FFTA

Foster Family-based Treatment Association

Domestic Minor Sex Trafficking/ Commercial Sexual Exploitation of Children

Resources for Treatment Foster Care Agencies

July, 2014

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Preface

This compilation of resources for addressing the identification and treatment of victim-survivors of Domestic Minor Sex Trafficking (DMST)/Commercial Sexual Exploitation of Children (CSEC) has been developed specifically for use by providers of Treatment or Therapeutic Foster Care (TFC).

TFC is recognized as one preferred treatment for these youth and young adults. Victim-survivors may be best served through the level of care, preparation, and interventions provided by TFC clinicians and foster parents to address their trauma and to begin a path of wellbeing and recovery.

If a youth needs a setting other than TFC, the national Foster Family-based Treatment Association (FFTA) supports the use of various trauma-informed treatment options, as determined by a specific assessment of that individual.

At this time, there is no other listing of professional resources for TFC providers. For this reason, FFTA undertook an extensive examination with FFTA members that have experience treating this population and with other national experts in preparation of this document.

Four key areas are addressed with recommendations of resources for those engaged in the treatment of the DMST/CSEC survivor:

1. Screening and assessment
2. Specialized training for TFC staff and for foster parents
3. Cross-agency collaboration and safety
4. The need for outcome measures unique to the DMST/CSEC population

We wish to thank the FFTA members who participated in this effort, the FFTA Board of Directors for its support, and national colleagues for their review of this document, specifically Dr. Judith Cohen (Center for Traumatic Stress in Children and Adolescents), Tammy Sneed (Department of Children and Families, State of Connecticut), and Melissa Snow and Meghan McCarthy (the National Center for Missing and Exploited Children).

Laura W. Boyd, Ph.D.
Public Policy and Government Relations Consultant
Foster Family-based Treatment Association

Domestic Minor Sex Trafficking/Commercial Sexual Exploitation of Children Resources for TFC Agencies/Providers

I. Screening and Assessment Tools:

The tools below are for screening and/or assessment of victims of DMST/CSEC. Distinction is not made between these two crucial elements for the purpose of this document. Clinicians are familiar with various screening tools upon which a more detailed assessment and resulting treatment plan is determined.

ACYF: In addition to trauma and social-emotional screening and assessment, physical health screening is also especially pertinent for victims of child sex trafficking, who have high susceptibility to STIs and other health-related concerns. In addition to medical screenings that may be provided onsite, mobile health clinics, community health centers, and local teen health clinics are other venues for serving victims of trafficking. http://www.acf.hhs.gov/sites/default/files/cb/acyf_human_trafficking_guidance.pdf

CA: Ending the Commercial Sexual Exploitation of Children: A Call for Multi-System Collaboration in California (Appendices A & B)
http://www.youthlaw.org/fileadmin/ncyl/youthlaw/publications/Ending-CSEC-A-Call-for-Multi-System_Collaboration-in-CA.pdf

Child and Adolescent Needs and Strengths (CANS) instrument: the CANS-Commercial Sexual Exploitation (CANS-CSE). WestCoast Children's Clinic (2012). Research to Action: Sexually Exploited Minors (SEM) Needs and Strengths. Oakland, CA: WestCoast Children's Clinic
http://www.westcoastcc.org/wp-content/uploads/2012/05/WCC_SEM_Needs-and-Strengths_FINAL.pdf

Child Behavior Checklist (CBCL):
http://www.cebc4cw.org/assessment-tool/child-behavior-checklist-for-ages-6-18/

CT Decision Map (See Appendix I)

OH: Human Trafficking Screening Tool (Ohio Human Trafficking Task Force): http://mha.ohio.gov/Portals/0/assets/Initiatives/HumanTraficking/2013-human-traffricking-screening-tool.pdf

Polaris: Comprehensive Human Trafficking Assessment:
http://www.polarisproject.org/resources/tools-for-service-providers-and-law-enforcement

SASSI-A2: www.nttac.org/index.cfm?event=gsg.WebtoolSearchResultsInstrumentDetails&id=48

Trauma Symptom Checklist for Children™ (TSCC™)
http://www4.parinc.com/Products/Product.aspx?Productid=TSCC

Out of the Shadows: A Tool for the Identification of Victims of Human Trafficking (VERA Institute)
http://www.vera.org/pubs/special/human-trafficking-identification-tool

NOTE: Thorough screenings and assessments require complete background information on a youth referred for care. It is important to consider whether the youth is a victim of trafficking that was gang-controlled, pimp-controlled, or family-controlled.

II. Training and Intervention Tools: Staff and Treatment Foster Parents

TFC foster parents are accustomed to working with multi-complex trauma youth, and victims of sexual abuse in particular. As always, a crucial key to success is the competence and confidence of the TFC therapist and the relationship between the therapist and the TFC foster family.

A. Staff: Frameworks for Training and Understanding Trauma Impact:

ACYF: Guidance to States and Services on Addressing Human Trafficking of Children and Youth in the United States: "Multisystemic Therapy (MST) addresses alcohol and drug use, behavioral problems, mental health, social functioning, and family/relationships. Designed to treat post-traumatic stress and related emotional and behavioral problems in children and adolescents, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) also impacts social functioning and family/relationships. The Adolescent Community Reinforcement Approach (A-CRA) is an intervention that has been tested with runaway and homeless youth, in addition to a more general at-risk youth population. While it focuses primarily on substance abuse and co-occurring disorders (depression and anxiety), it also impacts social stability (education, employment) and linkages to and participation in continuing care services."

http://www.acf.hhs.gov/sites/default/files/cb/acyf_human_trafficking_guidance.pdf

Attachment, Self-Regulation and Competency (ARC): ARC is a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. ARC is designed for youth from early childhood to adolescence and their caregivers or caregiving systems.
http://www.traumacenter.org/research/ascot.php

Cognitive-Behavioral Therapy: Combines cognitive therapy with behavioral interventions such as exposure therapy, thought stopping, or breathing techniques.
http://www.nacbt.org/whatiscbt.htm

ARC-HT: An Intervention Framework for Survivors of Human Trafficking (Project REACH):
http://www.ccvs.state.vt.us/sites/default/files/resources/E%20Hopper%20-%20PowerPoint%202.pdf

INTERVENE: Identifying and Responding to America's Prostituted Youth Practitioner's Guide and Intake Tool: This two-part resource package from Shared Hope International includes an in-depth look at the issue of domestic minor sex trafficking through the lens of service providers and advocates, offering tools to effectively reach sexually exploited youth. This resource is designed to specifically prepare service providers to improve identification and intake procedures to account for indicators of trafficking and use strength-based, trauma-informed intervention and assessment techniques appropriate for adolescent victims of trafficking. The outline Shared Hope uses to train service providers is as follows:

- Intro to sex trafficking/scope of problem
- Victim profiling (vulnerabilities, statistics, traditional ideologies)
- Primary manifestations of minor sex trafficking
- Trafficker profiling
- Recruitment/grooming techniques
- Methods of control/coercion
- "The Game" (terminology, rules)
- Gang trafficking (recruitment, control, indoctrination)
- Demand/Buyer profiling (mindset, belief systems)
- Impact of trauma on victims (psychological/behavioral indicators, basic overview of complex trauma)

- Creating and implementing questions/intakes for identifying victims with tips on interaction (basic)

For purchase: http://sharedhope.org/what-we-do/prevent/training/

My Life My Choice (MLMC) Curriculum (Justice Resource Institute):
http://jri.org/services/behavioral-health-and-trauma-services/community-based-behavioral-health-services/my-life-my-choice/about/MLMC-curriculum

Neurosequential Model of Therapeutics: The Neurosequential Model of Therapeutics (NMT) is a developmentally sensitive, neurobiology-informed approach to clinical problem solving. The Neurosequential Approach has three key components – training/capacity building, assessment and then, the specific recommendations for the selection and sequencing of therapeutic, educational and enrichment activities that match the needs and strengths of the individual.
http://childtrauma.org/nmt-model/faqs/

Therapeutic Treatment S.E.R.V.E. Model: A Brain-Based Approach for Complex Traumatic Stress: Recent advances in neuroscience have increased our knowledge of how stress impacts the body. Brain-based therapy envisions the therapeutic process as a method to change the brain in order to change mood and behavior, using evidence of brain function and activity and moving beyond the theoretical school paradigm. Using a synthesized model of neuroscience, attachment theory and evidence-based treatment, you will learn how to more effectively treat complex traumatic stress.
(Bonnie Martin, LPC, bonnielynnmartin@gmail.com)

Trauma Systems Therapy (TST): The essence of TST is to help the child gain control over emotions and behavior via enhancing the child's capacity to regulate emotion and diminishing the ongoing stresses and threats in the social environment.
http://www.aboutourkids.org/traumasystemstherapy/overview/tst-clinical-model

Trust-Based Rational Interventions® (TBRI®): Karen Purvis: TBRI® is based on a solid foundation of neuropsychological theory and research, tempered by humanitarian principles. It is a family-based intervention that is designed for children who have experienced relationship-based traumas such as institutionalization, multiple foster placements, maltreatment, and/or neglect.
http://www.child.tcu.edu/training.asp

NOTE: Among Evidence-based Treatments, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has the strongest evidence for treating child PTSD and CSEC. TF-CBT has 14 Randomized Controlled Trials documenting superiority over other treatment conditions for improving PTSD. In addition, there is an RCT documenting that TF-CBT is effective for sex trafficked children. This study showed that TF-CBT was effective in improving PTSD, depression, anxiety, conduct problems and pro-social behaviors for a CSEC population with complex trauma (O'Callaghan et al, 2013).

B. Staff: Evidence-based Options for Child PTSD and Related Problems in CSEC:

Cognitive Behavioral Intervention for Trauma in Schools: The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a school-based, group and individual intervention. It is designed to reduce symptoms of post-traumatic stress disorder (PTSD), depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills.
http://cbitsprogram.org/

Eye Movement Desensitization and Reprocessing: Combines general clinical practice with brief imaginal

exposure and cognitive restructuring (rapid eye movement is induced during the imaginal exposure and cognitive restructuring phases).
http://www.emdr.com/general-information/what-is-emdr.html

Functional Family Therapy: The FFT model has received international recognition for its outcomes in helping troubled youth and their families to overcome delinquency, substance abuse, and violence. It is a short-term treatment strategy that is built on a foundation of respect of individuals, families and cultures, but that includes powerful treatment strategies that pave the way for motivating individuals and families to become more adaptive and successful in their own lives.
http://www.fftllc.com/

Multi-Dimensional Family Therapy (MDFT) is an intensive, in-home, evidence-based youth treatment program, which is nationally recognized.
http://www.mdft.org/

Stress Inoculation Therapy (SIT): Combines psycho-education with anxiety management techniques such as relaxation training, breathing retraining, and thought stopping.
http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=15683&cn=1

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT): TF-CBT is based on learning and cognitive theories—addresses distorted beliefs and attributions related to the abuse and provides a supportive environment in which children are encouraged to talk about their traumatic experience.
https://www.childwelfare.gov/pubs/trauma/trauma.pdf
http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed

See also CBT for Children with Sexual Behavioral Problems:
http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy-tf-cbt-sexual-behavior-problems-in-children-treatment-of/

C. Foster Family

Foster Care Model, Training and Parent Resource Guide (State of CT-due out Summer, 2014)

Maple Star Training Guide (due out Summer, 2014)

Sarah's Home Training (TFC homes in CO)
http://www.maplestar.net/colorado/special-programming/minor-domestic-human-trafficking-victims

Understanding Girls: A Trauma Informed Perspective (CT DCF Trauma-Informed Care Practice Guide)
http://www.ct.gov/dcf/lib/dcf/trauma-informed_care/pdf/trauma-informed_care_-_practice_guide_september_2012.pdf

Recommendation: focus on the 'practical': i.e. use of cellphones, internet, 'normalize' running away behaviors, safety planning, etc. Provide shortened overview in training of DMST/CSEC statistics, legal discourse, etc. (this is of less interest and usefulness to foster families). Key for foster families: regardless of setting is long-term positive relationship with survivor: permanent, no blaming, support of foster mom/family and their trauma is crucial. Any configuration of two-parent home, single parent home, home with other youth (bio or DMST) can be considered.

NOTE: gang-related trafficked victims may require a higher level of care than TFC. Assessment should be a determining factor.

III. Cross Agency Collaboration and Safety Planning/Relapse Prevention:

Cross agency collaboration (health, legal, law enforcement, child welfare, schools and vocational training, etc.) is paramount in treatment planning for DMST/CSEC victims. Safety plans and relapse prevention plans are crucial. Providers and foster parents should anticipate use of these plans versus assuming they will be needed infrequently. Use of plans does not suggest 'fault' on part of therapist or foster parents.

ACYF: Guidance to States and Services on Addressing Human Trafficking of Children and Youth in the United States
http://www.acf.hhs.gov/sites/default/files/cb/acyf_human_trafficking_guidance.pdf

Federal Strategic Action Plan on Services for Victims of Human Trafficking in the United States 2013-2017
http://www.ovc.gov/pubs/FederalHumanTraffickingStrategicPlan.pdf

Safety planning recommendations from WA and CT:

- Develop an initial Safety Plan that addresses at a minimum: AWOL risk; response to trafficker if occurs: in person, telephone, internet; addressing reported fears and concerns
- Children and youth should be referred to and treated by only those behavioral health treatment providers who have specialty training in childhood trauma, trauma assessment, and evidence-based trauma-specific treatments.
- Relapse plan: contact #s, who to call, remind them to practice safe sex, let them know they are welcomed back.
- Safety focus should be on the needs and safety of the youth. DMST/CSEC victims are an easily replace commodity for pimps and traffickers. The risk of arrest is too high for pimps and traffickers to focus on foster families (i.e. safety).
- Expect DMST/CSEC victims to runaway. Provide trauma care for foster families, so they understand the 'pattern'. Do not blame foster parents if/when youth runs.

IV. DMST/CSEC Outcomes for Child Welfare Agencies

Dependency statutes, Children and Family Services Review (CFSR) outcomes, and Adoption and Foster Care Analysis and Reporting System (AFCARS) data sets come with presumptions to monitor and benefit most foster children. However, trafficked children may actually be harmed by a system that favors quick reunification, non-foster care placements, and fast-tracked permanency.

FFTA recommends that HHS in consultation with others be instructed to also examine appropriate outcomes for this specific population of trafficked victims. Outcomes unique to this population should be developed according to the unique needs of this population. The typical treatment and placement outcomes measured for youth in foster care do not apply to this population, e.g. running away from and returning to their foster home may not be a 'negative' for these youth. Outcomes measured need to go beyond current benchmarks for traditional foster youth.

Consideration is needed specifically for appropriate outcomes unique to this population around such measures as: timeliness and permanency of reunification, median length of stay in care, achieving permanency, placement stability, and safety.

Other measures of progress and well-being should be included for the trafficked population: stability of relationship with foster parent/home; improvement in education or employment attendance and performance; improvement in physical health, sleep patterns, and relationships with other students, co-workers, and foster parents; improvement in grooming and personal presentation; improvement in mental health status, including reduction in any self-destructive behaviors, outbursts of emotion and impulses, and withdrawal and depressive

traits; and changed perception/idealization/bonding with former perpetrators.

V. Other resources

CT: Practice Guide for Intake and Investigative Response to Human Trafficking of Children http://www.ct.gov/dcf/lib/dcf/policy/pdf/Human_Trafficking_PG.pdf

WA: Washington State Model Protocol For Commercially Sexually Exploited Children
http://www.ccyj.org/Project%20Respect%20protocol.pdf

CSEC: What Schools Need to Know to Understand and Respond to Human Trafficking (PowerPoint)
http://center.serve.org/nche/downloads/Webinar/csec.pdf

NCTSN: http://www.nctsn.org

NREPP: http://www.nrepp.samhsa.gov

ECPAT USA: http://www.ecpatusa.org/reports-guides

IL: Building Child Welfare Response to Child Trafficking
http://www.luc.edu/media/lucedu/chrc/pdfs/BCWRHandbook2011.pdf
(note: changes have been made in original from Loyola Univ. for application to TFC population of providers)

For Foster Families:

NCMEC: http://www.netsmartz411.org
NCMEC: http://www.missingkids.com/Families

APPENDIX

Appendix I

Domestic Minor Sex Trafficking Decision and Practice Map
Connecticut Department of Children & Families (Jan. 2014)

Referrals

⇩

Careline/ Risk Management

⇩

Area Office Social Worker ⇨

(HART)Human Anti-Trafficking Response Team Members	
Co-Chairs	Oversee All HART Initiatives
Consulting Psychiatrist	Provides clinical consultation per request
Consulting Psychologist	Provides clinical consultation per request
Regional Liaisons	Coordinate communication between AO team and HART team

Is the child a confirmed victim, at high risk, or at risk for commercial sexual exploitation and/or domestic minor sex trafficking?

Confirmed Victim- If yes to one or more of the following

	Yes	No
Has the child self reported being forced or coerced into sexual activity for the monetary benefit of another person?	☐	☐
Has law enforcement confirmed through an investigation that the child has been trafficked or engaged in any commercial, sexually-exploitive activity?	☐	☐
Has the child self reported *"consensual"* participation in a sexual act in exchange for shelter, transportation, drugs, alcohol, money or other item(s) of value?	☐	☐

High Risk - If yes to one or more of the following

	Yes	No
Have there been confirmed or reported uses of hotels for parties or sexual encounters?	☐	☐
Has there been unauthorized travel across county or state lines?	☐	☐
Does the child have unaccounted for injuries or tattoos?	☐	☐
Is the answer "yes" to 3 or more of the below "at risk" factors?	☐	☐

At Risk - If yes to fewer than 3 of the following:

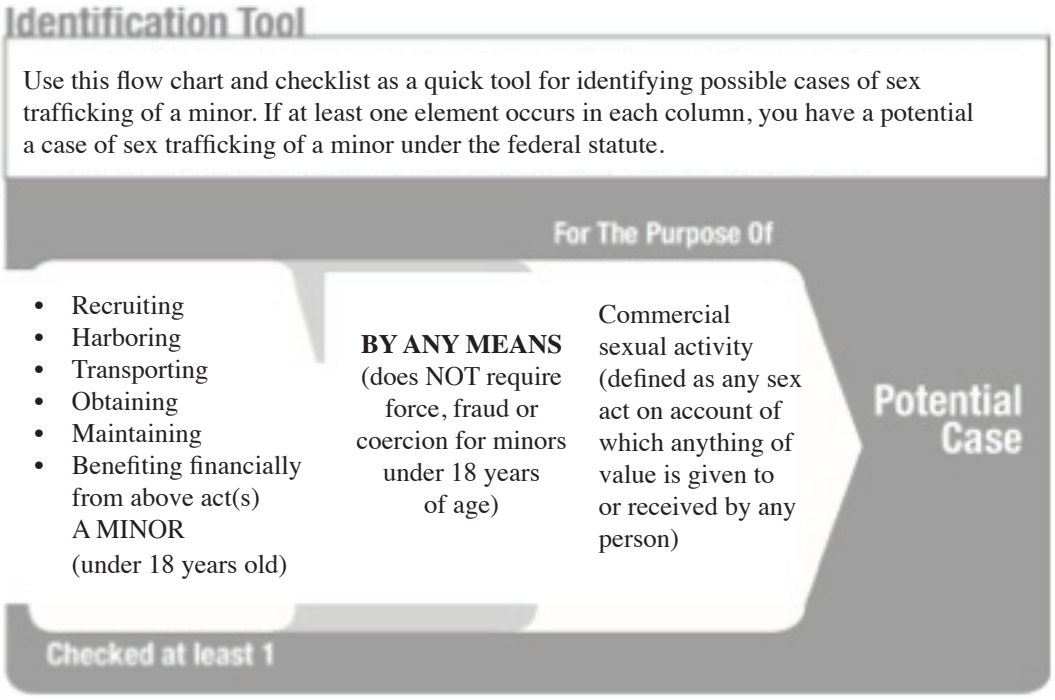
	Yes	No
Does the child have a history of multiple AWOLS?	☐	☐
Have there been reports of multiple anonymous sex partners?	☐	☐
Has the child been in possession of money, cell phone or other items that cannot be explained or accounted for?	☐	☐
Has the child used the internet for posting sexually explicit material?	☐	☐
Does the child have a self-disclosed or reported history of multiple and/or anonymous sex partners?	☐	☐
Is the child in a sexual/ romantic relationship with an older partner?	☐	☐
Is the child unable or unwilling to provide information about a boyfriend or sex partners?	☐	☐
Does the child have a history of multiple/chronic sexually transmitted disease?	☐	☐
Has gang affiliation been disclosed, reported or suspected?	☐	☐

If child is a **Confirmed Victim**	⇨	Follow DMST Policy & Practice Guidelines
If child is at **High Risk**	⇨	Contact Regional/Area Office HART Liaison for consultation.
If child is **At Risk**	⇨	Consult with AO team/ARG for individualized service & treatment.

Appendix II: Initial Identification Tool

Federal Criminal Definition of Sex Trafficking

Sex trafficking of children or by force, fraud, or coercion, 18 USC § 1591
To knowingly recruit, harbor, transport, provide, obtain, or maintain a person, or to benefit financially from such action, knowing or in reckless disregard of the fact that force, threats of force, fraud, or coercion will be used to cause the person to engage in a commercial sex act, or that the person is under 18 years old and will be caused to engage in a commercial sex act.



NOTE Children and "force:" Children are an exception to the "means" component of the human trafficking definition. Sex trafficking cases do not require force, threats of force, fraud, or coercion when involving minors. Any minor involved with prostitution is considered a victim of trafficking.

Appendix III

Summary of Services Available to Victims of Trafficking*

Both international and domestic victims of human trafficking are eligible for services to help them recover from their ordeal and rebuild their lives. The Senior Policy Operating Group (SPOG) Subcommittee on Domestic Trafficking prepared this chart to outline the types of services available to domestic and international trafficking victims. As the chart indicates, domestic human trafficking victims - both U.S. citizens and lawful permanent residents - are largely eligible for the same benefits and services as international victims.

SERVICE	AGENCY	DOMESTIC VICTIMS				INTERNATIONAL VICTIMS	
		CITIZEN & ADULT	RESIDENT & ADULT	CITIZEN & MINOR	RESIDENT & MINOR	ADULT	MINOR
Child Nutrition Programs	USDA	N/A	N/A	Yes	Yes	N/A	Yes
Food Stamp Program	USDA	Yes	Yes, after waiting period**	Yes	Yes, after waiting period**	Yes	Yes
Women, Infants and Children (WIC)	USDA	Yes	Yes	Yes	Yes	Yes	Yes
Refugee Cash and Medical Assistance	HHS-ACF	No	No	No	No	Yes	Yes
Services to Victims of Torture	HHS-ACF	No	Yes	No	Yes	Yes	Yes
Temporary Assistance for Needy Families (TANF)	HHS-ACF	Yes	Yes, after waiting period**	Yes	Yes, after waiting period**	Yes	Yes
Health Screenings	HHS-CDC	Yes	Yes	Yes	Yes	Yes	Yes
Medicaid	HHS-CMS	Yes	Yes, after waiting period**	Yes	Yes, after waiting period**	Yes	Yes
State Children's Health Insurance Program (SCHIP)	HHS-CMS	N/A	N/A	Yes	Yes, after waiting period*	N/A	Yes
Health Resources and Services Admin. (HRSA) Programs	HHS-HRSA	Yes	Yes	Yes	Yes	Yes	Yes
Substance Abuse and Mental Health Services Admin. (SAMHSA) Programs	HHS-SAMHSA	Yes	Yes	Yes	Yes	Yes	Yes
Public Housing Program	HUD	Yes	Yes	Yes	Yes	Yes	Yes
Tenant-Based Vouchers	HUD	Yes	Yes	Yes	Yes	Yes	Yes
Victims of Crime (VOCA) Emergency Funds	DOJ-Civil Rights	Yes	Yes	Yes	Yes	Yes	Yes
Emergency Witness Assistance	DOJ-Civil Rights	Yes	Yes	Yes	Yes	Yes	Yes
Victim Rights and Services	DOJ-Civil Rights	Yes	Yes	Yes	Yes	Yes	Yes
Witness Protection	DOJ-Civil Rights	Yes	Yes	Yes	Yes	Yes	Yes
OVC Services for Trafficking Victims Discretionary Grant	DOJ-OVC	No	No	No	No	Yes	Yes
VOCA Victim Assistance/Compensation	DOJ-OVC	Yes	Yes	Yes	Yes	Yes	Yes
One-Stop Career Centers & Job Corps	DOL	Yes	Yes	Yes	Yes	Yes	Yes

"Based on outlines submitted by agencies participating in the SPOG Subcommittee on Domestic Trafficking
". "These programs require a five-year waiting period before immigrants and refugees who become lawful legal residents are eligible for services

SOURCE: CENTER FOR THE HUMAN RIGHTS FOR CHILDREN, LOYOLA UNIVERSITY CHICAGO & INTERNATIONAL ORGANIZATION FOR ADOLESCENTS (IOFA)

Appendix IV

Child Trafficking Safety Assessment Form

Screening Date
Client Name

DCFS Caseworker
Case Number

This form is intended to assist the caseworker or licensed private contractor in ascertaining potential risks posed by the employer or guardian to the client or by the client's family. It can assist any staff working with the client to create a service plan that will maximize the safety of all involved. Additionally, service providers may want to inquire about other activities that increase risk, including organized crime, gang involvement, etc.

Great care should be taken to ask questions in a sensitive manner, allowing the client to answer at his or her own pace. Caseworkers should remind client of confidentiality, how this information will be handled and should document minimum details only.

**The term "employer" should be replaced when there is a more appropriate term or name (e.g., "aunt" "boyfriend, " etc.).*

A. HISTORY OF THREATS AND VIOLENCE	YES	NO
Did anyone ever actually harm you for any reason? If so, can you tell me a little about what happened? (Briefly note physical violence.)		
If client is overwhelmed and doesn't answer this question, you can provide the following list of more specific questions: • *Were you ever hit (i.e. struck/slapped with* a *hand, struck with an object)?* • *Were you ever burned?* • *Did someone touch you where they weren't supposed to?* • *Did someone try to have or have sex with you? Did someone ask you to have sex with anyone else?* • *Did someone ever take pictures with* a *camera or video camera of you? Tell* me *what you were doing?*		
Did anyone ever threaten to harm you if you ran away or if you told anyone what was happening to you? If yes, what did they tell you would happen?		
Was anyone (including survivor) ever caught trying to run away OR caught after they escaped? If so, what happened?		

SOURCE: CENTER FOR THE HUMAN RIGHTS FOR CHILDREN, LOYOLA UNIVERSITY CHICAGO & INTERNATIONAL ORGANIZATION FOR ADOLESCENTS (IOFA)

A. HISTORY OF THREATS AND VIOLENCE *continued*	YES	NO
Were you ever forced you to use drugs? If yes, please list the drugs.		
Did your "caretaker" ever use weapons? If yes, please list the weapons.		
Was your "caretaker" engaged in any other illegal activity?		

B. PRESENT SITUATION	YES	NO
Did anyone ever threaten to harm you for any reason? (Example: not working; getting sick; not obeying etc.)		
Has your "caretaker" attempted to contact you either directly or through someone else since you left?		
Are you in touch with anyone your "caretaker" knows?		
Is the "caretaker" from same geographic, ethnic, or religious community as the child?		
Have all interpreters and other parties involved in this case (particularly those of same geographic, ethnic, cultural, or religious background as child) been carefully screened for ties to "caretaker" ?		
Has child been sufficiently removed from any areas where exploitation took place? Consider all services, including shelter, foster home, school, community-based services, etc.		
Is the child a material witness or otherwise involved in a state or federal criminal case against the "caretaker" ?		
What is current location of employer? -Jail -At large within U.S. - At large overseas - Unknown		
Are any of the "caretaker's" associates still at large?		

SOURCE: CENTER FOR THE HUMAN RIGHTS FOR CHILDREN, LOYOLA UNIVERSITY CHICAGO & INTERNATIONAL ORGANIZATION FOR ADOLESCENTS (IOFA)

	YES	NO
Did anyone ever threaten to harm your family or someone you care about if you ran away or told anyone what was happening to you? If so, what did they tell you would happen?		
Do you know if your "caretaker" ever harmed another worker's family or loved ones for any reason? If so, please describe how they were harmed.		
Does your "caretaker" know where your family or loved ones are now?		
Has anyone contacted your family to try to find you?		
Has anyone threatened or harmed your family?		

Summary

From the answers provided in the boxes above, are any of the following key risks present?

- History of threats
- Is trafficker at large?
- History of physical violence
- Is trafficker under investigation?
- Presence of threats to child
- Is child fearful?
- Presence of threats to family
- Is the child a flight risk?

AFTER completing the Child Safety Assessment Form

If one or more of these key risks are checked

Service providers should consult with child welfare, supervisor, child's attorney, guardian at litem, etc. to develop and implement specific safety plan that addresses each of the relevant areas of risk.

Appendix V

New Client Checklist

Intake and First Appointment

Use Key Intake Documents
- o Privacy Notice/limits on Confidentiality
- o Informed Consent and Releases of Info
- o Rapid Screening Tool or Comprehensive Screening and Safety Tool as appropriate
- o Provide appointment calendar and folder/envelope to organize docs

Perform Assessment of Basic Needs
- o Interpretation by a safe and appropriate source
- o Food and non-food provision
- o Short and long term housing options
- o Phone cards
- o Mental health assessment
- o Medical and dental examinations
- o Items not provided by foster family or guardian or other sources of support

Case Assessment Process and Key Documents for Case File

Partition I-Case Management Forms
- o Intake form and key intake documents
- o Cover sheet/quick reference for pertinent info
- o Any documentation from the referent
- o Additional release of information forms
- o Tri-Partite Assessment & Service Plan

Partition II-Health Documents
- o Client appointment schedule
- o Copies of medical diagnoses and medication lists (with permission)
- o list of possible referral sources for ongoing health needs

Partition III-Legal/Immigration Documents
- o Copy of state 10 or other Identifying documents (library or school card)
- o Copy of passport, visa or country ID - if available
- o Copy of T Visa, EAD
- o Copy of Social Security Card
- o ORR Certification Letter/Letter of Eligibility (for minors)
- o Any other key immigration documents as collected

Partition IV-Benefits/Assistance Documents
- o Match Grant Letter if applicable
- o DPSS Paperwork
- o list of referrals and service providers assisting client

Partition V-Education/Employment/Housing
(Put housing separate, if room)
- o Referral forms for job search assistance
- o Enrollment forms
- o FAFSA
- o Applications for supportive housing

Partition VI-Case Notes

SOURCE: CENTER FOR THE HUMAN RIGHTS FOR CHILDREN, LOYOLA UNIVERSITY CHICAGO & INTERNATIONAL ORGANIZATION FOR ADOLESCENTS (IOFA)

Appendix VI

Child Trafficking-Informed Consent Form

The (name of state child welfare department) holds the responsibility to secure the wellbeing of minors in this State. As your Therapist/Caseworker/Social Worker, it is my responsibility to work with you and whoever's on our team (your legal guardian(s) and/or family members, school staff, attorney) to create a plan, with goals for your future, to help you stay safe and healthy. I will assist you in identifying your needs for services in housing, health, mental health, education, legal assistance, etc., and will do everything I can to help you get the services you need.

You have the right to say what you think and feel and to talk to me about anything that is troubling you about your case so I can try to help. You also have a right to have your personal information handled in a confidential manner. No one in this office will share your personal information with an outside person or party unless you have signed an Authorization for Release of Information, (show document) OR the outside party is legally entitled to information about your case (provide example). Please know that I discuss my clients with my supervisor and a limited group of coworkers for support and advice on how to do my job well.

Please know that under the law, I am bound to notify medical services and/or law enforcement if I learn that someone I am working with may harm himself or herself or another person, or is abusing or endangering the life of a child under the age of 18 or an elderly person over 65.

Once our "team" has agreed to a plan for services, I will follow through on this plan with you by coordinating the necessary services and will remain involved with you until your situation has stabilized and your case is closed. Over time, you may have other workers help out as well.

I want you to get the best services available, so it is important that we be open and honest with each other and work together as a team. We have a responsibility to communicate, to set and evaluate goals, and either change them or make new ones when we need to.

Signature of Client/Guradian Date

For clients who do not read, write, and/or speak English:
This release has been interpreted to me in my own language.

Signature of Client/Guradian Date

Signature of Interpreter Date

Appendix VII

Goal Attainment Scaling

Goal attainment scaling is a process for establishing realistic goals with a client in a manner that is trauma-informed and initiates self-determination. These tips are designed to help service providers achieve the greatest level of stability and success with case management of child victims of trafficking.

The goals of the process are:

- To identify strengths and to establish goals that are important to the client
- To present the process in a phased manner so client does not get overwhelmed
- To develop reasonable expectations and achieve perspective
- To work in partnership in developing of a service plan
- To build client's capacity to recognize incremental progress and better manage challenges to success

Tips for Goal Attainment Scaling:

1. Prepare for goal attainment process by having some ideas of your own about the client's case to assist client in articulating what they want.
2. Avoid broad goal setting when client is in crisis or clearly overwhelmed. Utilize basic crisis intervention techniques instead.
3. If client is or becomes overwhelmed, encourage him or her to limit goals to two or three-even just one if necessary. This will help client prioritize and, hopefully, realize that many of the things they seek to accomplish can only be done once other things are accomplished.
4. Do not put words in the client's mouth. Act as a coach to help him or her articulate his or her own priorities.
5. Be patient. It may be very difficult for the client to distinguish between goals and outcomes. The following example provides a framework for delineating goals and outcomes.

Examples

A. Goal:Employment

1	2	3	4	5
Least Favored Outcome		Somewhat Favored Outcome		Most Favored Outcome
Get cut off from welfare without finding a job	Stay on welfare, without finding a job	Stay on welfare, with a low-paying job in meantime	Get off welfare but not with the job I want	Get off welfare, with permanent, adequate job that will enable me to support myself

6. A client may resist focusing on anything other than the most favored outcomes for many reasons: he or she may want to please you, may not understand the process, or may want the interview to end. Whatever the case, continue to explain the purpose of the exercise, gently making suggestions, and offering reassurance that progress takes time AND steps.
7. Once complete, use the goals to develop a strategy, detailing what the client will do and what you will do. This is an effective way to hold each other accountable and to assess what resources the client might need help accessing in order to achieve his or her own tasks.
8. Develop a timeline or set a period at which point you and client will reassess goals. Prepare client for the possibility that goals and interim steps often change as we grow and learn. Validate such changes as self actualization and a normal part of learning about oneself.

Practice Pointer

Training in Trauma-Informed Interventions

The Goal Attainment Scaling process is an example of one tool that can be used in case management with a child victim of trafficking. It is strongly recommended that workers receive further training on working with traumatized clients.

Methods for establishing trust and safety with a client need to be applied consistently, especially when working with child victims of trafficking.

SOURCE: CENTER FOR THE HUMAN RIGHTS FOR CHILDREN, LOYOLA UNIVERSITY CHICAGO & INTERNATIONAL ORGANIZATION FOR ADOLESCENTS (IOFA)

About FFTA

FFTA

Established in 1998, the Foster Family-based Treatment Association (FFTA) is the leader in Treatment Foster Care, dedicated to strengthening agencies that support families caring for vulnerable children. Its membership of over 400 agencies provides an array of child welfare and mental behavioral services to over 600,000 vulnerable children and youth each year. Treatment Foster Care is provided to children and youth with significant emotional, behavioral and medical problems who receive intensive and therapeutic services in a family-based setting, with the support of specially trained foster parents and clinical staff. For more information, visit www.ffta.org