Document Title:	**Improving Outcomes for Child and Youth Victims of Commercial Sexual Exploitation: An Evaluability Assessment of the Love 146 Survivor Care Programs**
Author(s):	**Lisa M. Jones, Ph.D., Jennifer O'Brien, Ph.D., Kimberly J. Mitchell, Ph.D.**
Document Number:	**309569**
Date Received:	**October 2024**
Award Number:	**2020-V3-GX-0076**

Improving Outcomes for Child and Youth Victims of Commercial Sexual Exploitation: An Evaluability Assessment of the Love 146 Survivor Care Programs NIJ Grant No. 2020-V3-GX-0076

Final Research Report

Crimes against Children Research Center
University of New Hampshire
10 West Edge Drive, Suite 106
Durham, NH 03824

Lisa M. Jones, Ph.D. (PI), University of New Hampshire
Jennifer O'Brien, Ph.D. (Co-I), University of New Hampshire
Kimberly J. Mitchell, Ph.D. (Co-I), University of New Hampshire

This research was supported by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice through Grant 2020-V3-GX-0076 awarded to the University of New Hampshire. Opinions, findings, and conclusions or recommendations expressed in this report are those of the authors and do not necessarily reflect those of the Department of Justice.

Table of Contents

Introduction

Policy makers and advocates have urged the development of interventions and programs that can provide young victims of commercial sexual exploitation with needed services to reduce the likelihood of re-victimization and improve physical health, mental health, and education goals (Clawson & Grace, 2007). Communities have responded to the problem of commercial sexual exploitation of children (CSEC) by developing a variety of victim service models (Muraya & Fry, 2016). However, there has been almost no rigorous evaluation research conducted to help the field understand what service models provide victims with the best outcomes. One of the reasons that evaluation research has been slow to develop is that there are logistical and ethical issues that need to be carefully addressed before engaging youth in rigorous research. It is also important that before undertaking an outcome evaluation, service delivery and research partners have engaged in an evaluability assessment to ensure that the program is prepared for evaluation. The current report details the process and outcomes of an evaluability assessment conducted with the non-profit organization Love 146, who provide services to CSEC victims through their Survivor Care program since 2014.

Scope and Impact of CSEC

The U.S. Government defines CSEC, also sometimes referred to as child sex trafficking, as a commercial sex act induced by force, fraud, or coercion, or in which the person induced to perform commercial sex has not attained 18 years of age ("Trafficking Victims Protection Act," 2000). CSEC is not a new phenomenon, but it is a growing focus of the criminal justice system's fight against child sexual exploitation (National Research Council, 2013) Although the exact prevalence of CSEC in the United States has not been clearly established (Finkelhor et al., 2017), recent population-based estimates suggest prevalence rates of between 1.4 and 7.4%, depending on the context (Head et al., 2021; Martin et al., 2021). For some populations, prevalence rates are likely higher. For example, research suggests that children and youth with histories of adversity including physical and sexual abuse, and exposure to family violence are at higher risk for commercial sexual exploitation (Franchino-Olsen, 2021).

The serious physical and emotional consequences for youth victims of CSEC have been well documented by researchers. Substantial research has identified that in addition to commercial exploitation, victims often have histories of sexual abuse, physical abuse, psychological abuse and neglect (Countryman-Roswurm & Bolin, 2014; Friedman, 2005; Gragg et al., 2007; McIntyre, 2009; Smith et al., 2009; Tyler et al., 2000). CSEC victims also report higher levels of dating violence, homelessness, dropping out of school, running away, drug use, and poverty have also been shown to be elevated (Gibbs et al., 2018; Newcomb, 1995; Sanchez et al., 2006; Wang & Fredricks, 2014). CSEC victims report high levels of emotional problems (e.g., emotional, developmental, psychological, and behavioral dysregulation, traumatic stress), even when compared to a matched sample of sexually assaulted or abused children (Cole et al., 2016). As a result, researchers and service providers highlight victims' needs for intensive and tailored interventions and treatments (Clawson & Grace, 2007; Fong & Cardoso, 2010).

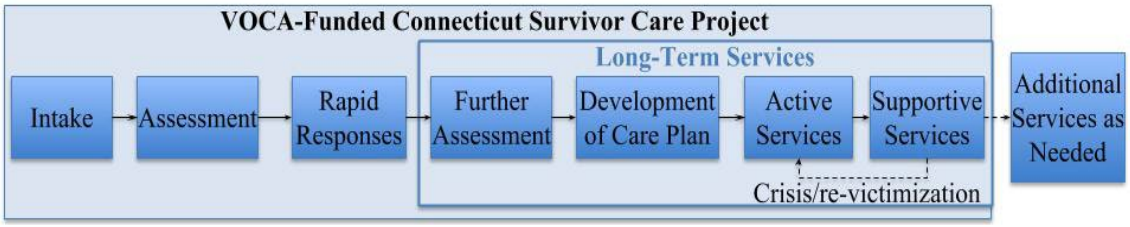
The Love146 Survivor Care Program

Love146 developed the *Survivor Care Program* in 2014 to support youth in the state of Connecticut who are known to be or highly suspected of being victims of CSE. Referred youth are provided with a range of services including psychoeducation, intensive case management, life-skills assistance, criminal justice support/advocacy, transportation, and crisis management/support (Williamson et al., 2019). Referrals to the Love146 Survivor Care Program are accepted from anyone who suspects that a youth may be a victim of CSEC. Most referrals are received from Connecticut's Department of Children and Families' (DCF) (86%), with smaller percentages of referrals coming from mental health professionals (6%), hospitals (2%), juvenile court or juvenile justice facilities (2%), multidisciplinary teams or child advocacy centers (1%), and police (1%). The program incorporates two types of services: Rapid Response and Long-Term Services (LTS) (see **Figure 1** below).

Rapid Response services. All youth who are referred to Love146 receive Rapid Response services, one-time intervention lasting about an hour that provides youth with information, safety

planning, and referral services. Following this service, referring agents or youth themselves may request entry into the long-term services program.

Figure 1: Love146 Survivor Care Program Flow Chart



The Long-Term Services (LTS) program. For youth referred to and enrolled in the LTS program, intensive services are provided by licensed, masters-level social workers, guided by individualized care plans. Care plans identify measurable goals and objectives around safety, emotional well-being, and skill development, as well as incentives (e.g., sporting events, concerts, musical instruments) to help survivors stay motivated. Throughout victims' tenure in LTS, social workers provide 3-4 hours per week of individualized direct services. In addition, social workers participate in case-level meetings for the youth including multidisciplinary team (MDT) meetings, and communicate with providers (e.g., health care providers, and law enforcement) about the youth's service needs. As part of LTS, survivors and their caregivers receive the following: (1) personal advocacy and emotional support; (2) support for emotional, psychological, and physical health and safety; (3) mental health counseling; (4) criminal justice support/advocacy; and (5) transportation services. Victims and caregivers receive regular weekly services for an average of 6-9 months, followed by bi-weekly (every other week) services for an average of 3-6 months.

Once a youth has participated in the LTS program for approximately twelve months, they are moved to Sustained Care. Sustained Care is a component of LTS in which services are not provided on a regular basis, but accessible if needed. To date, 49% of youth in Sustained Care have reached back out to Love146 to either share updates and celebrate important life events (e.g., graduations) or access additional service (e.g., housing assistance).

A Critical Need for Evaluation Research on CSEC Victim Services

Policy makers and advocates have urged the development of interventions and programs that can provide victims of CSEC with needed services to reduce the likelihood of re-victimization and improve physical health, mental health, and education goals (Clawson & Grace, 2007). Communities have responded by developing a variety of victim service models (Muraya & Fry, 2016). Given the extent of the adversity and trauma experienced by the majority of victims of CSEC, researchers and advocates have argued that specialized services are needed (Clawson et al., 2009; Fong & Cardoso, 2010). There are a number of reasons why victims of CSEC may have unique needs from other at-risk and victimized youth: the influence of traffickers, the stigma of commercial sex, and the heightened risk for sexual and physical abuse and emotional abuse and exploitation, for example, may require the availability of specialized services and training. However, it is not clear how these unique service approaches can be best combined with or incorporate services for high-risk youth that may already exist in the community (O'Brien et al., 2022).

The expansion of community services for victims of CSEC have been accompanied by calls for rigorous evaluation of services models (Felner & DuBois, 2017; National Research Council, 2013). Apart from some initial evaluation efforts (Cohen et al., 2011; Farrell et al., 2018; Pierce, 2012; Rothman et al., 2020; Saewyc & Edinburgh, 2010; Salami et al., 2018), few service programs have been rigorously evaluated in terms of their benefit for victims of CSEC, and prior evaluations have been limited by small sample sizes and no control groups. This makes it difficult to know which types of services are helpful at alleviating mental and physical health symptoms, increasing youth safety, and supporting improvements in educational, housing, and financial stability (Felner & DuBois, 2017; National Research Council, 2013).

Efforts at evaluation have been increasing. Preliminary evaluation research has found that services can increase youth knowledge about sex trafficking, and the data suggest improved outcomes such as decreased arrest rates, and improved grades, health, housing stability and social support (Cohen et al., 2011; Farrell et al., 2018; Pierce, 2012; Rothman et al., 2020; Saewyc & Edinburgh, 2010; Salami et

al., 2018). An evaluation by Rothman et al. (2020) found that after 6 months of receiving survivor-mentor services, youth showed reduced experiences with commercial sexual exploitation, and were less likely to have used illicit drugs or been arrested and showed improved social support and coping skills. However, the evaluation studies that have been done have relied on small sample sizes, did not include comparison groups, and had limited follow-up time frames (Davy, 2016; Dell et al., 2019; Felner & DuBois, 2017; National Research Council, 2013).

There are logistical and ethical concerns that may have slowed the pace of rigorous evaluation research for CSEC service models. First, the designation of youth involved in commercial sex as victims is fairly recent, and work is therefore needed to prepare newer programs for participation in outcome evaluation (Lutnick, 2016). Second, rigorous evaluation studies require recruiting large sample sizes, tracking changes in youth outcomes over time, and ideally using both self-report and agency data. These requirements are difficult with a population of youth who may have strained relationships with caregivers, unstable living arrangements, and whose vulnerable status as children and victims require heightened attention to sensitive consent procedures and privacy protections. Based on their work collecting longitudinal data from trafficked youth, Rothman and colleagues (2018) note several key risks when involving this population in research, including: 1) risks obtaining informed consent from parents and guardians; 2) the possibility of over-interrogating youth who typically intersect with multiple agencies; and 3) causing increased stress to the service providers whose primary responsibility is to be available to the youth.

Evaluability Assessment of the Love146 Survivor Care Program

In order to build a more rigorous evaluation base for comprehensive CSEC victim services, the current study describes an evaluability assessment conducted with the Love 146 Survivor Care program. A report put out by the Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP) (Kaufman-Levy et al., 2003) describes evaluability assessments as important to verifying that: 1) programs are running as intended; 2) the agency has the capacity to participate in the rigors of evaluation;

3) programs have a good chance of showing positive outcomes; and 4) there is a consensus among stakeholders on the purpose, structure, and use of evaluation. Furthermore, evaluability assessments also provide an opportunity to pilot measurement instruments, and test recruitment, consent and data collections procedures (Trevisan, 2007). Although the Love146 programs are well-established and have been providing services to victims for over five years, the team determined that an evaluability assessment would confirm that program materials and agreements were in place for successful participation in follow-up rigorous evaluation (Peersman et al., 2015; Smith, 2013; Trevisan, 2007; Wholey, 1987, 2004).

The research team sought to achieve two key objectives for this evaluability assessment. The first objective was to conduct a process evaluation in order to document the victim services model provided by the Rapid Response and Long-Term Services programs, assessing the extent and nature of services received by victims, and defining anticipated program outcomes. The second objective was to develop and pilot procedures and tools for ethically and sensitively including CSEC victims in services evaluation research. Below we outline results from both of these study components.

Summary of the Love146 Survivor Care Evaluability Assessment

Objective 1: Process Evaluation

The goal of process evaluation activities were to document the critical features of the Love146 Survivor Care program and understand the population of youth receiving these services (Moore et al., 2014; Moore et al., 2015). We worked to achieve these goals through 3 research efforts: a) focus groups with Love146 staff; b) an analysis of 5 years of Love146 client data, and c) the development of a logic model, a research-focused implementation guide, and fidelity tools that could be used in outcome evaluation research. Below we outline the processes and findings from these efforts.

Focus groups with Love146 staff

Focus groups were conducted with Love146 staff to better understand the strategies and techniques that Love146 social workers, administrators, and staff use to facilitate engagement and healing

with the children and youth they serve. Using semi-structured interviews, we sought to understand participants' perspectives on the skills needed to work with this population of youth, as well as the qualities possessed by those engaging with youth that most complement the aims and goals of Love146, including ending CSEC victimization, reducing overall risk of exploitation, and promoting victim health and wellbeing (O'Brien et al., 2023).

Qualitative data were collected from twelve service providers and two administrators at Love146. At the time these data were collected, Love146 employed fifteen service providers and two administrators. Therefore, data collection included 80% of all available supervisors, and 100% of administrators. Service providers were master's level social workers licensed in the state of Connecticut, per Love 146 protocols. Administrators included individuals working at Love146 who helped manage programmatic components of the Survivor Care program. Demographic information collected from the fourteen participants indicated that most were female (13), with one male, and with a range of ages: six were age 18–29, four were age 30–39, and four were age 40–49. Eight participants described themselves as White, five as African-American, one as Latino or Hispanic, and one as having multiple racial and ethnic backgrounds. Almost all had master's degrees, primarily in social work, with one participant currently working toward a master's degree in social work. Most of the participants had been working in the field of human trafficking for 1–5 years (11 participants), with two working in the field for more than 10 years and one less than 1 year. Collectively they had fairly long-standing experience working with the Love146 organization: four participants had worked with Love146 for less than a year; ten had been with Love146 for 1–5 years; and two had worked with Love146 for 6–10 years.

Qualitative data were collected through four focus groups led by two researchers. Each focus group included between 2–4 participants. Masters-level social workers in non-administrative or supervisory roles had two dedicated focus groups, each consisting of 4 participants. Focus groups were held via zoom in order to promote participation. The questions explored the following topics: (a) the nuanced aspects of the Love146 service delivery; and (b) the tangible and intangible qualities of staff that most complement the work (O'Brien et al., 2023). Focus group questions and coding categories have been

attached (see Appendix A). Three overarching themes regarding the needs and engagement of CSEC-impacted youth emerged from the focus groups with Love146 administrators and service providers. Specifically, themes included (a) the importance of using a trauma-informed approach; (b) trustworthiness; and (c) persistence. A description of each theme and example quotes have been included below:

Theme 1: A trauma-informed approach. The theme "a trauma informed approach" was characterized by participants' recognition of and response to the high levels of trauma experienced by youth impacted by CSEC. In the words of a direct care staff person:

> *"You definitely have to be very knowledgeable in trauma and how it effects a person because, like, all of the youth that I've worked with have had some sort of significant trauma- or multiple significant traumas- throughout their life."*

Participants (n = 8) noted that being cognizant of the trauma experienced by youth has to go beyond an acknowledgment of past traumas, and instead include the potential for ongoing traumas. Participants (n = 5) reported that sometimes youth had ongoing traumatic or abusive relationships that the youth were unable or unwilling to end, and so harm reduction in those relationships becomes part of the work service providers serving these youth must engage in. One direct care worker stated:

> *"Sometimes we have concerns about a family member being the trafficker, or that this youth is living with an intimate partner who we are concerned about being potentially a trafficker- an unhealthy person- and we are mindful then of where to meet this youth, um, one- just because that person could be listening, there could be some control issues there, and we want these youth to feel comfortable talking about opening up and disclosing anything to us . . . just experiencing life without that person around."*

Theme 2: Trustworthiness. This theme referred to emphasis by participants on the importance of building and demonstrating trustworthiness in professional interactions with youth impacted by CSEC. Participants (n = 12) noted that because of the trauma these youths have experienced, trust-building can take time, but participants emphasized that building initial rapport and trust was integral to engagement.

Direct care staff (n = 12) noted that building relationships with the youth often takes especially delicate, intentional rapport building, particularly because youth are often referred to the program following a mandated report to the state's child welfare system or because they are already system involved. One direct care respondent explained:

> *"You have to, like, notice a youth's body language, you really have to be in tune with some of that, and whether they're, um, being triggered by just the fact that they know why you're there."*

Theme 3: Persistence. Many participants (n = 5) noted that working with youth impacted by CSEC requires persistence, as many of the youth may be reluctant to engage with services, treatment, and/or do not acknowledge their victimization. This theme encompasses participant quotes that captured the importance of continuing to provide services, offer support, and maintain positive regard in the face of resistance and, occasionally, even animosity. A direct care staff noted:

"I think it's, like, a delicate balance of flexibility and consistency. Like, these kids really need, like, consistent, reliable people that are going to be patient and be able to roll with whatever comes up in the case. But also, they need to know that when you show up, you're going to be consistent in how you present yourself and how you speak and the rules and boundaries that you put into place."

Overall, results highlighted that CSEC-impacted youth are diverse in their needs and therefore necessitate flexible treatment that moves at the pace they determine, rather than a prescribed pace based on a specific number of sessions or length of stay. Given that all CSEC-impacted youth have likely had their agency taken from them at one time or another, it was imperative to participants that youth be given the power to choose their level of engagement in their treatment. Such a choice underscores personal agency while also allowing CSEC impacted youth to self-monitor their comfort and make behavioral choices independently without fear of retaliation or harm from a service provider. Notably, all of Love146′s services are 100% voluntary. Participants described that that this means youth may be more or less engaged over time, resulting in missed meetings, poor communication, or prolonged absence. These interactions necessitate staff patience and persistence. This does not mean that staff at Love146 always

agree with or validate the decisions made by youth in the program, but rather that the staff work to support youth in a non-judgmental way so that youth understand the decisions they are making and are able to make the most informed decisions possible. Despite occasional setbacks, results from the current study indicate that when ready to engage, youth are able to learn both how to ask for and receive service, as well as how to independently navigate the complex help-seeking relationship inherent to service provision.

Data Analysis of Client File Data

In order to understand more about the youth involved with the Love146 Survivor Care program, de-identified client data were shared with the research team by Love146 for 455 youth who were seen by Love146 for Rapid Response (RR) services between July 2016 and May 2021. One-hundred and eighty-five of the 455 referred youth (40%) were enrolled in the Long-Term Services (LTS) program. The data were provided from the client record database maintained by Love146; multiple reports were run connected for the purposes of these analyses by a unique research identification code created by Love146 for each youth. Analyses examined the following questions: 1) What are the characteristics and adversity histories seen in a large sample of youth who have experienced CSEC victimization that have been referred for services?; 2) What population of youth are triaged into longer-term intensive services by a CSEC victim service agency?; and 3) Looking at the sub-group of youth who were enrolled in LTS, what can we learn from case records about the characteristics of youth who are able to maintain longer-term connections with such a program, and with more successful outcomes? (Jones et al., 2024).

Sample. The youth referred to Love146 during the almost 5-year analysis period (N=455) were primarily older adolescents (15-17 years old) (67%); the remaining youth in the sample were between 11 and 14 years old (33%) (see Table 1). Most of the youth in the sample were female (9%), with 6.4% male and 2.2% another gender. Twenty-three percent of the sample were Black/African-American, 37.1% were Hispanic/Latino; 25.4% were White and 14.6% had other race or ethnicity backgrounds.

Case file data variables. Case-file data included information on youth demographics, adversity history (e.g., child abuse and mental health concerns as reported on an intake form by the referring agency), education status, legal guardian status, care plan goals (for youth enrolled in the LTS program), type and dates of service contacts the agency had with the youth, and service outcomes. The information had been entered into the case file by Love146 social workers based on information provided to them by the youth, information provided by the original referral source or were entered based on the social worker's work with the youth. The data has been archived with the National Archive of Criminal Justice Data (NACJD).

Data Analysis. First, demographic, youth background (e.g., confirmed trafficking history), and system (e.g., child welfare) involvement characteristics are provided for youth overall; differences in these characteristics between youth receiving RR services only and those with LTS enrollment were analyzed using chi-square and t-test statistics. Next, these groups were compared in terms of their adversity and risk history at the time of referral to Love146. Then, for the subgroup of youth enrolled in LTS (n=172), descriptive statistics were calculated on outcomes and chi-square and t-test analyses were used to compare characteristics of youth with successful and unsuccessful LTS completion. All analyses were conducted using SPSS 28.0 (IBM Corp, 2021).

Results. Case record data identified that youth were more likely to be enrolled in intensive LTS services if they were younger (39.7% of youth enrolled in LTS were ages 11-14 versus 29.2% of youth who received only Rapid Response, p =.020) (See Table 1). No differences in enrollment were found based on gender, race and ethnicity, or living situation (e.g., adoptive/biological parents vs. system/kinship care). Most referred youth (87%) had child welfare involvement, 36.9% had law enforcement involvement, and 29% had juvenile justice involvement. Almost one in four youth overall (22.2%) had a confirmed trafficking history (versus suspected) with more youth enrolled in LTS (31.0%) having this confirmed history compared to those receiving RR only (16.2%) ($p<.001$).

Table 1. Characteristics of youth victims of commercial sexual exploitation (CSE) referred for brief (Rapid Response) versus intensive (Long-Term) services

Youth characteristics at time of referral	All referred youth (N=455) % (n)	Rapid Response services only (n=271) % (n)	Long-Term Services enrollment (n=185) % (n)	X^2/t	p
Age					
11-14 years	33.4 (152)	29.2 (79)	39.7 (73)	5.45	**.020**
15-17 years	66.6 (303)	70.8 (192)	60.3 (111)		
Gender					
Male	6.4 (29)	6.6 (18)	6.0 (11)	0.83	.960
Female	91.4 (416)	91.1 (247)	91.8 (169)		
Other	2.2 (10)	2.2 (6)	2.2 (4)		
Race and ethnicity					
Black/African American	23.0 (104)	21.1 (57)	25.7 (47)	2.71	.438
Hispanic/Latino	37.1 (168)	38.9 (105)	34.4 (63)		
White	25.4 (115)	26.7 (72)	23.5 (43)		
Other race or ethnicity	14.6 (66)	13.3 (36)	16.4 (30)		
Living situation					
Adoptive or bio parents	56.5 (257)	58.3 (158)	53.8 (99)	0.90	.342
Other (e.g., child welfare, kin)	43.5 (198)	41.7 (113)	46.2 (85)		
School attendance					
Regularly attending	51.8 (219)	52.4 (129)	50.8 (90)	0.10	.747
Irregularly or not attending	48.2 (204)	47.6 (117)	49.2 (87)		
Child welfare involvement	87.0 (394)	84.8 (228)	90.2 (166)	2.87	.90
Juvenile justice involvement	29.0 (129)	26.5 (70)	32.6 (59)	1.27	.260
Police involvement	36.9 (164)	36.3 (95)	37.9 (69)	0.13	.723
Confirmed trafficking history (vs. highly suspected)	22.2 (101)	16.2 (44)	31.0 (57)	13.79	**<.001**

Note: Bolded values identify p-values ≤.05; SD=Standard deviation

We also examined differences across youth in terms of adversity histories (See Table 2). Most youth referred to Love146 had a documented history of child maltreatment (86.7%) noted by referral sources, most commonly sexual abuse (63.7%). The majority of referred youth also had histories of mental health concerns (79.6%), such as mental illness (69.1%), suicidal ideation (46.4%), and self-injury (44%). Histories of other risks were also documented for large percentages of youth, including running away (78.6%) and substance use (59.5%). Less frequently, youth histories included dating violence (12.7%), gang involvement (9.0 %), and pregnancy or parenting (7.0%). Over half of youth (61.3%) had

some form of family adversity noted in their files, including familial substance use (37.2%), having a family member who was mentally ill or suicidal (26.9%), domestic violence (26.5%), and having an incarcerated family member (17.1%). Overall, the average number of adversities for youth across the 17 adversities recorded in files was 6.28 (SD = 2.62).

Youth enrolled in LTS were more likely to have histories of sexual abuse than youth who received only RR services (p =.021), with no differences between groups for other types of child maltreatment or child maltreatment overall. LTS enrolled youth were also more like to have mental health concerns noted in their files (p =.008) including, in particular, suicidal ideation (p =.018) and self-injurious behavior (p<.001). LTS enrolled youth were also more likely to have a history of risk factors generally (p =.004), and specifically had higher rates of running away behavior (p =.001) and dating violence (p =.018). There were no differences between the two groups in terms of family adversity history. Overall, the total mean adversity counts reported by youth enrolled in LTS (6.96, SD=2.5) were significantly higher than youth who were not enrolled (5.86, SD=2.6) (p<.001).

Table 2. Adversity and risk histories for youth referred for brief (Rapid Response) versus intensive (Long-Term) services

Youth adversity and risk history at time of referral	All referred youth (N=455) % (n)	Rapid Response services only (n=271) % (n)	Long-Term Services enrollment (n=185) % (n)	X^2/t	p
Maltreatment					
Sexual abuse	63.7 (290)	59.0 (160)	70.7 (130)	6.39	**.011**
Sexual abuse images	25.3 (115)	24.4 (66)	26.6 (49)	3.01	.583
Physical abuse	27.5 (125)	25.5 (69)	30.4 (56)	1.36	.243
Physical neglect	42.4 (193)	42.1 (114)	42.9 (79)	0.03	.854
Emotional neglect	35.4 (161)	35.1 (95)	35.9 (66)	0.03	.759
Any of the above	86.8 (395)	85.6 (232)	88.6 (163)	0.85	.357
Mental health concerns					
Mental illness	69.2 (315)	67.5 (183)	71.7 (132)	0.91	.339
Suicidal ideation	46.6 (212)	42.8 (116)	52.2 (96)	3.87	**.049**
Self-injurious behavior	44.2 (201)	36.5 (99)	55.4 (102)	15.88	**<.001**
Any of the above	79.8 (363)	76.0 (206)	85.3 (157)	5.89	**.015**
Risk factors					
Running away	78.5 (357)	73.8 (200)	85.3 (157)	8.61	**.003**
Substance use	59.6 (271)	57.2 (155)	63.0 (116)	.551	.212
Gang involvement	9.0 (41)	7.4 (20)	11.4 (21)	2.17	.140
Dating violence	12.7 (58)	10.0 (27)	16.8 (31)	4.67	**.031**

Youth adversity and risk history at time of referral	All referred youth (N=455) % (n)	Rapid Response services only (n=271) % (n)	Long-Term Services enrollment (n=185) % (n)	X^2/t	p
Pregnancy or parenting	7.0 (32)	5.5 (15)	9.2 (17)	2.30	.129
Any of the above	88.0 (402)	84.6 (241)	93.6 (161)	5.83	**.016**
Family adversity					
Mentally ill/suicidal family member	27.0 (123)	25.1 (68)	29.9 (55)	1.28	.258
Familial substance use	37.4 (170)	35.4 (96)	40.2 (74)	1.07	.300
Domestic violence	26.6 (121)	25.8 (70)	27.7 (51)	0.20	.655
Incarcerated family member	16.9 (77)	16.6 (45)	17.4 (32)	0.48	.826
Any of the above	61.3 (279)	57.9 (157)	66.3 (122)	3.24	.072
Adversity sum (mean, SD)	6.29 (2.61)	5.90 (2.59)	6.87 (2.55)	-3.96	**<.001**

Note: Bolded values identify p-values ≤.05; SD=Standard deviation

Study Implications. The case-file data documented that youth referred to Love 146's Survivor Care program have very high rates of system involvement, and adversity and traumatic stress histories. Over 85% of referred youth had child welfare involvement histories; and juvenile justice and law enforcement involvement were present for approximately a third and a quarter of all youth, respectively. The youth also had extensive histories of victimization, adversity, and risk, with over 85% documented histories of maltreatment. High rates of mental health concerns were also common among the youth referred to the Survivor Care program, with almost 70% of youth case files noted a mental health condition, and over 40% of the youth had histories of suicidal ideation and self-injurious behaviors.

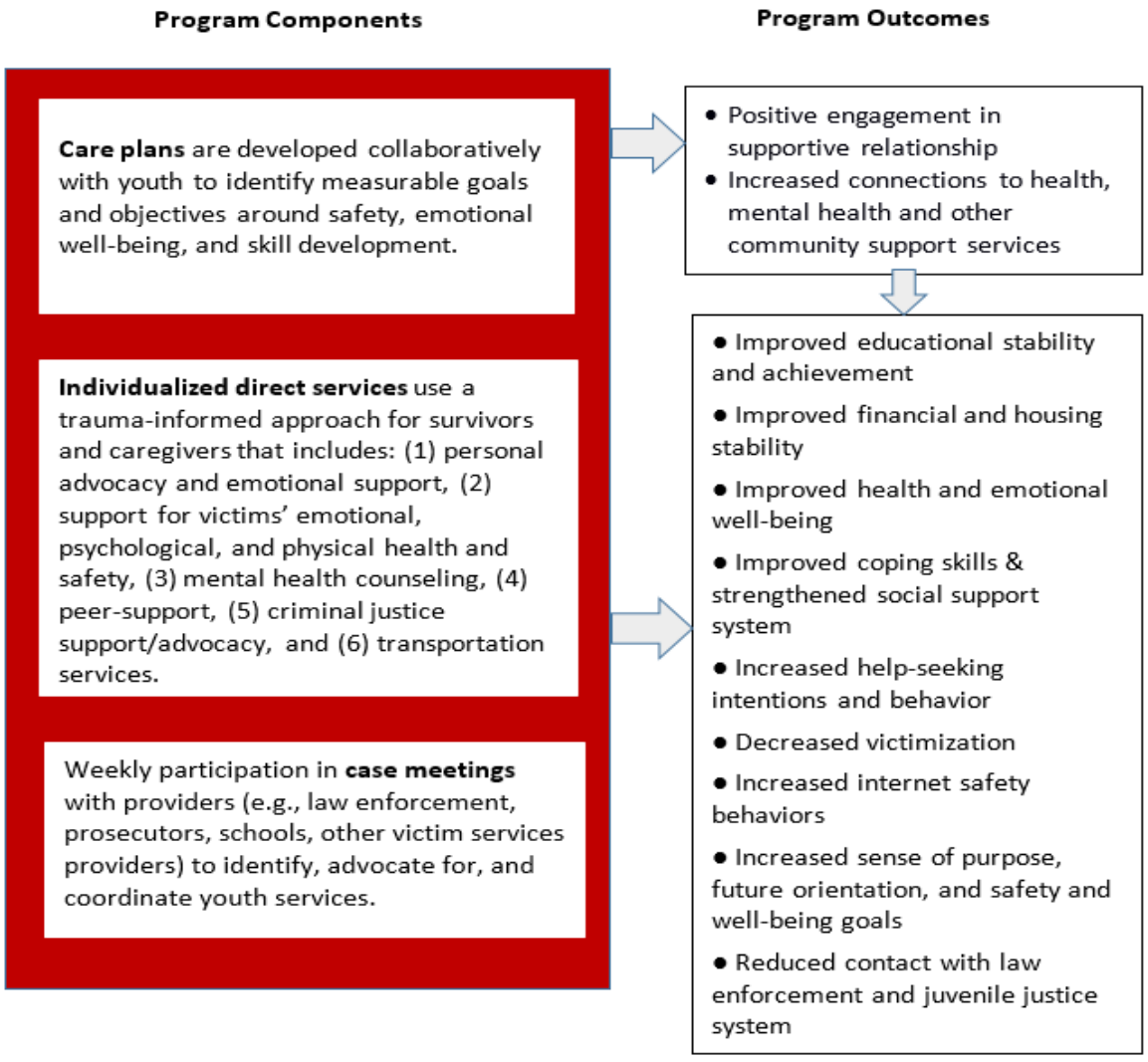
Long-term care for CST victims requires intensive services that can address a wide range of needs of victims. CST victims can often be reluctant to engage in treatment or have difficulties sustaining connections with clinicians. Intensive services require a high level of resources to meet similarly complex mental health and safety needs. When high-resource systems are faced with high-need populations, many agencies and communities establish methods for triaging youth and establishing waitlists. One risk to triaging resource-intensive services is that in order to ease the burden on clinical staff, or to increase successful outcomes, agencies may prioritize youth with lower risk-profiles and who evidence signs of more stability. However, the case-report data that we analyzed were able to demonstrate that this is not a

procedural concern for Love 146: When comparing youth who were enrolled in long-term services versus those who were not, the LTS youth had more child welfare involvement, confirmed trafficking histories, sexual abuse victimization, suicidal ideation, and self-injurious behavior, running away behavior, dating violence histories, and total adversity histories at intake.

Development of Logic Model, Implementation Guide and Fidelity Tools

As recommended by the evaluability assessment literature, (Peersman et al., 2015; Smith, 2013; Trevisan, 2007; Wholey, 1987, 2004), we worked with Love146 to develop a draft implementation guide, fidelity tools and a logic model linking the LTS services program with outcomes and a tool that could be

Figure 2. LTS Logic Model



used to measure LTS program delivery fidelity and dose. Through a review of Love146 program material and a series of focus groups held with Love146 staff, we completed our initial draft of the implementation guide and fidelity checklist (see Appendix B). Figure 2 provides the logic model developed in collaboration with the Love 146 staff that was used to develop pilot measures.

Objective 2: Development of Procedures and Tools to Involve CSEC Victims in Evaluation Research

A second goal of the evaluability assessment was to pilot measurement instruments, and test recruitment, consent and data collections procedures for use in follow-up rigorous evaluation research (Trevisan, 2007). Our aim, given the challenges of involving trafficking victims in evaluation research, was to develop recruitment, consent and data collection procedures that were sensitive to the vulnerable status of the youth, accounted for challenges of tracking victims over time, and prioritized youth privacy and safety protections. We worked closely with national advisors, including researchers, practitioners, and survivor-advocates, as well as our local Research Advisory Board members, to develop a feasible and sensitive research plan. Once the plan was developed, we worked with a number of human subjects' oversight boards, including the UNH Institutional Review Board, and the Connecticut Department of Children and Families' Committee of the Protection of Human Subjects (CPHS), to ensure that the recruitment, consent, and data collection procedures met with their approval for ethical involvement of youth in research. We describe the planned procedures below.

Subject recruitment and consent procedures. It was important to the team that providing information about the study to potential youth participants occurred in a way that did not interfere with the rapport building that is central to the Rapid Response service provided by Love146. For the evaluability assessment, and in consultation with Love146 staff and the Research Advisory Board members, a plan was developed with sensitivity to this process that followed the following procedures: 1) clinical staff providing Rapid Response services briefly mentioned the study to caregivers and youth during the Rapid Response service, getting consent for someone to follow-up with more information; 2) a research team member located in New Haven, CT followed-up with the caregiver and the referred youth

approximately one week after the Rapid Response meeting, describing the study in more detail; and 3) after carefully reviewing consent forms, including risks of participation and privacy and confidentiality protections, if signed consent for participation was provided by the legal guardian and the youth provided assent, the youth was enrolled in the study.

Survey administration procedures. Given that locating and sustaining contact with youth trafficking victims can be difficult, survey administration requires innovative strategies. Text and private message communication is increasingly identified as a successful strategy for tracking and communicating with hard-to-reach populations (Bolanos et al., 2012; Heckathorn, 1997; Hokke et al., 2018; Leonard et al., 2014; Wright et al., 2015; Ybarra et al., in press). Additionally, compared to survey methodologies that use an in-person interviewer, private survey response options (e.g., via computer or mobile devices) promote confidentiality and are associated with greater honest self-disclosure of sensitive information among young people (Brener et al., 2003). Consultation with Love146 staff and the Research Advisory Board members suggested that sending electronic survey links by text messaging was the method likely to obtain the highest response rate from youth referred to Love146, and that this outreach could be done in a way that protects youth from others learning about the participation. For example, messaging can come from a neutral sounding source and include a link to a private short survey that cannot be re-entered once closed.

As part of the evaluability assessment, we created consent and enrollment forms that obtained consent for short survey links to be sent by the research team to the youth via text, email or through social media direct messages, according to the youth's preference. We created study accounts with non-descriptive name and developed plans to send links to online surveys via private message to youth enrolled in the study. Once developed, surveys were constructed on Qualtrics, a web-based survey service that protects data using industry best standards. The research team developed a series of short surveys (15-minutes), that could be responded to via cell phone or on a computer, with plans to send pilot surveys once a month over a period of six months. To incentivize survey response, online gift cards ($15 Amazon gift cards) were provided to youth as an incentive for completing each survey.

Youth Self-Report Survey Development

Through a measurement model guided by the program logic model, self-report surveys were designed to collect data on a number of health, mental health, educational, and relational markers that the Love 146 services aim to improve for CSEC victims. Draft survey measures were aimed at providing information on whether youth involvement in the Love146 LTS program improves: 1) system involvement (e.g., reduced arrest or involvement in juvenile justice systems); 2) educational stability and achievement; 3) financial and housing stability; 4) health outcomes; 5) emotional health; 6) coping skills; 7) social support; 8) victimization rates (e.g., partner abuse, sexual victimization); 9) help-seeking intention and behavior; 10) sense of purpose/future orientation; 11) internet safety; 12) and general safety and well-being.

Pilot Testing

The procedures described above were piloted with a short two-month enrollment period (6/1/2022-8/5/2022) and a six-month follow-up period for enrolled youth. During the two-month enrollment period 16 youth were referred to Rapid Response services and 7 were successfully enrolled int the study (43%). Youth who were not enrolled were either excluded for various reasons by Love146 staff (n=2), or caregivers either declined consent (n=4) or were not reachable (n=2). In one case the caregiver provided consent, but the youth was not reachable. Out of the seven youth enrolled in the study, five completed all seven surveys over the following six months (71%). Two of the enrolled youth completed the baseline study but did not respond to follow-up surveys. Although the limited amount of data provided by participants in the five full participants in the pilot do not provide generalizable research data, they do provide support for the pilot procedures that were developed as part of the evaluability assessment.

Future Research Directions

The evaluability assessment activities described above have important implications for conducting program evaluation research on services for victims of commercial sexual exploitation of

children (CSEC). The study established an important foundation for rigorous outcome evaluation of the Love 146 Survivor Care Program. Our research team successfully documented the Survivor Care program through secondary data analysis of existing case file data; focus groups with agency staff; and the completion of logic models, fidelity measures, and implementation manual. We developed measurement tools and procedures for enrolling and collecting data from youth victims of commercial sexual exploitation, and successfully piloted the tools and procedures. Using this work as a foundation, the team applied for and was awarded funds through NIJ for a 5-year grant (2023-2027) to rigorously evaluate the Survivor Care program. This next-step outcome evaluation will examine program impact on a range of social, emotional, health and education outcomes for youth trafficking victims, using a non-equivalent cohort methodology with repeated pre-post measures.

Using procedures piloted in the evaluability assessment, we will collect self-report data from youth via short surveys sent every two months over a 2-year data collection period to capture longitudinal changes in outcomes such as: 1) coping skills and help-seeking behaviors; 2) service access; 3) emotional distress symptoms (e.g., depression/anxiety); 4) social support; 5) housing and employment; 6) substance use; 7) physical health; 8) school connectedness; and 9) safety (e.g., trafficking victimization and partner abuse). Outcomes for trafficking victims receiving Survivor Care LTS services (treatment condition, n=150) will be compared with trafficking victims who are not enrolled in the LTS program (wait-list or usual care control group, n=200). In addition to the self-report data, case-file data will be drawn from Love146 and the Connecticut Department of Children and Families (DCF) agency files. The objectives aim to use these additional data sources to test program impact on youth educational attainment rates (e.g., school attendance, engagement, grades, graduation rates); health outcomes (e.g., reduced in-patient hospitalizations, delayed and reduced pregnancy, reduced drug problems and overdose rates); environmental stability (e.g., housing, running away, employment); and system-involvement (e.g., reduced arrest or involvement in juvenile justice systems).

References

Bolanos, F., Herbeck, D., Christou, D., Lovinger, K., Pham, A., Raihan, A., Rodriguez, L., Sheaff, P., & Brecht, M.-L. (2012). Using Facebook to maximize follow-up response rates in a longitudinal study of adults who use methamphetamine. *Substance Abuse: Research and Treatment*, *6*, SART. S8485.

Brener, N. D., Billy, J. O. G., & Grady, W. R. (2003). Assessment of factors affecting the validity of self-reported health-risk behavior among adolescents: Evidence from the scientific literature. *Journal of Adolescent Health*, *33*(6), 436-457.

Clawson, H. J., Dutch, N. M., Salomon, A., & Grace, L. G. (2009). *Study of HHS Programs Serving Human Trafficking Victims: Final Report*. US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Retrieved from: https://aspe.hhs.gov/sites/default/files/private/pdf/75966/index.pdf.

Clawson, H. J., & Grace, L. G. (2007). *Finding a path to recovery: Residential facilities for minor victims of domestic sex trafficking*. U.S Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Retrieved from: https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//42536/ib.pdf.

Cohen, M. I., Edberg, M. C., & Gies, S. V. (2011). F*inal report on the evaluation of the SAGE Project's LIFESKILLS and GRACE programs.* Washington, DC: US Department of Justice, Office of Justice Programs, National Institute of Justice. Retrieved from: https://www.ojp.gov/pdffiles1/nij/grants/234464.pdf.

Cole, J., Sprang, G., Lee, R., & Cohen, J. (2016). The trauma of commercial sexual exploitation of youth: a comparison of CSE victims to sexual abuse victims in a clinical sample. *Journal of Interpersonal Violence*, *31*(1), 122-146.

Countryman-Roswurm, K., & Bolin, B. (2014). Domestic Minor Sex Trafficking: Assessing and Reducing Risk. *Child & Adolescent Social Work Journal*, *31*(6), 521-538.

Davy, D. (2016). Anti–human trafficking interventions: how do we know if they are working? *American Journal of Evaluation*, *37*(4), 486-504.

Dell, N. A., Maynard, B. R., Born, K. R., Wagner, E., Atkins, B., & House, W. (2019). Helping survivors of human trafficking: A systematic review of exit and postexit interventions. *Trauma, Violence, & Abuse*, *20*(2), 183-196.

Farrell, A., Rothman, E., Bright, K., & Paruk, J. (2018). *Outcomes of an evaluation of CSEC survivor mentorship services on Boston-area girls who have experienced sexual exploitation.* Paper presented at the 74th Annual Meeting of the American Society of Criminology, Atlanta Georgia.

Felner, J. K., & DuBois, D. L. (2017). Addressing the commercial sexual exploitation of children and youth: A systematic review of program and policy evaluations. *Journal of Child & Adolescent Trauma*, *10*(2), 187-201.

Finkelhor, D., Vaquerano, J., & Stranski, M. (2017). *Sex trafficking of minors: How many juveniles are being prostituted in the US?* Crimes Against Children Research Center, University of New Hampshire. Retrieved from: https://www.unh.edu/ccrc/sites/default/files/media/2022-03/sex-trafficking-of-minors-how-many-juveniles-are-being-prostituted-in-the-us.pdf.

Fong, R., & Cardoso, J. B. (2010). Child human trafficking victims: Challenges for the child welfare system. *Evaluation And Program Planning*, *33*(3), 311-316.

Franchino-Olsen, H. (2021). Vulnerabilities relevant for commercial sexual exploitation of children/domestic minor sex trafficking: A systematic review of risk factors. *Trauma, Violence, & Abuse*, *22*(1), 99-111.

Friedman, S. A. (2005). *Who is There to Help Us?: How the System Fails Sexually Exploited Girls in the United States: Examples from Four American Cities*. ECPAT-USA, Incorporated. Retrieved from: https://d1qkyo3pi1c9bx.cloudfront.net/00028B1B-B0DB-4FCD-A991-219527535DAB/b5db40fd-d002-4be7-8645-55d60d33afb4.pdf.

Gibbs, D. A., Henninger, A. M., Tueller, S. J., & Kluckman, M. N. (2018). Human trafficking and the child welfare population in Florida. *Children and Youth Services Review*, *88*, 1-10.

Gragg, F., Petta, I., Bernstein, H., Eisen, K., & Quinn, L. (2007). *New York prevalence study of commercially sexually exploited children: Final report*. New York State Office of Children and Family Services. Retrieved from: https://ocfs.ny.gov/main/reports/csec-2007.pdf.

Head, S. K., Eaton, D., Lloyd, P. C., McLaughlin, A., & Davies-Cole, J. (2021). Exchange Sex Among High School Students—Washington, DC, 2017. *Journal of Adolescent Health*, *68*(2), 350-356.

Heckathorn, D. D. (1997). Respondent-driven sampling: a new approach to the study of hidden populations. *Social Problems*, *44*(2), 174-199.

Hokke, S., Hackworth, N. J., Quin, N., Bennetts, S. K., Win, H. Y., Nicholson, J. M., Zion, L., Lucke, J., Keyzer, P., & Crawford, S. B. (2018). Ethical issues in using the internet to engage participants in family and child research: A scoping review. *PLoS one*, *13*(9), e0204572.

Jones, L. M., O'Brien, J., & Mitchell, K. J. (2024). *Characteristics of youth referred to intensive services for commercial sexual exploitation and trafficking.* Manuscript submitted for publication. University of New Hampshire.

Kaufman-Levy, D., Poulin, M., Orchowsky, S., Michel, N., & Peterson, E. (2003). *Evaluability assessment: Examinig the readiness of a program for evaluation*. Juvenile Justice Evaluation Center, Justice Research and Statistics Association. Retrieved from: https://www.ojp.gov/ncjrs/virtual-library/abstracts/evaluability-assessment-examining-readiness-program-evaluation.

Leonard, A., Hutchesson, M., Patterson, A., Chalmers, K., & Collins, C. (2014). Recruitment and retention of young women into nutrition research studies: practical considerations. *Trials*, *15*(1), 23.

Lutnick, A. (2016). *Domestic minor sex trafficking: Beyond victims and villains*. Columbia University Press.

Martin, L., Rider, G. N., Johnston-Goodstar, K., Menanteau, B., Palmer, C., & McMorris, B. J. (2021). Prevalence of trading sex among high school students in Minnesota: Demographics, relevant adverse experiences, and health-related statuses. *Journal of Adolescent Health*, *68*(5), 1011-1013.

McIntyre, S. (2009). *Under the radar: The sexual exploitation of young men*. Alberta Children and Youth Services.

Moore, G., Audrey, S., Barker, M., Bond, L., Bonell, C., Cooper, C., Hardeman, W., Moore, L., O'Cathain, A., & Tinati, T. (2014). Process evaluation in complex public health intervention studies: The need for guidance. *Journal of Epidemiological Community Health, 68*(2), 101-2.

Moore, G. F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., Moore, L., O'Cathain, A., Tinati, T., & Wight, D. (2015). Process evaluation of complex interventions: Medical Research Council guidance. *BMJ*, *350*:h1258.

Muraya, D. N., & Fry, D. (2016). Aftercare services for child victims of sex trafficking: A systematic review of policy and practice. *Trauma, Violence, & Abuse*, *17*(2), 204-220.

National Research Council. (2013). *Confronting commercial sexual exploitation and sex trafficking of minors in the United States*. National Academies Press. Retrieved from: https://ojjdp.ojp.gov/sites/g/files/xyckuh176/files/pubs/243838.pdf.

Newcomb, M. D. (1995). Identifying high-risk youth: Prevalence and patterns of adolescent drug abuse. *NIDA Research Monograph*, *156*, 7-38.

O'Brien, J., Finkelhor, D., & Jones, L. (2022). Improving services for youth survivors of commercial sexual exploitation: Insights from interventions with other high-risk youth. *Children and Youth Services Review*, *132*.

O'Brien, J. E., Jones, L. M., & Mitchell, K. J. (2023). "Flexibility and Consistency": Qualitative insights on valuable skills for providers working with survivors of child sex trafficking. *Journal of Evidence-Based Social Work*, 1-16.

Peersman, G., Guijt, I., & Pasanen, T. (2015). *Evaluability assessment for impact evaluation: Guidance, checklists and decision support.* Methods Lab. Retrieved from: https://media.odi.org/documents/9802.pdf.

Pierce, A. (2012). American Indian adolescent girls: Vulnerability to sex trafficking, intervention strategies. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center*, *19*(1), 37-56.

Rothman, E. F., Farrell, A., Bright, K., & Paruk, J. (2018). Ethical and practical considerations for collecting research-related data from commercially sexually exploited Children. *Behavioral Medicine*, *44*(3), 250-258.

Rothman, E. F., Preis, S. R., Bright, K., Paruk, J., Bair-Merritt, M., & Farrell, A. (2020). A longitudinal evaluation of a survivor-mentor program for child survivors of sex trafficking in the United States. *Child Abuse & Neglect*, *100*, 104083.

Saewyc, E. M., & Edinburgh, L. D. (2010). Restoring healthy developmental trajectories for sexually exploited young runaway girls: Fostering protective factors and reducing risk behaviors. *Journal of Adolescent Health*, *46*(2), 180-188.

Salami, T., Gordon, M., Coverdale, J., & Nguyen, P. T. (2018). What therapies are favored in the treatment of the psychological sequelae of trauma in human trafficking victims? *Journal of Psychiatric Practice*, *24*(2), 87-96.

Sanchez, R. P., Waller, M. W., & Greene, J. M. (2006). Who runs? A demographic profile of runaway youth in the United States. *Journal of Adolescent Health*, *39*(5), 778-781.

Smith, L., Vardaman, S. H., & Snow, M. (2009). *The national report on domestic minor sex trafficking: America's prostituted children.* Shared Hope. Retrieved from: https://sharedhope.org/wp-content/uploads/2012/09/SHI_National_Report_on_DMST_2009.pdf.

Smith, M. F. (2013). *Evaluability assessment: A practical approach* (vol. 26). Springer Science & Business Media.

Trafficking Victims Protection Act, 22 U.S.C. 7101 (2000). https://www.govinfo.gov/content/pkg/BILLS-106hr3244enr/pdf/BILLS-106hr3244enr.pdf.

Trevisan, M. S. (2007). Evaluability assessment from 1986 to 2006. *American Journal of Evaluation*, *28*(3), 290-303.

Tyler, K. A., Hoyt, D. R., & Whitbeck, L. B. (2000). The effects of early sexual abuse on later sexual victimization among female homeless and runaway adolescents. *Journal of Interpersonal Violence*, *15*(3), 235-250.

Wang, M. T., & Fredricks, J. A. (2014). The reciprocal links between school engagement, youth problem behaviors, and school dropout during adolescence. *Child Development*, *85*(2), 722-737.

Wholey, J. S. (1987). Evaluability assessment: Developing program theory. *Bridging Foresight and Evaluation, 33*, 77-92.

Wholey, J. S. (2004). Evaluability assessment. In J. S. Wholey, H. P. Hatry, & K. E. Newcomer (Eds.), *Handbook of practical program evaluation* (2nd ed., pp. 33-62). John Wiley & Sons, Inc.

Williamson, E., O'Brien, J., Jones, L., Mitchell, K., & Dunford, L. (2019). Featured counter-trafficking program: Love146. *Child abuse & neglect*, 104131.

Wright, R., Burgos, G., Krygsman, A., & Brown, J. (2015). Methodological constructs of tracking and retaining highly mobile participants. *Intervention*, *142*, 93-102.

Ybarra, M. L., Prescott, T. L., & Holtrop, J. S. (2014). Steps in tailoring a text messaging–based smoking cessation program for young adults. *Journal of health communication*, *19*(12), 1393-1407.

APPENDIX A

Survivor Care Evaluability Assessment
Focus Groups s with Love 146 Administrators and Staff

Focus Group Questions

Interviews and focus groups were conducted with different levels of staff at Love146 including administrators and direct care providers for both the Rapid Response (RR) and Long-Term Services (LTS) program. Although the questions below guided conversations with all participants, some questions were primarily directed at administrators (e.g., program sustainability) and direct care providers were only asked questions relevant to the services they provide.

Rapid Response Program (RR)

- Can you tell us about more about the RR program and the intended population of youth to be served?
- Can you tell us a bit about which staff at L146 provide RR services- What backgrounds, trainings, personal characteristics are important to do this job well?
- Please tell us about typical RR services- how do folks get referred, connect with staff, and get to know the L146 RR program?
- Can you tell us a little bit about situations that do not follow typical RR procedures? What kinds of problems to staff sometimes deal with in delivering RR program? Are there safety issues that can come up either for the staff or the youth and how are these handled?
- What do you believe are the hoped for goals of youth who receive RR services?

Long-Term Services (LTS)

- Broadly, what are Long-Term Services? Who is the program intended for?
- How does the referral process work? Are there success and/or challenges that are worth noting?
- Can you tell us a bit about the backgrounds and characteristics of the folks at L146 who provide LTS services?
- Please tell me about typical LTS services. What's the process of connecting with youth, creating a care plan, and tailoring services?
- What do you feel are the goals of the LTS program?

For administrators:

- When you think of the Survivor Care Program over time, what are some lessons-learned from an administrative perspective? What has gone well? What are some areas for new or continued growth? What are some key lessons learned?

SC Codebook Version: Final

Tag	Code	Definition	Examples
• Referral • Identification • Rapid Response • Client Characteristics	Clientele	This code captures mentions of clients, potential clients, and Rapid Response completion for potential acceptance to long-term service	"Clients aren't sure about us; they have been in contact with a lot of service providers. We have to be different, and we want them to want to engage."
• Skill Development • Safety Planning • Education/awareness • Care Plans • Referrals to Services • Therapeutic Support	Goal Development	This code captures the goals developed by staff in conjunction with the youth. While there be some goals L146 mentions or suggests, all goals are created in collaboration with the youth	"We always try to talk about what trafficking is in the rapid, but it might be they don't want to talk about it long-term- like in long-term care. So, we ask what they do want to talk about—maybe it's finishing school. We focus on that."
• Engagement • Parents • Outside systems • Buy in	Road Blocks/Barriers	This code captures the road blocks and/or barriers to service engagement- both initially and over time. These can be physical (e.g., distance), emotional (e.g., distrust), or structural (e.g., child welfare/JJ involvement).	"Sometimes we are working with someone, and they catch a case, or they have to go into the hospital. We stay with them. But it does mean we have to start again when them come back out. It's a setback- not always, but sometimes."
• Screening into LTS • Engagement • Waitlist • Length of Service	Long-term services	Any details about long-term service (LTS) delivery including initially being offered this service, being taken from a waitlist, or longevity of engagement with this service.	"What we see is that the youth develop a real relationship with their worker in LTS. We do that on purpose. After the rapid, we try to match with a staff person who will be a good fit, so that it's easier for the youth to connect and engage."

Tag	Code	Definition	Examples
• Initial referral • Engagement • Support Services • Activities associated with this service • Waitlist	Rapid response	Details about Rapid Response (RR) service provision including youth's initial referral, promoting engagement, service provided (e.g., education/awareness; care plan), and waitlist referral for either initial RR or LTS.	"You never know what you're going to walk into with a rapid. So, we come prepared. Youth are usually referred by their [child welfare] worker and so we get a few details, and we try to meet with them with their caregiver, and also alone. We want to know they can talk to us and feel comfortable."
• Inter-agency collaboration • Intra-agency collaboration	Collaboration	Collaboration with others across service provider (inclusive of RR and LTS). Any strategies for collaboration or key considerations would be included in this theme.	"I talk with all their providers. I talk with them about their providers. I'll drive them to appointments. Sometimes I go it—a lot of times we practice so they feel comfortable going alone. I want to work so they don't have to be retraumatized with every appointment. I also want them to practice navigating systems and see me showing them how to do that. It has a dual purpose: It shows I really care, and it teaches them to do it themselves."
• Age • Sex • Race/ethnicity • SGM Status • Other	Service Provider Characteristics	Physical characteristics of L146 staff or outside service providers that foster (or deter) trust, service provision, or engagement.	"They see me- they know I'm Latino. So, they might say 'You know how Mexican grandmas are.' And I do! (laughing) So, there's that automatic connection. It's beyond the language, it's the culture. It's a connection."

Tag	Code	Definition	Examples
• Human trafficking • Ethics • Evidence based practices • Trauma informed care	Service Provider Training	Trainings that service providers may have that help with this work. This includes trainings participants have taken they felt were helpful, or trainings they feel others should take and/or skills that would be useful for service providers to obtain. This code includes non-physical characteristics, such as interpersonal skills, that may be useful when providing services to CSEC-impacted youth.	"You need to be trauma informed and also see that trauma in yourself- like, know when it's time for you to take a break" "You have to be firm and clear. I think behavioral trainings- like DBT- they help with that. But some of how you do that can't be taught. It's just you. Like communicating, 'I like you, but these are the rules so you can't do the thing you want' or 'I'm not doing that for you. That's that. But I still like you.' That's hard but really necessary for these kids."
• Pandemic • Pre/Post COVID behaviors and/or support • Illness associated with COVID	COVID	Any mention of COVID will be coded as "COVID." This includes changes mentioned from pre-post COVID, agency or protocol shifts, and the impact of COVID on the population(s) served.	"During COVID, you know, everything was remote, so we weren't in the office much and it hasn't gone back. It might never go back! We do a lot texting with youth and setting things up outside the office." "Technology became so big during COVID! And it's good and bad. There's a lot of misinformation. They look things up before we come for a Rapid- they know who we are and why we are there which can be good or really challenging, depending on the person."

APPENDIX B

Implementation Guide: Love146 U.S. Survivor Care Program

MAY 2023

LISA JONES, PH.D., JENNIFER O'BRIEN, PH.D., KIMBERLY MITCHELL, PH.D.
Crimes Against Children Research Center

University of New Hampshire

This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

Contents

This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

HOW TO USE THIS GUIDE

This guide was created as part of an evaluability assessment of the Love 146 Survivor Care Program funded by the National Institute of Justice (NIJ) (2020-V3-GX-0076). Love 146 is a non-profit anti-trafficking agency that has developed a **Survivor Care program** to provide intensive services to youth who are confirmed survivors of- or at high-risk for- child sex trafficking.

The aim of this implementation guide is to: 1) identify key essential components of the Survivor Care program content and delivery; and 2) translate those elements into fidelity measures that that can be used in evaluation research and can guide program replicability.

Program fidelity measurement is critical to evaluation research in order to successfully understand variations in outcomes and to measure program dose for recipients. One of the complexities of understanding program impact for victim service programs is that many victims are not able to participate in every element of services being offered, nor necessarily complete the full set of recommended service components. This issue is of particular concern for youth trafficking victims, for whom running away behavior, drug use, or further involvement with traffickers can interrupt service delivery. Youth may participate in some program services, disconnect from services providers, and re-connect at a future date.

Love 146 services are designed to account for interrupted connections, but the variations in program participation pose difficulty in assessing program impact for researchers. The fidelity measurement tools developed and included with this guide provide options for measuring program implementation quality and dose. They also offer a framework for replicating the Survivor Care program in different communities.

CHILD SEX TRAFFICKING: A PROBLEM WORTH ADDRESSING

Child sex trafficking (CST) refers to the recruitment, harboring, transportation, provision, or obtaining of an individual under the age of 18 for the purpose of a commercial sex act. Force, fraud or coercion may be frequent elements of these crimes and are key components to the legal definition of sex trafficking in adults. However, children and youth are unable to legally consent to commercial sex. Accordingly, all forms of commercial sex that involve an individual under the age of 18 in the United States legally constitute sex trafficking, regardless of the minor's perceived agency. Examples of commercial sex include stripping, livestreamed sexualized videos, pornography, survival sex (i.e., sex for food or shelter), prostitution, and/or self-produced sexual images.

While the exact scope of CST remains unknown (Finkelhor, Vaquerano, & Stranski, 2017), research has documented that CST is a form of victimization that has substantial negative health complications and sequelae for youth. Specifically, survivors of CST have statistically higher clinical problems (emotional, developmental, psychological, and behavioral dysregulation), greater levels of trauma symptoms, more functional impairments and high-risk

behaviors, and increased involvement in juvenile justice and child welfare systems when compared to a matched sample of sexually assaulted/abused children (Cole, Sprang, Lee, & Cohen, 2016). In addition, the effects of chronic sexually transmitted infection (STIs), including infertility, are more commonly seem among sexually exploited youth (McClain & Garrity, 2011). Finally, survivors of CST have a higher rate of adverse childhood experiences (ACEs), even when compared to children involved in the juvenile justice system (Naramore, Bright, Epps, & Hardt, 2017). High ACE scores put survivors of CST at elevated risk for re-victimization as well as many other adverse physical and behavioral health outcomes (Campbell, Walker, & Egede, 2016).

Importantly, federal and state governments have made important strides in recognizing CST as a form of child abuse (e.g., Justice for Victims of Trafficking Act [P.L. 114-122], Preventing Sex Trafficking and Strengthening Families Act [P.L. 113-183]). These laudable pieces of legislation have facilitated both the identification of and service provision for sexually exploited youth. Once identified, survivors of CST often need crisis intervention, safety planning, assistance meeting basic needs, medical care, mental health services, sexual health services, assistance navigating the criminal justice system, and education/employment services (Gibbs, Walters, Lutnick, Miller, & Kluckman, 2015).

CST advocates and service providers have decades of critical experience working with survivors to improve health and mental health trajectories, and have unique perspectives on the challenges that must be met by policy-makers and community providers. Love146, founded in 2002, is an international human rights organization working to end child sex trafficking and exploitation. Love146's work began in Southeast Asia and later expanded to the United Kingdom, Liberia and Madagascar. In the United States, Love146's Survivor Care Program serves as Connecticut's primary provider of specialized services for survivors of CST.

THE LOVE 146 SURVIVOR CARE PROGRAM

Love146 is an international human rights organization founded in 2002, exclusively focused on the issue of child trafficking. Based in New Haven, CT, Love146 provides targeted services to youth who are confirmed survivors of- or at high-risk for- child sex trafficking. Love146 also offers services to caregivers and providers so that they are better able to support and meet the needs of these youth. The overall mission of Love146 is to journey alongside children impacted by trafficking today and prevent the trafficking of children tomorrow through survivor intervention, prevention education, and caregiver support. This mission is embodied through their Survivor Care Program.

In 2014, Love146 developed their comprehensive Survivor Care Program (SCP) to serve child sex trafficking (CST) survivors in the state of Connecticut. The SCP provides survivors with a range of services including psychoeducation, intensive case management, life-skills assistance, criminal justice support/advocacy, transportation, and crisis management/support. Services are organized in two ways: (1) rapid response services; and (2) long-term services.

Rapid Response Services. Love146's rapid response service is a one-time, one-hour intervention administered to all referred youth. It is designed to provide youth with

information, safety planning, and referral services. Youth also receive a backpack filled with products they and providers have identified as important to this population. Items include hygiene products, a journal, an activity book, condoms, a list of national hotline numbers, and a teddy bear. Additionally, Love146 staff provides information and safety planning to families and other caregivers, as needed.

Rapid response service outcomes indicate that 95% of survivors report learning something new from the service and can articulate what they have learned, and 87% report intentions to take specific actions in order to improve their safety. Following the rapid response services, Love146 completes a *Rapid Response Summary Form*, which provides an overview of what was discussed, any disclosures they were mandated to report to the child welfare system, and recommendations for follow-up service provision.

Long-term services. Following rapid response services, referring agents and survivors may request long-term services. Love 146 currently has the capacity to provide long-term services to 50 youth at any given time. Requests for long-term services have typically exceeded this capacity; therefore, Love146 has had to triage long-term service provision. Prioritization criteria include: the length, severity, and recency of the victimization; immediate and long-term needs; the presence, type, and number of other providers in the survivor's life; and the survivor's level of engagement in their rapid response services. All long-term services are provided by licensed, masters-level social workers, and are guided by individualized care plans. Care plans identify measurable goals and objectives around safety, emotional well-being, and skill development, as well as incentives (e.g., sporting events, concerts) for participation.

During youth involvement in the LTS program, Love146 social workers provide 3-4 hours per week of direct services to each survivor and their support network. In addition, Love146 social workers spend approximately 2 hours per week participating in case meetings, multidisciplinary team (MDT) meetings, and collaborating with providers (e.g., health care providers, law enforcement, schools) to identify, advocate for, and coordinate services. As part of long-term services, survivors and their caregivers receive the following: (1) personal advocacy, (2) support for emotional, psychological, and physical health and safety, (3) mental health counseling, (4) criminal justice support/advocacy, (5) education, employment, and life-skills assistance, and (6) transportation services, including having a Love 146 social worker accompany survivors to medical appointments. Additionally, Love146 social workers are available via phone and text to respond to urgent client needs. Long-term services may be provided for 6 months to 2 years depending on a youth's needs. Once a survivor is showing sustained progress towards their care plan goals, Love146 continues to work with the survivor and provide services on a bi-weekly basis.

Once a survivor has received bi-weekly services for approximately 6 months, survivors are moved to *sustained care.* Survivors receiving sustained care do not receive services on a regular basis but are able to access services if needed. To date, 49% of survivors who have received long-term services have reached back out to Love146 after they have moved into sustained care. In these instances, Love146 may provide short-term direct services or connect survivors with more appropriate service providers, depending on survivors' needs.

In the following sections we provide a more detailed descriptions of program components for the Rapid Response Service and Long-Term Service components of the Survivor Care program.

RAPID RESPONSE SERVICES

Rapid response is a one time, one hour intervention directed toward providing youth information about CST, basic safety planning, and referral services. Importantly, the youth does not have to self-identify as having experienced CST to receive these services. Any youth who is deemed to be a high risk of having experienced CST victimization may be referred to rapid response. The majority of referrals to Love146's SCP are received from Connecticut's Department of Children and Families' (DCF) (86%). The remaining youth are referred through outpatient mental health services (6%); a hospital or in-patient facility (2%); juvenile court or a juvenile justice facility (2%); a multidisciplinary team or child advocacy center (1%); and police (1%).

Given the acuity of the youth, the high likelihood that the youth does not self-identify as a CST victim, and the importance of establishing clinical rapport quickly and effectively, social work clinicians deliver rapid response services. Love146 hires clinicians for these roles who have experience working with high-risk youth, including youth involved in state-level systems such as child welfare. Job training includes information specific to CST, general training on reducing acuity and risk, familiarity with area supports accessible to- or specializing in- CST victims, information about the continuum of care provided by Love146, and safety planning. Individuals hired to deliver rapid response services also supervise entry-level clinicians, and therefore must meet state licensure requirements for providing clinical supervision.

When a youth is referred to Love146's rapid response service, the clinician will contact the youth directly to set a time to meet. The clinician will then confirm the date and time with the youth's caregiver. Rapid response services are always delivered face-to-face, and may delivered at the location of client's choosing. Often, this is at the client's home/place of residence. The clinician will meet with the client and caregiver at the agreed upon date, time, and location, and introduce themselves as well as Love146. Then the clinician will then focus specifically on talking to the youth about CST, as well as provide some basic information about healthy relationships, safety planning, and help-seeking. The clinician also provides the youth with a pre-packed backpack, and will review the contents with the client. The content of the backpack is as follows:

- Hygiene products
- A journal
- An activity book
- Condoms
- A list of human trafficking national hotline numbers
- A teddy bear or other stuffy

Before leaving the youth, the clinician will do a basic safety assessment with the client, to ensure they are not currently residing with their trafficker. In cases where the clinician is made aware that the identified caregiver is participating in (or otherwise facilitating) their trafficking situation, the clinician acts as a mandated reporter and will await next steps to ensure client safety.

Both the identified client and the caregiver are provided information about local and national resources that may be appropriate for victims and survivors of trafficking including national hot-lines, survivor networks, therapeutic supports, child advocacy centers, and SANE nurses. They are also given a detailed information regarding Love146's long-term services and are asked about their interest in receiving these services.

Data collected during Rapid Response services is minimal in order to ease the burden of participation on the child and their caregiver. Love146 acknowledges that often, rapid response services may be provided in the context of many other services, including child-welfare services.

LONG-TERM SERVICES (LTS)

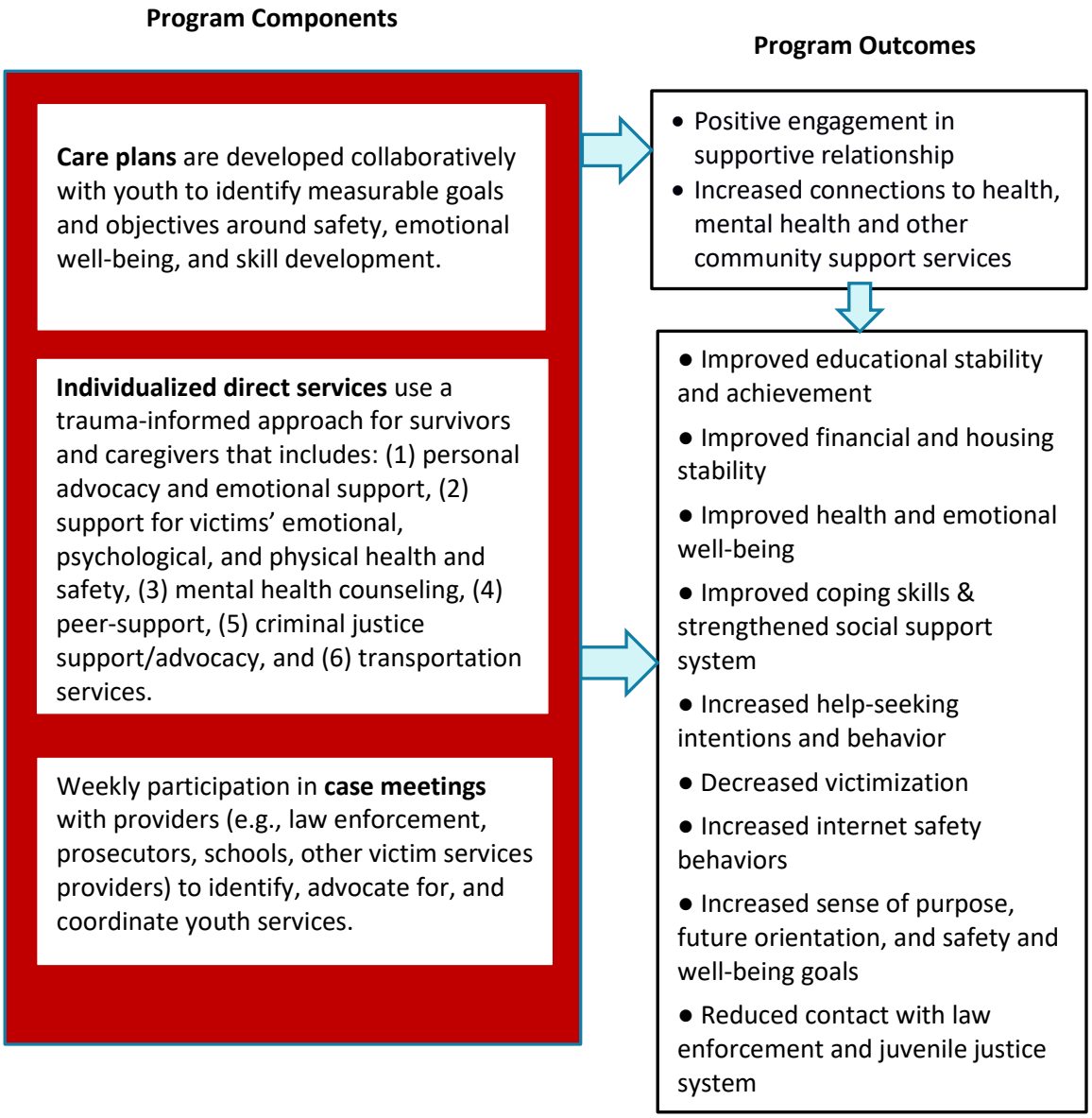
Following rapid response services, referring agents and survivors may request long-term services. Love146 currently has the capacity to provide long-term services to 50 youth at any given time. Requests for long-term services have typically exceeded this capacity; therefore, Love146 has had to triage long-term service provision. Prioritization criteria include: the length, severity, and recency of the victimization; immediate and long-term needs; the presence, type, and number of other providers in the survivor's life; and the survivor's level of engagement in their rapid response services.

All long-term services are provided by masters-level social workers (LMSW), who are supervised by the licensed social work clinicians (LCSW) who deliver the rapid response. Accordingly, the LCSW supervisors who have delivered rapid response services and have met the youth can mindfully choose LMSW providers who are most likely to connect with youth and help guide services. All services that are provided to youth are guided by individualized care plans. Care plans identify measurable goals and objectives around safety, emotional well-being, and skill development, as well as incentives (e.g., sporting events, concerts) for participation. While youth receive long-term services, Love146 social workers provide 3–4 h per week of direct services to each survivor and their support network. In addition, Love146 social workers spend approximately 2 hrs per week participating in case meetings, multidisciplinary team (MDT) meetings, and collaborating with providers (e.g., health care providers, law enforcement, schools) to identify, advocate for, and coordinate services. As part of long-term services, survivors and their caregivers receive the following: (1) personal advocacy, (2) support for emotional, psychological, and physical health and safety, (3) mental health counseling, (4) criminal justice support/advocacy, (5) education, employment, and life-skills assistance, and (6) transportation services, including having a Love 146 social worker accompany survivors to medical appointments. Additionally, Love146 social workers are

available via phone and text to respond to urgent client needs. Long-term services may be provided for 6 months to 2 years depending on a youth's needs.

Once a youth has participated in the LTS program for approximately twelve months, they are moved to Sustained Care. Sustained Care is a component of LTS in which services are not provided on a regular basis, but accessible if needed. To date, 49% of youth in Sustained Care have reached back out to Love146 to either share updates and celebrate important life events (e.g., graduations) or access additional service (e.g., housing assistance).

Long Term Services Logic Model



MEASURING FIDELITY

Intervention fidelity refers to the degree to which a specific intervention is implemented as completely as intended. It is a critical component of intervention research, and underlies the reliable examination of the program effectiveness. Specifically, fidelity measurement ensures the accurate presentation and examination of an intervention approach. Adequate fidelity measurement and reporting of intervention fidelity improves the interpretability of the outcome data in research studies as well as the replicability of the intervention, thereby easing clinical translation. While some studies indicate that higher levels of intervention fidelity contribute to better intervention outcomes (Dane & Schneider, 1998; Durlak & DuPre, 2008), other research points to the importance of client engagement (Low, Van Ryzin, Brown, Smith, & Haggerty, 2013). Our review of Survivor Care Program materials, and focus groups with program staff, highlight that for child trafficking victims, client engagement is a key component of fidelity. Given that it is impossible to determine poor effectiveness versus poor implementation fidelity unless fidelity measurement are included in evaluation research, we have created a fidelity measurement that integrates client engagement and rapport.

Integrating engagement and rapport into intervention fidelity measures is new though not entirely novel, particularly when evaluating the work of human service agencies like Love146 (e.g., Benjamin, 2012). Consistently, researchers and human service staff point out that often fidelity measures and, subsequently outcome evaluations, fail to capture the day-to-day work being done with clients (Carman, 2007; Carman & Fredericks, 2008; Hwang & Powell, 2009). To respond to this disparity, there have been calls to look more closely at the work that is being done by human service agencies and develop measures that accurately reflect the interventions being delivered on the front-lines by staff (Benjamin, 2012; Brodkin, 2008).

Creating an intervention-specific fidelity tool includes at least 2-steps (T MOWBRAY, Holter, Teague, & Bybee, 2003): (1) Identification of intervention key components; and (2) Development of fidelity measurement tools based on key components.

Identification of Intervention Key Components. The first step includes identifying possible indicators or key components of the intervention or approach. This implementation guide, which was developed with extensive feedback from individuals who have developed and delivered the Survivor Care Program, is meant to fulfill this first step and identifies key components of the focal intervention.

In addition to the identification of key components of the Survivor Care Program, we have situated these components for measurement purposes within a broader framework of intervention components commonly used in frontline work with marginalized communities. These components include listening, naming, challenging, and linking (Benjamin, 2012; See Table 1). Situating components of the Love146 program within this broader framework allows us to borrow and adapt from extant evidenced informed measurement tools, while still integrating unique components of the Survivor Care Program.

This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

Table 1: Frontline Work with Marginalized Communities (Adapted from Benjamin, 2012)

Relational Work	Examples from Human Services
Listening	Listen to clients for evidence of willingness to change
Naming	Work with clients to define individual service plan
Challenging	Challenge clients to make behavioral changes while recognizing clients as authorities on their problem.
Linking	Connect clients with other community supports

Development of fidelity measurement tool. The second step is to establish a measurement system, which involves decisions about how to measure the key components of the focal intervention and how to determine if the intervention is implemented with acceptable fidelity. Below, we provide a fidelity tool developed specifically for the Rapid Response component of the Survivor Care Program.

REFERENCES

Benjamin, L. M. (2012). Nonprofit organizations and outcome measurement: From tracking program activities to focusing on frontline work. *American Journal of Evaluation, 33*(3), 431-447.

Brodkin, E. Z. (2008). Accountability in street-level organizations. *Intl Journal of Public Administration, 31*(3), 317-336.

Campbell, J. A., Walker, R. J., & Egede, L. E. (2016). Associations between adverse childhood experiences, high-risk behaviors, and morbidity in adulthood. *American journal of preventive medicine, 50*(3), 344-352.

Carman, J. G. (2007). Evaluation practice among community-based organizations: Research into the reality. *American Journal of Evaluation, 28*(1), 60-75.

Carman, J. G., & Fredericks, K. A. (2008). Nonprofits and evaluation: Empirical evidence from the field. *New Directions for Evaluation, 2008*(119), 51-71.

Cole, J., Sprang, G., Lee, R., & Cohen, J. (2016). The trauma of commercial sexual exploitation of youth: a comparison of CSE victims to sexual abuse victims in a clinical sample. *Journal of Interpersonal Violence, 31*(1), 122-146.

Dane, A. V., & Schneider, B. H. (1998). Program Integrity in Primary and Early Secondary Prevention: Are Implementation Effects Out of Our Control? *Clinical Psychology Review, 18*(1), 23-45.

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41*(3), 327-350.

Finkelhor, D., Vaquerano, J., & Stranski, M. (2017). Sex trafficking of minors: How many juveniles are being prostituted in the US? 2017 Update. Retrieved from https://www.unh.edu/ccrc/resource/sex-trafficking-minors-how-many-juveniles-are-being-prostituted-us

Gibbs, D. A., Walters, J. L. H., Lutnick, A., Miller, S., & Kluckman, M. (2015). Services to domestic minor victims of sex trafficking: Opportunities for engagement and support. *Children and Youth Services Review, 54*, 1-7. doi:https://doi.org/10.1016/j.childyouth.2015.04.003

Hwang, H., & Powell, W. W. (2009). The rationalization of charity: The influences of professionalism in the nonprofit sector. *Administrative Science Quarterly, 54*(2), 268-298.

Low, S., Van Ryzin, M. J., Brown, E. C., Smith, B. H., & Haggerty, K. P. (2013). Engagement matters: lessons from assessing classroom implementation of Steps to Respect: A bullying prevention program over a one-year period. *Prevention Science, Online only*, 1-12. doi:10.1007/s11121-012-0359-1

McClain, N. M., & Garrity, S. E. (2011). Sex trafficking and the xxploitation of adolescents. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 40*(2), 243-252. doi:10.1111/j.1552-6909.2011.01221.x

Naramore, R., Bright, M. A., Epps, N., & Hardt, N. S. (2017). Youth Arrested for Trading Sex Have the Highest Rates of Childhood Adversity: A Statewide Study of Juvenile Offenders. *Sexual Abuse, 29*(4), 396-410. doi:10.1177/1079063215603064

T MOWBRAY, C., Holter, M. C., Teague, G. B., & Bybee, D. (2003). Fidelity criteria: Development, measurement, and validation. *The American Journal of Evaluation, 24*(3), 315-340.

University of New Hampshire

RAPID RESPONSE FIDELITY TOOL

1. On a scale of 1-7, how responsive was the caregiver to initial outreach to set up this meeting? By responsive, we mean that they responded to calls from the intake coordinator and were helpful in assisting in the facilitation of the meeting.

1	2	3	4	5	6	7
Not responsive at all						Very responsive

2. Was the youth contacted by Love 146 prior to the RR meeting?
   ____Yes
   ____No

3. Where was the Rapid Response meeting held?
   ____Youth's home
   ____Somewhere else: (specify)_____

4. Was anyone else with you during the Rapid Response meeting with the youth, besides the youth?
   ____No
   ____Yes: (specify)_____

5. On a scale of 1-7, how private would you rate the Rapid Response meeting with this youth?

1	2	3	4	5	6	7
Not private at all						Very private

6. Which of the following topics were you able to discuss in this initial meeting (check all that apply):

   _____Definition of Human Trafficking
   _____Safety Planning
   _____Healthy Relationships
   _____Help Seeking
   _____Hotline cards

This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

_____Types of Grooming-In Person
_____Types of Grooming-Online
_____Vulnerabilities
_____Laws around Sharing Photos

7. Did you provide a backpack to the youth?

   _____Yes
   _____No

8. Did you ask the youth any of the following questions? (Check all that apply.)

   _____Did you learn anything new?
   _____Would you do anything differently?
   _____Referral requests?
   _____Can you identify people who are supportive (adults)?

9. Did the youth request any referrals?

   _____Yes (specify: _____)
   _____No

10. On a scale of 1-7, how attentive did the youth appear during the Rapid Response meeting?

1	2	3	4	5	6	7
Not at all attentive						Very attentive

11. Overall, on a scale of 1-7 how open did this youth's caregiver seem to the help being provided by the Love146 clinician during Rapid Response?

1	2	3	4	5	6	7
Not at all open						Very open

12. Did you debrief this case with the program manager following the Rapid Response?
    _____Yes
    _____No

13. Was the youth asked about meeting with Love 146 again (Long-Term Services)?
    _____Yes
    _____No

14. Did the youth agree to meeting with Love 146 again (Long-Term Services)?
    _____Yes
    _____No

15. Was the youth formally referred to Long-Term Services following the Rapid Response?
    _____Yes
    _____No

Additional notes: