whether their placement array is meeting youth's needs as providers work on transitioning to meet the new requirements.

States are preparing current providers for licensure and certification as new qualified settings. The states reviewed are continuing to work through their legislative and internal policy process to adopt the new standards in licensing language. States plan to issue guidance and provide training for providers that will be serving these at-risk youth. Several states reported that most of their child welfare providers are interested in being licensed as qualified settings; some are waiting to see how initial implementation goes. Five states will require providers to meet new licensing standards, and additional training is occurring for trauma-informed care and caring for youth who have experienced trafficking. Depending on each state's current service array, they are considering the utilization of qualified residential treatment programs (QRTPs) and at-risk homes.[33] States remain committed to placing youth in placements that are the least restrictive setting for their individualized treatment and safety needs. Three states plan on licensing and placing youth in at-risk homes, and one state reported that four providers have already received certification and are operating 14 specialized settings for at-risk youth. Four states plan to certify QRTP placements that will be licensed through their human services agencies; one state is still conducting research and pilot testing for these settings; and one state will utilize its current therapeutic foster homes. The cost for implementing these new requirements and the need for setting new rates for placements were common concerns reported by the states we reviewed. Additionally, states reported needing to solidify their expectations for standards of care for providers licensed under these new settings.

Services in QRTPs and at-risk homes will align with a youth's care and safety needs. Youth who screen in and are placed in at-risk placements will receive additional prevention protections, including awareness and prevention trainings. Youth in QRTPs will receive a higher level of clinical services. With FFPSA requirements, an emphasis on trauma-informed care, family involvement, and discharge planning will be part of a youth's treatment.

[33] 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 these placements.

Florida is finalizing policies to serve youth at risk for trafficking under FFPSA; licensing for new placements will begin in the summer of 2021. DCF staff finalized rule promulgation in May 2021 for child care licensing, which included the definition of at risk for trafficking and new licensing requirements for the placements that will serve these youth. The department received federal approval of the definition and will include it in the final submission of the state plan. Florida's definition shares similar elements to other state definitions, including history of runaway episodes, sexual abuse or sexually inappropriate behavior, and out-of-home placement instability. The definition also includes additional risk factors, such as inappropriate interpersonal or social media boundaries and family history of exposure to human trafficking. Though many factors of the definition are consistent with youth who would come into the dependency system, DCF staff confirmed that youth in the community may also be considered at-risk.

The department reported that the new placement settings will expand their current continuum of care. (See Appendix E for more information on how new placements will fit in Florida's continuum of care.) DCF staff has coordinated with the lead agencies and estimate that approximately 450 youth currently in group care will meet eligibility criteria for at-risk.[34] The department has identified 132 existing providers (totaling 1,473 beds) interested in going through the new licensing process for at-risk homes, and training has begun.[35] The department's goal is to have these settings licensed by June 30, 2021. These settings will be a standalone license and will serve youth 12 and older, have a staffing ratio of 1:6, and have the ability to choose between a shift or house parent model.[36,37] Services in the setting include counseling, screenings for substance abuse and mental health, life skills, vocational and education support, mentoring, and prevention curriculum related to sex trafficking. While the DCF staff identified the at-risk homes as possible placements for verified youth, with a higher level of services than group homes, staff does not anticipate placing any verified youth in these settings.

DCF and the Agency for Health Care Administration (AHCA) are planning to transition current residential treatment programs to QRTPs; many aspects of these programs will be consistent with what is currently provided.[38,39] Services provided in QRTPs must include substance abuse and mental health screening and treatment, family/group/individual therapy, behavioral management, psychiatric services, support groups, specialized intervention services, social and rehabilitative services, and psychoeducational services. AHCA will license QRTPs, and DCF will credential providers; credentialing will require providers to receive trauma-informed training. At the time of our review, there were no plans to create a specialized CSE track within QRTP settings.

[34] This is out of the 1,669 children in congregate care that DCF has identified as being affected by FFPSA.

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

[36] Waiver requests are required for dependent youth under the age of 12 who are recommended for placement in an at-risk home setting or safe house and must include supporting documentation of all efforts to place the youth with a relative or fictive kin, in an available Level III safe foster home within Florida, and in an available Level II foster home within the youth's lead agency catchment area. The age differential waiver form must be approved prior to initial placement with each individual child-caring agency.

[37] The recommendation to include an age limit of 12 years old to be admitted into an at-risk setting was from the Casey Foundation and was consistent with what department staff saw in the data.

[38] AHCA licenses therapeutic group homes and residential treatment centers to serve as placement settings for youth with severe mental health needs. These facilities offer a variety of treatment modalities in a more restrictive and structured setting.

[39] Florida's requirements for placing youth in therapeutic settings are stricter than federal requirements; thus, the agencies are not planning to change this process. While Florida statute requires a suitability assessment for placement in a residential treatment program to be completed prior to the child being admitted to the program, federal law permits placement as long as an assessment is completed within 30 days.

OUTCOMES (2013 THROUGH 2019)

CSE victims continue to have high rates of involvement with DCF and DJJ in the years following their verification; one-year K-12 outcomes appear to be improving

This section includes youth identified in our prior reports, from 2013 through 2019. We examined children's short-term outcomes in four areas: (1) child welfare, (2) involuntary examinations, (3) juvenile justice, and (4) education. For these measures, we examined 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.[40,41,42] We also include comparisons for certain measures where children could be tracked for at least three years.[43,44] 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 F for information on outcomes for CSE victims who are now adults.)

Outcomes at both one and three years after CSE verification show high rates of subsequent involvement with DCF. More than half (54%) 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 missing from care (19% and 14%, respectively).[45] The remainder of their time was spent in placements such as foster homes, safe houses, and residential treatment.

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.[46] When considering unbridged placements, and including interruptions due to episodes where a child was missing from care, victims' placement changes increased to 11 changes in one year. The majority (58%) of those in out-of-home care were missing from care at least once during the year. Rates of missing children were highest for those in group care; while group care made up 24% of the placement records, these placements accounted for 42% of missing episodes.

[40] The total outcomes population includes 1,695 youth; however, because not all youth can be tracked for one- and three-year intervals, the number of children included for each measure varies.

[41] DCF and DJJ one-year measures include data on 1,257 youth. The education measures included data on 1,614 youth. These numbers may further vary across individual measures.

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

[43] The three-year outcomes measures include the following numbers of youth: 273 for DJJ measures, 283 for DCF measures, and 421 for education measures. These numbers may further vary across individual measures.

[44] 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.

[45] For these measures, group care includes traditional group homes and maternity homes but does not include safe houses.

[46] Bridged placement calculations do not include temporary placement changes due to a child being missing from care, hospitalized, having visitations, etc. For example, if a child is missing 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.

In addition to the frequent changes in children's placements, many children remained in out-of-home care for at least a year.[47] 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 (73%) 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 22% of their time in group care and 15% of their time missing from care.

As reported in our 2020 review, placement changes appear to stabilize for children who could be tracked for three years. Using a bridged calculation, over three years, these children averaged 6.2 formal placement changes per year. Using an unbridged calculation, they averaged nine changes per year. While the number of placement changes is slightly lower for this group, the percentage of children who had an interruption where they were missing from care is higher. Seventy-two percent were missing from at least one placement over three years, with children most frequently missing from safe houses (41%) and group homes (40%).

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, 68% 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 (20%), living with a guardian (5%), adopted (2%), emancipated (3%), or had died (1%).

When including all the children in our outcome population, 22% had at least one subsequent verification of CSE, 48% of whom were community children. Children with at least one subsequent verification averaged 296 days between their first and second CSE verifications. Black children and children who were 13 to 14 years old at the time of their first verification had the highest rates of re-victimization. Nearly half (46%) of re-victimized children were living with a parent at the time of their first verification, with 15% living in an out-of-home group or residential treatment setting. While the plurality (38%) of children were living with a parent at the time of their second verification, 24% were living in a group home or residential treatment setting. 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. These children spent the largest amounts of time in group homes or missing from care (23% and 21%, respectively).

Many CSE victims had Baker Act examinations following their CSE verifications; the plurality of exams for children in out-of-home care were initiated during group home placements. As part of this year's review, we analyzed data from the Baker Act Reporting Center for youth who had been involuntarily examined under the Baker Act from July 1, 2013 through December 31, 2020.[48,49] Due to missing Baker Act Reporting Center identifying information, the percentages of CSE children examined may not be complete. (See Appendix G for more information on the limitations of data on involuntary

[47] 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.

[48] The Baker Act Reporting Center, housed at the University of South Florida, receives involuntary examination forms from the DCF-designated receiving facilities on behalf of the department, in accordance with Ch. 65E-5, *F.A.C.*

[49] This data does not contain information on the findings of the examination or whether the child was subsequently committed.

examinations and commitments.) According to our analysis, at least 53% of victims in our outcomes population were involuntarily examined under the Baker Act at some point during this period; of these, 65% had more than one exam during this time. Additionally, 39% of the outcomes population had an exam following their initial CSE verification.

Approximately half (52%) of the CSE victims who matched to a Baker Act exam were in out-of-home care at the time of at least one exam. The most common placement from which an exam was initiated was group homes (27%), followed by residential treatment centers (11%). Eleven percent of exams were initiated while the child was missing from care. Looking at children's placements immediately following their exam, our analysis found that in 22% of exams, children were placed in group homes immediately following their exam, with 15% placed in residential treatment centers and 13% in traditional foster homes.[50,51] (See Exhibit 4.)

Exhibit 4
Group Homes Were the Most Common Placements Pre- and Post-Baker Act Exam

Placement Type	Percentage of Pre-Exam Placements[1]	Percentage of Post-Exam Placements[2,3]
Correctional placement	4%	7%
Emergency shelter	8%	11%
Group care	27%	22%
Residential treatment	11%	15%
Relative/non-relative care	8%	4%
Safe house	8%	4%
Therapeutic foster home	8%	7%
Traditional foster home	11%	13%
Missing from care	11%	8%

[1] Two percent of exams were initiated while children were placed in maternity homes, wilderness camps, and temporary placements (e.g., hospitals, visitations, and mental health services).
[2] Four percent of exams had subsequent placements in maternity homes, wilderness camps, and temporary placements (e.g., hospitals and visitations).
[3] Four percent of exams did not have a subsequent placement in the same removal episode.
Source: OPPAGA analysis of Department of Children and Families data.

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, 48% were referred to DJJ in the year following their first CSE verification.[52] The majority (71%) of those children were referred more than once within that year. The primary charges for these referrals were assault and/or battery (17%), aggravated assault and/or battery (15%), and violation of probation (13%).[53] Nearly half (46%) of these victims received at least one DJJ service within the year, including detention (37%), probation (25%), diversion (10%), and residential commitment (9%).

[50] Due to the limitations of the data, we can only report where the youth was placed immediately prior to and following their exam and cannot specify the cause of the exam or the relationship of the exam and the placement.
[51] For the purpose of this analysis, temporary medical and mental health placements were bridged with the youth's prior placement in the removal episode.
[52] To account for all involvement with DJJ, we are reporting all referrals to DJJ. In prior years, we focused on physical arrests only. DJJ defines a referral as a youth directed to the department based on an allegation of criminal law violation.
[53] Children may have been charged with multiple offenses during these referrals; however, for the purposes of these calculations, we only include the most serious charge associated with each child for the follow-up year.

Of those individuals who could be tracked for three years, 59% were referred to DJJ in the three years following their first CSE verification; 80% of those children were referred more than once. Thirty-two percent of the primary charges were for aggravated assault and/or battery. Among these victims, 58% received at least one DJJ service in the three-year period, a 5% increase from our 2020 report. These included detention (50%), probation (36%), residential commitment (17%), and diversion (17%).

While many CSE victims remain behind in grade level and have low attendance, most one-year educational outcomes appear to be improving. 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 (DOE) data on K-12 school enrollment, grade level, and attendance. While overall enrollment levels are consistent with those seen in prior reports, other one-year educational outcomes have improved for the more recent outcomes cohort. In the school year following their CSE verification, 83% of school-age CSE victims had a K-12 enrollment in a Florida public school.[54] However, 54% of those enrolled the next school year were in a lower-than-expected grade level based on their age (5% lower than our 2020 report), 40% of whom were two or more years behind. Additionally, 39% of those enrolled attended for less than half the school year, which is 6% lower than our 2020 report. (See Exhibit 5.)

Exhibit 5
Grade Level and Attendance Have Improved for the 2019 Outcomes Cohort

Outcomes Measure	2015	2016	2017	2018	2019	Five-Year Average
K-12 enrollment[1]	81%	85%	85%	84%	79%	83%
Attended less than half the year	45%	42%	35%	36%	35%	39%
Lower-than-expected grade level	64%	57%	55%	44%	42%	54%

[1] While there was a decrease in enrollment for the 2019 cohort, this may be an anomaly attributable to the COVID-19 pandemic, as the school year following their verification included spring of 2020.
Source: OPPAGA analysis of Department of Education data.

For those individuals that we could track for three years in the K-12 system, 93% were enrolled at some point during this time. Two-thirds (69%) 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.

UPDATES

COVID-19 presented challenges for agencies and providers serving CSE youth

On March 1, 2020, the Governor issued an executive order directing the Florida State Health Officer and Surgeon General to declare a public health emergency for the COVID-19 pandemic. State agencies followed by entering into emergency orders and adjusting operations. As part of the modified protocols, the Agency for Health Care Administration authorized additional telehealth flexibilities for behavioral health providers. These virtual services allowed many service providers to continue to see

[54] 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.

youth on their caseloads but also presented additional challenges. Pandemic responses reported by agency staff included modification of service delivery, including the use of virtual services when possible, and delayed timelines for several human trafficking initiatives.

Providers and agency staff reported several COVID-related issues affecting service provision for CSE youth. Due to the pandemic and related protocols, service provision for CSE victims was affected in several ways. Department of Children and Families staff and service providers reported challenges among youth and providers during the past year with maintaining safety and privacy in the use of virtual services as well as limited availability of certain services and placements. Issues reported by providers include the following.

- One safe house closed following a COVID outbreak, while others had to limit capacity due to staff shortages resulting from staff being in quarantine.
- Service providers, including survivor mentors, who were required to switch to virtual means of communicating with youth encountered challenges with privacy, youth's and residential staff's willingness to engage with these services, and reduced communication overall.
- One provider reported increased needs among youth as a result of the pandemic, including the need for additional psychiatric and substance abuse services.
- Open Doors Outreach Network reported having to delay expansion into additional counties due to uncertainty among providers during the pandemic.[55]

In addition, two agencies reported having to delay certain human trafficking initiatives due to the pandemic.

- Department of Health (DOH) staff paused efforts to establish their human trafficking training as evidence based for the public health system.
- Department of Juvenile Justice staff delayed implementation of a human trafficking prevention curriculum in residential settings.

Agency and legislative initiatives aim to better serve CSE victims; stakeholder collaboration continues to improve

Despite the challenges presented by the pandemic, several state agencies reported new initiatives and improvements in their ability to identify and serve CSE victims, including new or increased areas of stakeholder communication as well as several policy changes related to the identification of victims. In addition, the 2021 Legislature passed legislation pertaining to training and confidentiality for CSE victim advocates, the expungement of CSE victims' records, and the filing of charges against traffickers.

The Institute for Child Welfare continues to review DCF's use of the Human Trafficking Screening Tool. The 2014 Legislature directed DCF to develop a screening tool for use with minor victims of human trafficking and validate the tool if possible.[56] DCF, in conjunction with DJJ, developed the Human Trafficking Screening Tool (HTST) in 2015; the tool was implemented statewide in

[55] The Open Doors Outreach Network is a part of Voices for Florida and provides 24/7/365 trauma-competent care and treatment to commercially sexually exploited and sex trafficked victims age 10-24. Victims are supported by a team that includes a survivor mentor, regional advocate, and clinician that work together to create appropriate, individualized wellness plans.

[56] Section 409.1754, *F.S.*

2016.[57,58] In 2019, DCF requested the Institute for Child Welfare at Florida State University to conduct an analysis of the department's use of the tool. The subsequent study concluded that the HTST was a promising tool for detecting human trafficking, demonstrating predictive validity, although reliability is low. While there have been various attempts to assess the tool, to date, the HTST has not been validated.[59]

Since our last review, the institute conducted interviews and focus groups to explore screener interpretations and implementation of the HTST. This analysis builds upon its prior findings and aims to explore differences in screener perception of youth responses and individual completion of the tools. Institute staff anticipate completion of the qualitative data analysis by the summer of 2021. DCF has no changes planned for the HTST while the tool is undergoing review; institute staff anticipates recommendations for the department related to training and further data collection efforts for reassessment. While the institute has plans for further research steps, including an interrater reliability study, no plans were finalized with the department at the time of our review.

DCF responded to provider concerns with changes to case management and a step down option for safe houses. There are nine licensed safe homes throughout Florida; consequently, most residents in a safe home are not from the county in which the safe house is licensed. To address issues around CSE victims being placed in safe houses outside of their catchment areas, including multiple case managers being assigned to the residents, delays in receiving needed documentation from the home county, and difficulty meeting the child's immediate needs at placement, which can risk the child's stabilization and lead to negative behavior, DCF staff reported changing department policy to require the designation of a single courtesy case manager for all residents of each safe house.[60] Staff reported that having one assigned case manager for each safe house will offer several benefits, including the case manager having familiarity with the dynamics of current residents, immediate connection with newly placed residents, facilitation of the transition process, and expedition of meeting the child's immediate needs.

In May 2021, the department finalized changes to its rule governing safe house licensing and certification.[61] Among the FFSPA-related changes detailed above, the revised rule creates a second, less restrictive tier of safe houses. Current safe houses will be considered Tier 2 safe houses and are the initial housing option for children and youth recommended for a safe house placement. Tier 1 safe houses will serve as a less restrictive initial placement if recommended by the HTST or multidisciplinary team (MDT) for youth who need a safe house but do not have more intensive service needs that meet criteria for Tier 2 safe houses. Tier 1 safe houses will also serve as a stepdown option from Tier 2 safe houses when youth are ready to move to a less restrictive placement but are not ready to re-enter the community. Tier 1 safe houses will have less restrictive policies than Tier 2 regarding schooling options, cell phones, outside activities, and other practices to enhance normalcy.

DJJ staff reported several policy and administrative changes, some of which are still in progress; two changes reflect recommendations from OPPAGA's 2020 report. The department has initiated changes to better identify all CSE youth that enter the system. Consistent with a recommendation in

[57] 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.
[58] 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.
[59] For more information on validation efforts, see OPPAGA Reports 16-04, 17-09, and 20-05.
[60] Courtesy case managers are assigned to children who are placed outside of their county and whose case managers are unable to conduct in-person visits.
[61] Chapter 65C-14, *F.A.C.*

our 2020 report, DJJ has made multiple changes to improve and increase data sharing. Data exchanges with DCF regarding CSE victims have increased from quarterly to monthly, and DJJ has created a dashboard to relay updated screening and investigation outcome information with DJJ staff. Staff can utilize the dashboard to track the department's documentation of alerts related to CSE youth. In addition to the dashboard, over the past year, DJJ staff reviewed older human trafficking cases to update youth CSE alerts as necessary to ensure the accuracy of all existing files.[62]

DJJ staff reported recent policy and administrative changes that will expand the utilization, dissemination, and screening criteria for the HTST. The department incorporated the HTST pre-screening tool into its electronic system, which will prompt staff when a full screening is needed during the intake process. Additionally, DJJ expanded the criteria for initiating an HTST pre-screening to include a broader array of charges that may be related to exploitation, including fraud impersonation, obstructing criminal investigations, public order crimes, and contempt of court. The department also increased the number of individuals who will have knowledge of a youth's screening. Previously, when department staff identified a youth through their HTST and placed a call to the hotline, the completed screening tool was sent to three individuals: DJJ's human trafficking director, the local DJJ human trafficking liaison, and the DCF local human trafficking representative. Now, all HTSTs that result in a call to the hotline accepted under trafficking maltreatment codes are sent electronically by additional individuals in both departments, such as the local child protective investigation unit, juvenile probation officer, regional DCF human trafficking coordinator, and DCF statewide human trafficking director.

To introduce human trafficking resources into the service array at residential facilities, department staff is establishing a CSE prevention curriculum, consistent with a recommendation in our 2020 report. The staff has identified and received training for a curriculum utilized with other states' juvenile and child welfare systems. The department would like to utilize the curriculum in its residential programs, but because the current available curriculum does not meet DJJ's evidence-based standards, department staff reports that a study is needed before its full implementation.[63] Additionally, precautionary travel restrictions due to COVID-19 delayed the staff training needed to pilot test implementation in DJJ residential programs.

OPPAGA's 2020 report noted that the department added human trafficking training requirements for Fiscal Year 2020-21 to strengthen existing training requirements. DJJ staff reported that they have adjusted their definition of direct care providers, which will now require community-based providers to receive human trafficking training.[64] The department's future training efforts will focus on education staff in DJJ facilities and will be conducted in partnership with DOE. DOE staff reported that educators in those settings are often contracted and may not have the same training requirements as district staff, so the agencies are working on coordinating training for these alternative settings.

DOE initiatives support school district efforts to educate youth and staff on human trafficking. In 2019, the Department of Education promulgated rules establishing requirements for instruction in child trafficking prevention and awareness for students in grades K-12 and making every school a trafficking-free zone. According to DOE staff, all school districts are in compliance with this

[62] Our 2020 report found a number of missing CSE alerts in youth's DJJ case files. For more information, see OPPAGA Report No. 20-05.

[63] Evidence-based practices are treatment and practices that have been independently evaluated and found to reduce the likelihood of recidivism or at least two criminogenic needs with a juvenile offending population. The department also allows delinquency interventions identified as a promising practice or a practice with demonstrated effectiveness to be utilized for youth.

[64] DJJ staff reported that they are in the process of revising Ch. 63H-2, *F.A.C.*, to include this expanded definition of direct care staff.

requirement and have created Child Trafficking Prevention Implementation plans.[65] Prevention curricula are determined by each school district, and districts have adopted a variety of materials, such as the Child/Teen Safety Matters programs developed by the Monique Burr Foundation for Children.[66] In addition to student instruction, districts were required to identify actionable steps to make schools trafficking-free zones. DOE staff reported that districts are in different stages of implementation for this requirement, and department staff will help identify model districts for peer-to-peer sharing of resources and knowledge. The department continues to provide training and materials, including a human trafficking guidebook, and has one full-time staff member as a designated contact and support to districts.

Department staff recognizes that many youth who are victimized are not in a traditional classroom setting or are not connected to the school system at all. To equip educators at alternative school sites, such as DJJ settings, DOE facilitates communication between school districts and those settings to make sure they have trainings and supports available to youth. Additionally, department staff reported using community partnerships to help school districts better identify youth in need of services in their area.

DOH continues to train staff and utilize data sources to identify victims that come in contact with the health system. New human trafficking screening questions were released in 2019 as part of DOH's updated Violence Screening Tool, administered by the county health departments (CHDs).[67] A medical professional conducts the screening, which may occur during any visit but is recommended during the initial visit with any of the following individuals: those who answer affirmatively to two initial screening questions; those that present the risk factors and indicators incorporated in department guidance; any female 12 and older; all women who are pregnant; and any male who shows signs of victimization.[68] Screenings are intended to be a client-directed process with screener discretion for next steps, including a follow-up visit, community resource referral, and safety planning. Since 2014, DOH has completed 179 human trafficking screenings with both adults and children. Actions taken by CHD staff with identified youth include safety planning, calls to the hotline, connecting youth with an advocate, and creating human trafficking service referrals.

DOH recommends that CHD staff be trained in the use of the screening tool as well as receive a one-time, two-hour human trafficking training. Department staff developed the training in collaboration with the National Human Trafficking Training and Technical Assistance Center and reported that they are working with the center to make the training evidence based for the public health system. Florida statute requires practitioners licensed under specified boards, including the board of medicine, to complete a one-hour human trafficking training.[69,70] Within the past year, the department conducted webinars to inform health departments about the requirement and reported that the Stop, Observe,

[65] These plans must be updated annually.
[66] Other prevention curricula utilized in plans included Safer, Smarter Schools developed by Lauren's Kids and KidSmartz/NetSmartz developed by the National Center for Missing and Exploited Children.
[67] In 2017, DOH partnered with the Human Trafficking Workgroup and 10 CHDs to evaluate DOH's Sexual Assault, Domestic Violence, and Human Trafficking Screening Tool. The human trafficking screening questions were subsequently updated, and the screening tool title was changed to the Violence Screening Tool.
[68] In the department's technical assistance guide, risk factors for human trafficking include running away or homelessness (particularly for youth); history of interpersonal abuse or violence; involvement in commercial sex industry; and minority/immigrant status. Indicators for victimization include being accompanied by controlling companion; inconsistent history; medical or physical neglect; and submissive, fearful, hyper-vigilant, or uncooperative behavior.
[69] Section 456.0341, *F.S.*
[70] Training is required for the following licensed professionals: Acupuncture, Medicine, Osteopathic Medicine, Chiropractic Medicine, Podiatric Medicine, Optometry, Pharmacy, Dentistry, Nursing Home Administration, Occupational Therapy, Dietetics and Nutrition, Respiratory Care, Massage Therapy, and Physical Therapy.

Ask, Respond training accessible through the Training Finder Real-Time Affiliate Integrated Network platform can satisfy that requirement.[71,72]

The department's multi-year Human Trafficking Surveillance Plan approaches human trafficking from a public health perspective. The department is implementing the plan in partnership with several other state agencies to strengthen the department's understanding of the effects of human trafficking and provide a roadmap for collecting, analyzing, reporting, and disseminating information. Staff has begun the first stage of the plan by identifying data sources for human trafficking prevalence and has initiated data sharing agreements to begin analyzing the data.

FDLE created human trafficking training courses in compliance with Florida statutes. The 2019 Legislature implemented a requirement for all law enforcement officers to complete four hours of training in identifying and investigating human trafficking.[73] Current officers must complete the training by July 1, 2022; newly certified officers must complete the training within one year of employment. This one-time training counts toward the officers' 40 hours of mandatory retraining. On May 7, 2020, the Criminal Justice Standards and Training Commission approved two specialized courses that meet this requirement—one designed for classroom delivery and the other for online instruction.

The 2021 Legislature passed Senate Bill 1826, pertaining to human trafficking. Certain aspects of the law address some of the concerns reported by survivor mentors and other stakeholders. Under the law, human trafficking victim advocates and trained volunteers will have to complete 24 hours of human trafficking training; within three years of completing the initial 24 hours, an additional 8-hour training update is required. Communications between a victim advocate or trained volunteer and a victim will be confidential in certain circumstances.

In addition, the law prohibits the clerk of the court from charging any fees related to a petition to expunge a criminal offense of a human trafficking victim and requires that a petition to expunge more than one eligible offense be treated as a single petition. It also clarifies that a victim may petition to expunge a criminal history record resulting from the arrest or filing of charges for one or more offenses committed or reported to have been committed while the person was a victim of human trafficking, except for certain offenses.[74] Additionally, the law requires the state attorney to determine whether to file, non-file, or divert criminal charges against the trafficker even if there is no cooperation from, or over the objection of, the victim. This law will take effect on July 1, 2021.

[71] Training Finder Real-Time Affiliate Integrated Network is a learning management system with a centralized, searchable database of courses relevant to public health, safety, and emergency preparedness. DOH staff has access to credible public health training in subject areas including human trafficking.

[72] The Stop, Observe, Ask, Respond human trafficking training equips health care professionals with skills to identify, treat, and respond appropriately to human trafficking.

[73] Section 943.17297, *F.S.*

[74] See s. 775.084(1)(b)1, *F.S.*, for the list of excepted offenses.

APPENDIX A

Allocations and Expenditures for Serving CSE Youth

The Department of Children and Families allocates funds to lead agencies to provide placements and services to suspected or verified minor victims of CSE. Lead agencies pay for CSE services using CSE-specific billing codes.[75] While payment data included in our prior reports have been limited to payments made under the CSE billing codes and those included in lead agency expenditure reports, our reviews of placement data and interviews with lead agency staff found that CSE victims are often placed with non-CSE-specific providers and receive a wide array of services paid for under a variety of billing codes.[76,77,78] To provide a more comprehensive picture of the cost of serving CSE victims, OPPAGA requested all Florida Safe Families Network (FSFN) payment data associated with verified CSE victims (including those who are over the age of 18 but are still in DCF care) in Fiscal Year 2019-20.[79,80]

In Fiscal Year 2019-20, DCF allocated $3 million in state funds across the lead agencies to serve CSE victims. During this year, lead agencies paid for services for 434 youth, spending approximately $10.8 million (an average of approximately $25,000 per child).[81] These payments were for a variety of services, including residential services, mental health services, extended foster care, clothing, and adoption subsidies.[82] (See Exhibit A-1 for lead agency payments by categories of billing codes.)

[75] Allowable payments under these billing codes are for suspected or verified minor victims who are either dependent or are the subject of an open investigation. Payments may be made for placements in safe houses or safe foster homes, or for the services specified under s. 409.1678, *F.S.*

[76] Payment data in our prior reports did not include payments for youth over the age of 18.

[77] In addition to those services billed under the CSE-specific billing codes, lead agencies often pay for CSE-specific services under other billing codes (e.g., many of the payments to safe houses were made under codes used for out-of-home care costs and not just under the CSE codes).

[78] While the lead agency expenditure reports include costs for serving CSE victims, these expenditures are specific to the use of core funds. Section 409.991, *F.S.*, defines all funds allocated to lead agencies as core services funds, with the exception of independent living, maintenance adoption subsidies, child protective investigations training, nonrecurring funds, designated mental health wraparound services funds, designated special projects, and funds appropriated for the Guardianship Assistance Program. The payments included in the OPPAGA analysis are inclusive of all FSFN payments and are not specific to the use of core funds.

[79] Expenditures related to service provision for children, youth, and/or families receiving in-home, out-of-home, adoption services, adoption subsidies, and post-foster care support are recorded in FSFN. Payments in FSFN are categorized by reporting category, child eligibility, and billing code (referred to as other cost accumulators).

[80] OPPAGA staff provided DCF with a list of 2,138 child IDs, including dependent and community children, and requested all payments associated with those IDs in Fiscal Year 2019-20.

[81] These figures include payments from lead agencies for CSE victims identified by OPPAGA and do not include any appropriations to specific providers described in Appendix B. These amounts cannot be compared to amounts presented in prior OPPAGA reports due to changes in how the data were requested.

[82] While more comprehensive than the payment data included in our prior reports, lead agency staff reported that there are still some costs that may not be included in the FSFN payment data or are not tied to a specific child, including those related to mobile response teams and some wraparound services.

Exhibit A-1
Fiscal Year 2019-20 Payments Associated With CSE Youth

Expense Type	Total Payment Amount	Percentage of Total Payments[3]
Placement and service costs for minors in out-of-home care	**$9.1 million**	**84%**
Placement costs	*6.5 million*	*60%*
CSE-specific billing codes[1]	*2.5 million*	*23%*
Service costs	*121,213*	*1%*
Placement and service costs for youth 18 and older[2]	**$1.3 million**	**12%**
Adoption service and subsidy costs	**$361,985**	**3%**
Total	**$10.8 million**	**100%**

[1] While these codes are used for safe houses, safe foster homes, and CSE-specific services, our analysis found a large number of payments for these providers and services under the other categories of out-of-home care billing codes.
[2] Includes costs related to Extended Foster Care, Postsecondary Education Services and Support, and After Care Services.
[3] Numbers in this column do not add to 100% due to rounding.
Source: OPPAGA analysis of Department of Children and Families data

According to expenditure reports for Fiscal Year 2019-20, lead agencies expended $3.4 million (112% of the CSE allocation) to serve CSE victims. However, the CSE reporting category in these reports is specific to the use of core funds, which excludes certain types of services, including mental health wraparound services and independent living. Payments included in OPPAGA's analysis of FSFN data include all payments regardless of category or funding source. According to our analysis, amounts expended by lead agencies to serve CSE youth ranged from approximately $56,000 (St. Johns County Board of County Commissioners) to $1.8 million (ChildNet Broward). Three lead agencies spent over $1 million: Families First Network ($1.1 million), Citrus Family Care Network ($1.3 million), and ChildNet Broward ($1.8 million). (See Exhibit A-2.)

Exhibit A-2
Fiscal Year 2019-20 Lead Agency Allocations and Expenditures for CSE Youth

Lead Agency	DCF CSE Allocation[1]	Lead Agency-Reported CSE Expenditures[2]	Total FSFN Payments for CSE Youth[3]	Number of CSE Youth Served Through FSFN Payments[4]
Brevard Family Partnership	$30,612	$114,00	$105,241	9
ChildNet Broward	505,102	430,357	1.8 million	51
ChildNet Palm Beach	306,122	319,089	852,140	17
Children's Network of Southwest Florida	107,143	223,842	470,250	23
Citrus Family Care Network	841,837	407,568	1.3 million	62
Communities Connected for Kids	61,225	40,000	312,820	15
Community Partnership for Children	15,306	49,620	456,476	21
Eckerd Connects (Hillsborough)	187,856	165,464	324,119	18
Eckerd Connects (Pasco-Pinellas)	210,104	29,352	524,017	21
Embrace Families	198,979	225,391	824,037	33
Families First Network	15,306	399,244	1.1 million	25
Family Integrity Program	15,306	-	56,903	7
Family Support Services of North Florida	76,531	218,732	484,784	34
Heartland for Children	183,673	54,829	366,855	21
Kids Central	61,225	342,780	417,908	22
Kids First of Florida	-	69,900	149,685	5
Northwest Florida Health Network (formerly Big Bend Community-Based Care)	61,224	7,295	456,966	22
Partnership for Strong Families	61,224	59,581	234,601	14
Safe Children Coalition	61,225	202,620	481,052	19
Total	**$3 million**	**$3.4 million**	**$10.8 million**	**439[5]**

[1] Based on Department of Children and Families Budget Ledger System.
[2] Based on Fiscal Year 2019-20 Community-Based Care Lead Agency Monthly Actual Expenditure Reports. These figures only include expenditures for core services.
[3] Includes all payments made to serve CSE youth, including extended foster care, adoption subsidies, and wraparound services.
[4] Based on OPPAGA's analysis of all FSFN payments associated with CSE youth in Fiscal Year 2019-20.
[5] While the payment data contained information on services provided to 434 children, 5 children were served in more than one county.
Source: OPPAGA analysis of Department of Children and Families data.

Of the payments made to provide placements and services to CSE youth in Fiscal Year 2019-20, 28% of the payments were made to CSE-specific providers.[83] While lead agencies receive specific funds to serve CSE victims (billed under the CSE billing codes), lead agencies also bill for CSE-specific providers under other billing codes, including those related to out-of-home care placements and services. Additionally, nearly $29,000 of the payments included in Exhibit A-3 were for youth receiving extended foster care or after care services.

Exhibit A-3

Fiscal Year 2019-20 Payments to CSE-Specific Providers for CSE-Verified Youth[1]

Provider	Type of Provider	Total Payment Amount	Percentage of Total Payments Statewide
Vision Quest Sanctuary Ranch	Safe house	$785,608	26%
Bridging Freedom	Safe house	384,050	13%
Wings of Shelter	Safe houses (3)	310,206	10%
Citrus Behavioral Health	Various[2]	236,246	8%
Safe Foster Homes	Foster homes	232,842	8%
One More Child	Safe house	232,642	8%
Images of Glory	Safe house	226,524	8%
Aspire	Residential treatment	192,900	6%
U.S. Institute Against Human Trafficking	Safe house	154,635	5%
Devereux Delta	Residential treatment	153,635	5%
From the Ground Up Ministries	Safe house	61,751	2%
Path2Freedom	Safe house	31,565	1%
Total		**$3 million**	**100%**

[1] CSE providers received payments under the following categories of billing codes: CSE out-of-home care, out-of-home care (not specific to CSE), extended foster care, and after care services.
[2] 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.

[83] Due to variation in the use of service types across lead agencies, there may be additional payments that were made to CSE providers that we were unable to identify in the data.

APPENDIX B

Appropriations and Expenditures for CSE Programs

In addition to the funds appropriated to the lead agencies through the Department of Children and Families to serve children in their care, the Legislature directly appropriates funds to specific providers. In Fiscal Year 2020-21, the Legislature appropriated $2.8 million in general revenue to five providers to serve CSE children, of which, providers have spent $1.7 million to date.[84] In addition to the general revenue 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. Including legislative appropriations and VOCA awards, Florida CSE providers have received nearly $22 million over the past three years.[85] (See Exhibit B-1.)

Exhibit B-1
From Fiscal Year 2018-19 through Fiscal Year 2020-21, Providers in Florida Have Received Nearly $22 Million to Serve CSE Victims

Provider	Funds Appropriated/VOCA Award	Funds Expended	Source of Funds
Fiscal Year 2018-19			
Bridging Freedom	$700,000	$642,775	General Revenue
Citrus Behavioral Health	400,000	134,161	General Revenue
Devereux	500,000	500,000	General Revenue
One More Child	200,000	200,000	General Revenue
Redefining Refuge	500,000	500,000	General Revenue
Voices for Florida–Open Doors	1,800,000	1,746,540	General Revenue
	$3,581,797	$2,670,357	VOCA
Fiscal Year 2019-20			
Bridging Freedom	$700,000	$504,899	General Revenue
Nancy J. Cotterman Center	100,000	80,849	General Revenue
One More Child	100,000	100,000	General Revenue
Voices for Florida–Open Doors	750,000	750,000	General Revenue
	$4,350,579	$1,585,051	VOCA
Fiscal Year 2020-21[1]			
Bridging Freedom	$700,000	$508,642	General Revenue
Devereux	250,000	175,000	General Revenue
Nancy J. Cotterman Center[2]	175,000	80,186	General Revenue
One More Child	400,000	285,000	General Revenue
Voices for Florida–Open Doors	1,250,000	603,072	General Revenue
	$5,452,894	$484,483	VOCA
Three-Year Funding Total	**$21,910,270**	**$11,551,015**	

[1] At the time of this review, payments were still being made/reimbursements submitted for Fiscal Year 2020-21 grants and appropriations.
[2] This appropriation is for an array of services for both adult and child CSE victims as well as victims of sexual assault, abuse, and child abuse.
Source: Florida Accountability Contract Tracking System and Department of Legal Affairs data as of May 2021.

[84] This does not include appropriations for providers exclusively serving adult CSE victims or funds used by lead agencies to pay for CSE children's room and board in these and other programs.
[85] For appropriations and expenditures for years prior to Fiscal Year 2018-19, see OPPAGA Report No, 20-05.

APPENDIX C

County-Level Prevalence Data

OPPAGA's analysis identified 383 victims of commercial sexual exploitation verified by the Department of Children and Families in 2020. Broward (47), Escambia (31), Miami-Dade (31), and Duval (28) had the highest numbers of verified victims and accounted for 36% of all cases. (See Exhibits C-1 and C-2.)

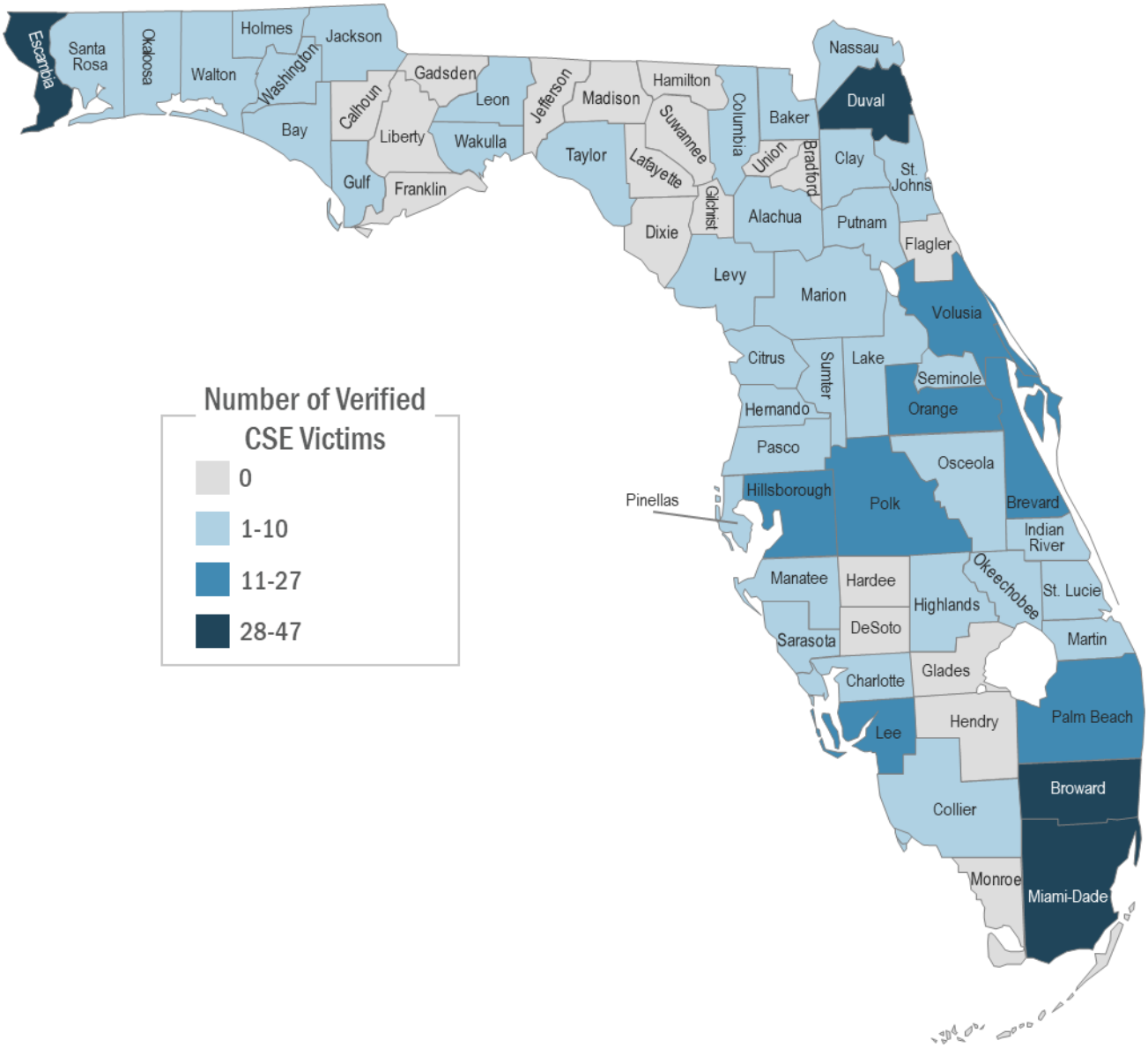
Exhibit C-1
Number of Verified CSE Victims by County[1]

Community-Based Care Lead Agency	County	Verified CSE Victims	Percentage of Verified CSE Victims
Brevard Family Partnership	Brevard	13	3.4%
ChildNet	Broward	47	12.3%
	Palm Beach	17	4.4%
Children's Network of Southwest Florida	Charlotte	3	0.8%
	Collier	1	0.3%
	Lee	12	3.1%
Citrus Family Care Network	Miami-Dade	31	8.1%
Communities Connected for Kids	Indian River	3	0.8%
	Martin	2	0.5%
	Okeechobee	2	0.5%
	St. Lucie	7	1.8%
Community Partnership for Children	Putnam	2	0.5%
	Volusia	12	3.1%
Eckerd Connects	Hillsborough	18	4.7%
	Pasco	2	0.5%
	Pinellas	7	1.8%
Embrace Families	Orange	25	6.5%
	Osceola	7	1.8%
	Seminole	8	2.1%
Families First Network	Escambia	31	8.1%
	Okaloosa	5	1.3%
	Santa Rosa	5	1.3%
	Walton	3	0.8%
Family Integrity Program	St. Johns	2	0.5%
Family Support Services of North Florida	Duval	28	7.3%
	Nassau	1	0.3%
Heartland for Children	Highlands	1	0.3%
	Polk	20	5.2%
Kids Central	Citrus	1	0.3%
	Hernando	1	0.3%
	Lake	5	1.3%
	Marion	10	2.6%
	Sumter	1	0.3%
Kids First of Florida	Clay	6	1.6%

Community-Based Care Lead Agency	County	Verified CSE Victims	Percentage of Verified CSE Victims
Northwest Florida Health Network (Big Bend Community-Based Care)	Bay	10	2.6%
	Gulf	2	0.5%
	Holmes	1	0.3%
	Jackson	2	0.5%
	Leon	4	1.0%
	Wakulla	1	0.3%
	Washington	1	0.3%
Partnership for Strong Families	Alachua	6	1.6%
	Baker	1	0.3%
	Columbia	5	1.3%
	Levy	2	0.5%
	Taylor	1	0.3%
Safe Children Coalition	Manatee	7	1.8%
	Sarasota	1	0.3%
Total		**383**	**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 C-2
Number of Verified Victims by County in 2020



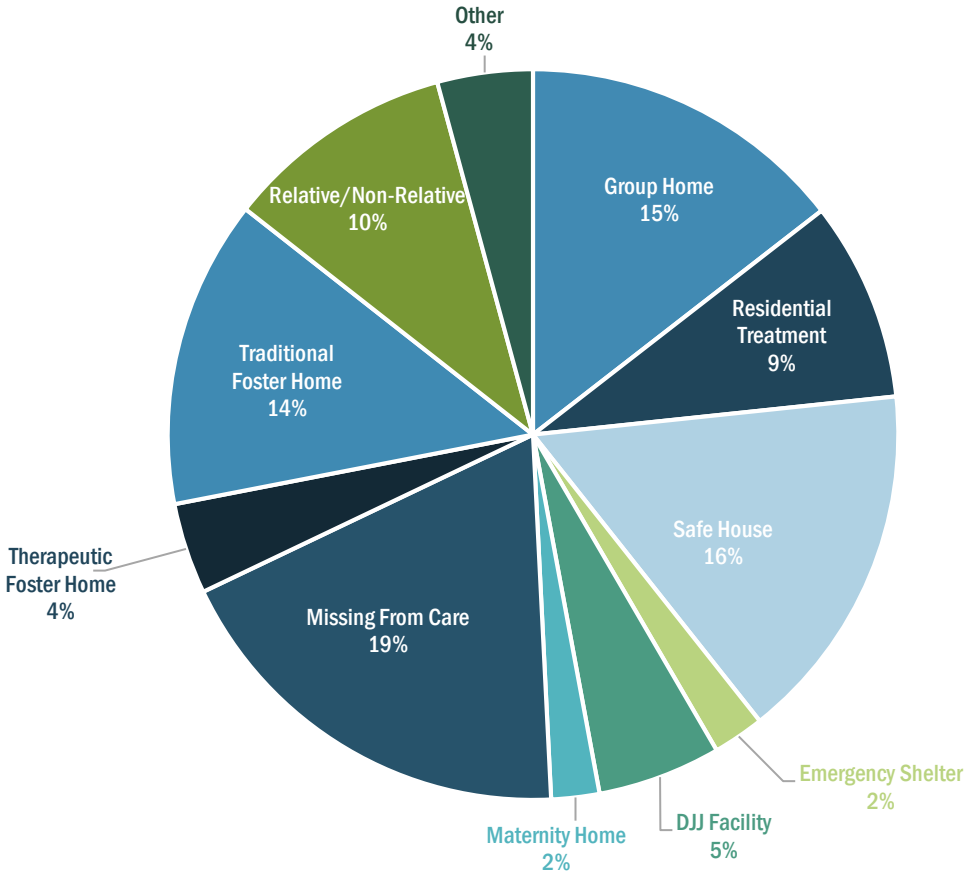
Source: OPPAGA analysis of Department of Children and Families data.

APPENDIX D

Percentage of Time in Out-of-Home Care Placements for 2020 CSE Victims

In 2020, 125 of the 383 CSE victims spent some time in out-of-home care following their CSE investigation. These children spent the plurality of their time in out-of-home care missing from care (19%); the greatest amount of time spent in placements were in safe homes (16%), group homes (15%), and traditional foster homes (14%). (See Exhibit D-1.)

Exhibit D-1
CSE Victims Spent the Largest Percentage of Their Time in Out-of-Home Care Missing From Care[1]



[1] Other includes temporary placements such as hospitalizations and visitations.
Source: OPPAGA analysis of Department of Children and Families data.

APPENDIX E

Array of Placement Options for CSE Children

Regardless of whether a child is verified as a CSE victim, when a child welfare professional determines that protective, treatment, and remedial services are necessary to ensure a child's safety, permanency, and well-being, the following options are considered, from least to most restrictive. The child

- remains in their home with no judicial actions;
- remains in their home with judicial actions; or
- is placed out of their home temporarily.[86]

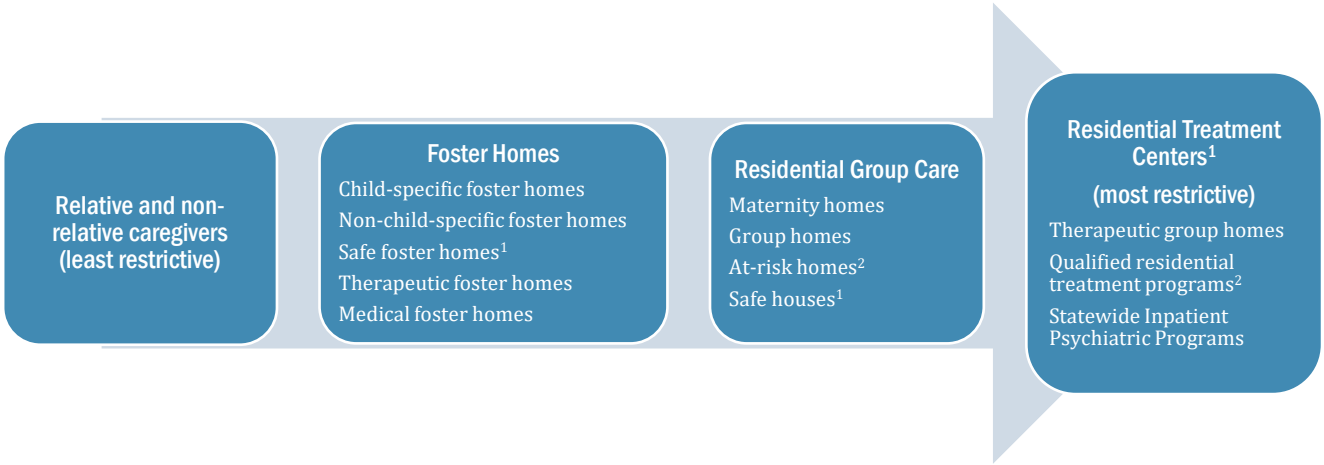
When a child cannot remain safely at home and needs out-of-home care, the child protective investigator must complete a Comprehensive Placement Assessment to recommend level of care. If a child cannot be placed with relative or non-relative caregivers, the child protective investigator contacts the lead agency for a multidisciplinary team staffing to gather and review information to determine the most appropriate placement.[87] The MDT members may include a representative from the department, the child's case manager, therapist, child's attorney, guardian ad litem, teachers, coaches, current caregiver (if applicable), Children's Medical Services, and other community service providers and individuals who know the child. The MDT will gather and review information known at the time, such as medical, developmental, mental health, and behavioral health needs; medication history; alleged type of abuse/neglect and trafficking history; educational needs; community ties; placement of siblings; the child's age, maturity, interests, and placement preferences; and the child's Adverse Experiences Questionnaire score. The Comprehensive Placement Assessment must be updated when a change in the level of care is recommended and must be reviewed every three months. Youth who are suspected or verified victims of CSE must have an MDT staffing to determine their need for services and need for placement in a safe house or safe foster home.

To serve the varying needs of all children in out-of-home care, DCF has an array of placement settings. (See Exhibit E-1 for the continuum of care from least to most restrictive.) In preparation for the changes in federal funding under the Family First Prevention Services Act, three new placement options will be available beginning in 2021, two of which will specifically serve youth determined to be at risk or verified for sex trafficking. At-risk homes will be available for youth meeting the state's definition for at risk of sex trafficking who are at least 12 years of age, though waiver requests are available for youth under the age of 12. There will also be a new, less restrictive type of safe house. While existing safe houses will be considered Tier 2 homes, the department has also created a new placement type, referred to as Tier 1 safe houses. These Tier 1 homes will serve as a step-down option from Tier 2 safe houses or as a less restrictive initial placement as recommended by the MDT or Human Trafficking Screening Tool; they will have less restrictive policies than Tier 2 safe houses regarding schooling options, cell phones, outside activities, and other practices to enhance normalcy. Tier 2 safe houses will serve as the initial housing option for children and youth recommended for safe house placement. Qualified residential treatment programs will serve youth with serious emotional or behavioral disorders or disturbances. All staff in a QRTP must complete training in trauma-informed care. At this time, the department does not plan to have a specialized CSE track within QRTPs.

[86] Section 39.6012 (2)(d), *F.S.*; Rule 65C-30.009, *F.A.C.*

[87] Federal and state laws require that youth be placed in the least restrictive, most family-like setting available in close proximity to the home of their parents that meets their needs.

Exhibit E-1
Children Should Be Placed in the Least Restrictive Setting Possible



Relative and non-relative caregiver placements are unlicensed placements with caregivers that can provide for the health and safety of the child and have an established relationship with the child. These caregivers must ensure the child's well-being, including ensuring that medical, educational, and mental health needs are met. Although these placements do not require licensure, they have the option to seek a Level 1 licensure type that allows them to become a child-specific foster home.

Foster homes are a licensed placement with foster parents that are responsible for the care and well-being of the child. There are five levels of foster home licensure.

Level 1: Child-specific foster homes are designed for relatives and non-relatives who have an existing relationship with the child for whom they are seeking licensure.

Level 2: Non-child-specific foster homes (traditional foster homes) are available to individuals in the community who may be interested in fostering. These are commonly thought of as a traditional family foster home.

Level 3: Safe foster homes are for victims of human trafficking; parents must receive specialized training on CSE and implement specific security features in their homes.

Level 4: Therapeutic foster homes serve dependent children who have significant emotional, behavioral, or social needs.

Level 5: Medical foster homes utilize caregivers who have received specialized training to provide care for children and adolescents with chronic medical conditions.

Residential group care provides 24-hour staffed supervisions and care to children who cannot safely remain in their own home.

Maternity homes provide care and specialized support for prenatal, post-partum, and parenting youth.

Group homes provide care to meet the physical, emotional, and social needs of children in a single or multi-family community.[3]

At-risk homes will serve youth meeting the criteria of at-risk for sex trafficking as defined in r. 65C-14.001, *F.A.C.*

Safe houses are single sex, therapeutic environments and have awake staff 24 hours a day. Staff must receive specialized training on CSE children. Tier 1 safe houses are less restrictive, and Tier 2 safe houses are more restrictive.

Residential treatment centers (RTCs) are intended for the observation, diagnosis, or treatment of an emotional disturbance. These therapeutic placements are licensed by AHCA and require a suitability assessment before placement. CSE children must be provided a single sex environment within these facilities. Some RTCs have a specialized therapeutic track for CSE children.

Therapeutic group homes are 24-hour residential programs that provide community-based mental health treatment and extensive mental health supports in a homelike setting to children and adolescents with serious emotional disturbances.

Qualified residential treatment programs (QRTPs) are a type of RTC that will be licensed by AHCA and credentialed by DCF. QRTPs will not have a specialized CSE track.

Statewide Inpatient Psychiatric Programs (SIPPs) are a type of RTC that provide services to individuals under the age of 21 with emotional disturbances or serious emotional disturbances who require treatment in a psychiatric residential setting.

[1] These programs offer specialized services for CSE children.
[2] These programs were created as part of DCF's preparation for FFPSA implementation.
[3] With federal funding changes under FFPSA, federal reimbursements under Title IV-E for traditional group homes will be limited to 14 days.
Source: OPPAGA analysis of Florida statutes and rules, DCF policy, the Florida Medicaid Statewide Inpatient Psychiatric Program Coverage Policy, and the Florida Medicaid Therapeutic Group Care Services Coverage Policy.

APPENDIX F

Outcomes of Previously Identified CSE Victims Who Are Now Adults

In addition to examining outcome measures focused on CSE victims who are still minors, our analysis included a few age-specific measures for those who have turned 18, including Department of Children and Families data on young adults who received services through Extended Foster Care; Florida Department of Law Enforcement data on arrests and charges; and Department of Education data on continuing education enrollments, public benefit usage, and employment.[88,89]

Few youth received services through the state's Extended Foster Care program. When youth age out of the foster care system, they have the option to continue receiving certain services and supports through their lead agency, including Extended Foster Care (EFC).[90] EFC allows youth ages 18 to 21 to continue to reside in licensed care, including safe houses, while finishing school or gaining work experience.[91] Of the youth in the outcomes population who could be tracked for at least a year, 16% received services under EFC.[92]

Young adults previously verified as CSE victims continued to have involvement with law enforcement; however, this appears to be decreasing for the most recent cohorts. Twenty-five percent of all young adults who could be tracked for a year after turning 18 were arrested within that year. When looking at each cohort year for the outcomes population, this percentage has decreased each year since 2017 (from 24% in 2017 to 19% in 2019).[93] The most common charges were for battery and larceny. In looking at the three years following their 18th birthday, 43% of those who could be tracked were arrested. Again, the most common charges were for battery and larceny, while 2% had an arrest for prostitution.

CSE victims continued to have low rates of high school completion and continuing education; many received public assistance and/or worked in an unemployment insurance-covered job at some point. Twenty-two 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 (54% of which were GEDs). Twenty-six percent had at least one continuing education record within the year; 12% were enrolled in high school or remedial continuing education courses, 10% in a post-secondary institution, 2% in dual enrollment, and 1% in a certificate or trade program.

In examining rates of public assistance and employment, 54% received benefits through the Supplemental Nutrition Assistance Program (SNAP) at some point in the year after turning 18; 41% of these young adults received SNAP for all four quarters. Only 2% received benefits through the Temporary Assistance for Needy Families (TANF) program, most of whom (52%) only received

[88] For the one-year outcomes, we were able to track the following numbers of young adults for the year following their 18th birthday in each data source: EFC data (1,024), law enforcement data (1,023), education data (909), SNAP/TANF data (1,023), and employment data (960).
[89] For the three-year outcomes, we were able to track the following numbers of young adults for the three years following their 18th birthday in each data source: law enforcement data (482), education data (370), SNAP/TANF data (483), and employment data (416).
[90] Youth who do not achieve permanency before turning 18 are eligible to receive services through the Extended Foster Care program if they meet program requirements, which include meeting education or employment requirements, meeting with their caseworker monthly, attending court hearings, and living in an approved supervised living arrangement.
[91] Youth may remain in EFC until the age of 22 if they have a documented disability.
[92] This analysis includes youth who had any payments under the EFC program.
[93] Cohort years are based on the year in which the child was first verified as a victim of CSE.

benefits for one quarter. Forty-five 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. Thirty-one 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 percent received SNAP at some point during this time, and 66% 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 40% to 46% having a job in any given year); again, the most common job was in food service.

APPENDIX G

Data Limitations for Involuntary Examinations and Commitments in Florida

Our prior reports have contained qualitative information regarding CSE victims being involuntarily examined under the Baker and Marchman Acts, including reports from CSE providers and notes in children's case files; however, we had not previously obtained data on these examinations. For this year's review, we spoke with agency staff and reviewed materials regarding the availability of these data in Florida and ultimately analyzed data from the University of South Florida's Baker Act Reporting Center. Our review found that while several entities collect data on these exams, there are many limitations to the available data, including missing identifying information in exam records and agencies only maintaining data on certain individuals.

Several offices collect information on Baker and Marchman Act exams in Florida; however, none appear to be complete data sources. Data on individuals who have been involuntarily examined and/or committed in Florida have several limitations. While both the University of South Florida's Baker Act Reporting Center and the Department of Children and Families maintain data on exams, these data are incomplete.[94] The Baker Act Reporting Center, through a contract with DCF, receives the required cover sheets that initiate Baker Act examinations, though it does not maintain data on exam findings or subsequent treatments, or on exams or treatments initiated under the Marchman Act. Cover sheets for all Baker Act examinations are required to be submitted to the reporting center within 45 days.

The cover sheets contain several types of information, including identifying information on the person being examined; information on the provider conducting the exam; and for children being examined, whether the child was in the custody of DJJ or DCF. However, the reporting center does not have the staff to support entering all fields from the sheet into the data system.[95] Further, reporting center staff reported that certain fields on the form are often incomplete upon receipt (particularly for minors), including the patient's name and social security number, though reporting center staff have worked to create unique identifiers and fill in missing fields when possible.[96]

DCF maintains data on Baker and Marchman Act exams and treatments that were paid for by the department; this occurs when individuals who are involuntarily examined and/or treated do not have insurance, or their insurance does not cover the cost of the exam. This is not a data source we pursued, as nearly all children in the child welfare system are covered by Medicaid, and we were unsure how many community children would not be covered by some form of insurance.

[94] Baker Act Reporting Center staff reported that information on Baker Act and Marchman Act hearings, including ex parte orders and placement petitions, are available through the Office of the State Courts Administrator; however, they reported that this information is incomplete, as only half of counties submit this information.

[95] The Baker Act cover sheets are mailed or scanned and sent to the reporting center, requiring staff to enter the data manually. Staff report that data entry for one field requires one FTE. Staff reported that they requested funding from DCF for a machine that could read the forms in lieu of manual data entry, but this request was not approved.

[96] Reporting center staff send compliance reports to receiving centers requesting missing information; however, some receiving centers do not respond to the requests.

In addition to our exploration of the possible data sources, the 2017 Legislature created a task force within DCF to address the issue of involuntary examinations of minors.[97] In addition to its work to address the larger issues around inappropriate use of involuntary exams, the task force was charged with analyzing data on these exams. The task force examined a variety of data sources and concluded that additional data are needed due to significant gaps in data reporting requirements and incomplete Baker Act forms. Specifically, the task force collected and examined data from several sources, including AHCA, DCF, DJJ, DOE, and the Baker Act Reporting Center. This review found the following.

- AHCA was unable to provide data within the timeframe needed by the task force. Data for services/encounters are reported by the Medicaid Health Plans, but there is no field to identify that an encounter claim was for a Baker Act exam.
- DJJ does not have readily available data on the numbers of youth transported to receiving facilities.
- DCF maintains data on crisis stabilization units that are licensed by AHCA; however, the data are limited to public facilities, and utilization data are only available for DCF-funded admissions.[98]
- DOE does not track the number of Baker Act examinations initiated from schools.
- The Baker Act Reporting Center data has limitations, including no indication of the result of the examination or length of stay and missing data elements.

OPPAGA's analysis of Baker Act Reporting Center data found a large gap in identifying information. While the data from the Baking Act Reporting Center appear to be the most comprehensive on involuntary exams in Florida, our review still found a large amount of missing information in the data received. Among the 397,619 records we received for exams completed from July 2013 through December 2020, 47% were missing both first and last names and 51% were missing a valid social security number.[99] When looking at receiving facility region, the percentage of exams returned with valid social security numbers ranged from 26% valid in the southern region to 62% valid in the northwest region. An additional 4% of records were missing date of birth. In Fiscal Year 2018-19, the reporting center started developing a unique identifier for individuals receiving an examination. These unique identifiers are available in 51% of the records we received.

Extensive missing identifiable data makes it very difficult to match to outside datasets for analysis. Despite the identified gaps, 53% of the 2,027 children that have been identified as CSE victims in our reports matched to a Baker Act exam record.

[97] DCF convened the Task Force on Involuntary Examination of Minors in July 2017. The task force includes stakeholders and other individuals with expertise in various aspects of Part I of Chapter 394, the Florida Mental Health Act, commonly referred to as the Baker Act. Task force membership included representatives of the law enforcement, mental health, legal, and education fields, along with community stakeholders and family members of individuals who were involuntarily examined as minors.

[98] Private designated and licensed Baker Act receiving facilities provide involuntary examination and treatment services; however, they are exempt from certain reporting requirements, including data that captures utilization.

[99] Data provided included individuals 25 or younger on the data pull date and individuals with missing dates of birth.

AGENCY RESPONSE

FLORIDA DEPARTMENT OF JUVENILE JUSTICE

June 28, 2021

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, 2021." 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. Administrative rule changes expected to be implemented in FY 2021-22 will strengthen and increase human trafficking training requirements for DJJ and DJJ-contracted staff working directly with youth in detention, residential, and probation settings. As noted in the report, DJJ also is in the process of implementing a human trafficking prevention and education curriculum for youth in residential commitment programs.

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

Respectfully,

Josefina M. Tamayo
Interim Secretary

State of Florida
Department of Children and Families

Ron DeSantis
Governor

Shevaun L. Harris
Secretary

June 30, 2021

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

Dear Coordinator Twogood:

Thank you for the opportunity to review the draft report issued by the Office of Program and Policy Analysis & Government Accountability (OPPAGA) to the Department of Children and Families (Department) on June 16, 2021 titled *Annual Report on the Commercial Sexual Exploitation of Children in Florida, 2021*. The Department 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.

The Department would like to offer the following comments to add additional context to the report.

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Regarding Hotline staff screened out … 5% of cases (88 reports) because the perpetrator was someone other than the child's caregiver, despite department policy to the contrary.

Comment: This week we completed a review of these 88 intakes and determined that although FSFN entries were entered incorrectly, the screen outs were all appropriately screened out; please see breakdown of correct entries below.

Does Not Rise to the Level of Reasonable Cause to Suspect	80
No Means to Locate	5
Out of State Inquiry	2
Caregiver guidelines not met (Wrong maltreatment, should have been coded for HHVTC not CSEC)	1

Staff have not prioritized proper entries of screen out entries because this information has not been used beyond the screening decision, but we understand the need to ensure information is correct for data integrity. We will provide training to our teams to ensure selection of the proper screen out decision in FSFN.

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Demographics for verified youth in 2020 remain similar to prior reports; the percentage of dependent children missing from care during their CSE investigation has more than doubled. …Of these youth, 32% were in a residential setting (e.g., a group home, residential treatment center, or correctional placement) and 31% were missing from care (an increase from 14% in 2019).

Comment: The Human Trafficking Prevention unit has encouraged reports to the Hotline for children that are suspected to be involved in human trafficking while missing so that a response/service plan can be in place upon their recovery. This may have contributed to the increased numbers.

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Survivor mentors identified beneficial services as well as gaps in services and supports. …Additionally, mentors reported that safe harbor and foster home placements also lack trauma-informed training, treatment, and services. Lead agencies and safe house providers also reported a need for more training, specifically for staff in safe harbor and foster placement settings.

Comment: In 2020, the Human Trafficking Prevention unit created a 24-hour train-the-trainer curriculum which includes an 8-hour section related to trauma informed care (trauma triggers, the impact of trauma, and motivational interviewing) that is facilitated by Sunshine Health. This 24-hour training is mandatory for all Safe House staff, safe foster homes, and at-risk group homes.

While collaboration among stakeholders that work with CSE youth has improved, some challenges remain. …For example, mentors reported interactions with youth that lacked empathy and continued use of the term prostitution, which they have found to re-traumatize youth. This is consistent with the literature, which highlights the importance of trauma-informed interactions, empathy, and nonjudgmental attitudes to reduce the risk of re-traumatization, which is high for CSE victims and can result in youth either remaining with or returning to their traffickers.

Comment: Importance of language is a topic that is now discussed in the 24-hour (and 6-hour HT Specialized) training.

Once again, thank you for the opportunity to review the draft report and to provide comments to ensure it provides a clear and accurate picture. 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,

Stefanie Camfield, Esq.
Assistant Secretary for Child Welfare

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OPPAGA

Office of Program Policy Analysis and Government Accountability

OPPAGA provides performance and accountability information about Florida government in several ways.

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