RESILIENCE INTERVENTIONS FOR SEXUAL EXPLOITATION: THE RISE PROJECT

FINAL PROGRAM EVALUATION 2015-2020

Jill D. Sharkey, Ph.D.
Evaluation Consultant

Santa Barbara County Department of Behavioral Wellness
The RISE Project

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Report Reference:
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Lisa Conn-Akoni, MA, MFT, devoted many years of tireless advocacy for specialized behavioral health services for survivors and victims of sex trafficking. Lisa served as the Program Developer and Supervisor for the RISE Project until her retirement from Behavioral Wellness in April 2019, after 20 years of service. Without Lisa and her valuable dedication and expertise, there would be no RISE Project.

Jill Sharkey, Ph.D., Professor, Department of Counseling, Clinical, and School Psychology in the Gevirtz School of Education at the University of California, has been instrumental in the evaluation and program improvement of the RISE Project. She has provided numerous Commercial Sexual Exploitation of Children and Youth (CSECY) related trainings, assistance with the development of numerous CSECY related clinical tools, planned and guided data collection efforts, and conducted extensive research to inform various components of the County’s efforts to address CSECY.

Carrick Adam, MD, MSPH, FAAP, Medical Director for the Santa Barbara County Juvenile Justice Facilities & Sexual Assault Response Team (SART), helped with the RISE Project program development and co-led countless trainings to community members in order to increase awareness.

We appreciate the RISE Project Team who dedicated their work to supporting the resilience of survivors of sexual exploitation. The RISE Project Team includes Lisa Conn-Akoni, MA, MFT, Hadisha Person, LMFT, Crystal Martinez, LMFT, Lisa Villa, LVN, Anne Norfleet, MA, MFT, Yule Cervantes, Maria Valencia, Karina Villanueva, AMFT, Annette Piper, Clarissa Padilla, Yaneris Munoz, Annie Chen, and Philip Wong.

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We are grateful to the Santa Barbara County District Attorney, Joyce E. Dudley, for launching the Santa Barbara County Human Trafficking Task Force (HTTF) in 2013 in recognition that an interdisciplinary, collaborative, and victim-centered effort is needed to combat human trafficking. The HTTF was instrumental in helping foster collaborations needed to effectively respond to exploited youth.

RISE Project consultation was also provided by Runaway Girl founder Carissa Phelps and her team. Runaway Girl is a company of survivor leaders and experts who provide training and consultation with the goal of improving services for runaway and homeless youth.

Finally, execution of the RISE Project relied on the leadership of the following Behavioral Wellness Department staff members: Celeste Andersen, JD, Eric Baizer, Caitlin Lepore, PhD, LCSW, John Lewis, PhD, Pam Fisher, PsyD, and Lindsay Walter, JD.
# TABLE OF CONTENTS

Table of Contents ............................................................................................................. 4

MHSA Summary .................................................................................................................. 6

Executive Summary ............................................................................................................. 7

Introduction ......................................................................................................................... 12

Components of the RISE Project ....................................................................................... 13

Key RISE Project Areas .................................................................................................... 14

Evaluation Design .............................................................................................................. 14

RISE Project Logic Model ................................................................................................. 15

#1: Effectiveness and Impact of Using a Shared Screening Tool ....................................... 16

First Responder Identification Tool ................................................................................. 16

Westcoast Children’s Clinic CSE-IT Tool ......................................................................... 17

Increased Identification: Santa Barbara County Child Welfare Services CSEC Protocols ... 17

Increased Identification: Santa Barbara County Behavioral Wellness CSECY Protocols .... 18

#2: Impact of RISE for Young Women Vulnerable to or Involved in CESCY .................... 21

Participant Demographics ................................................................................................. 22

RISE Admissions .............................................................................................................. 22

Adverse Childhood Experiences ..................................................................................... 23

Behavioral Wellness Services History ............................................................................. 24

Engaging Participants: Overview Of The RISE Project ................................................... 26

RISE Project Phases of Development ............................................................................ 28

Engaging Participants: Overview of Services Provided ................................................... 29

Increase Engagement for LGBT/GNC CSEC Youth ......................................................... 31

Increase Attention to Race, Ethnicity, Culture, And Discrimination ................................ 31

Increase Participant Strengths ......................................................................................... 32

Decrease Participant Needs ............................................................................................. 34

Achieve Participant Satisfaction ...................................................................................... 36

#3: Inter-Agency Collaboration and Impacts on Improved Recognition and Response ........ 43

Developing a CSECY Inter-Agency Protocol MOU ......................................................... 44

Participant Referrals and Interagency Collaboration ....................................................... 46

Increased Public Awareness of CSECY ............................................................................ 47
#4: Increases in Funding and Other Public Support................................................................. 48
Discussion ................................................................................................................................ 52
Appendices .................................................................................................................................. 57
  Glossary^1................................................................................................................................. 58
  First Responder ID Tool ........................................................................................................... 60
  CSEC Hierarchy of Needs .......................................................................................................... 61
  LGBT/GNC Tool and Results ................................................................................................. 63
  Race, Ethnicity, Culture, and Discrimination Tool and Results .................................................. 65
  Adverse Childhood Experiences: Details .................................................................................. 73
  Child and Adolescent Needs and Strengths: Methodology and Results ................................. 76

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^1 Please refer to the Glossary for a list of terms with definitions.
MHSA SUMMARY

The Resiliency Interventions for Sexual Exploitation (RISE) Project empowered and supported 163 youth participants, ages 10 to 28, who were either at risk or exposed to commercial sexual exploitation (CSE). From 2015-2020, the RISE Project collaborated with several partner agencies across Santa Barbara County (SBC) to offer a multi-faceted approach that addressed participants’ needs and built on their strengths. Providing bio-psycho-social support, the RISE Project approached intervention within stages, recognizing that clients have different needs as they progress through engagement and treatment. Each stage took days, weeks, or years, depending on each individual’s journey. At the onset of treatment, when clients were in the engagement and stabilization stages, the focus was on developing rapport and gaining trust before implementing assessment protocols. The RISE Project developed and implemented new “smart” tools to better support gender- and cultural-specific goals of services. Data from assessments indicate that participants entered with a long history of prior admissions to mental health services and a significant history of adverse childhood experiences. Fortunately, RISE Project participants also presented with a lot of strengths they could build on. Participants typically cycled between stages, often returning to “stabilization” several times before more consistently advancing into “coping strategies” or “maintenance.” Thus, few clients reached the “leadership” stage, which is a journey that took several years. RISE Consumer Surveys revealed that RISE Project participants tended to be very highly satisfied with RISE Project services and felt supported by the RISE Project staff. Results provided evidence that the RISE Project was experienced as a safe and supportive program that provided meaningful support and opportunities.

The RISE Project helped multiple SBC agencies institute CSE trainings, protocols, prevention, and intervention. Central to RISE Project success was the pre-planning process and ongoing collaboration between County partners. These collaborative partnerships were key in shifting the community toward a trauma-informed lens and changing the culture from criminalization to treatment and support. This included partnering with the SBC District Attorney’s Human Trafficking Task Force to develop and implement a countywide First Responder Identification Tool, which includes indicators of suspected CSE and instructions to make a suspected child abuse report. The RISE Project was also key in adopting the WestCoast Children’s Clinic Commercial Sexual Exploitation Identification Tool for use in service delivery systems. Multidisciplinary teams and the Helping to Achieve Resiliency Treatment Court for CSE children were also new and formalized methods of interagency collaboration established in partnership with RISE. Media coverage and newly developed partner resources about CSE are evidence of the improved recognition and response to CSE achieved since the RISE Project was implemented. Together, partners have provided trainings including developing a documentary that summarizes CSE in SBC. The RISE project has been designated as a promising program, been presented about at professional conferences, and has been documented in peer-review publication. The RISE Project also developed a Toolkit for Developing an Effective Multidisciplinary Response to Serve Exploited Youth to help disseminate lessons learned to other counties, behavioral health departments, and community-based organizations.
EXECUTIVE SUMMARY

The Resiliency Interventions for Sexual Exploitation (RISE) Project aimed to empower and support youth, ages 10 to 28, who are either at risk or exposed to sexual exploitation or trafficking. From 2015-2020, the RISE Project collaborated with several partner agencies across Santa Barbara County to offer a multifaceted approach that addressed participants’ needs and built on their strengths as depicted in the following logic model.

The report addresses accomplishments in each of the four project target areas.

| Evaluation Goal #1: Effectiveness and Impact of Using a Shared Screening Tool |
|---|---|---|---|
| Objective | Met? | Evidence | Barriers |
| Implement Countywide First Responder Identification Tool (FRIT) | Met | FRIT integrated as practice with: Behavioral Wellness, Child Welfare, & Probation | Expanding FRIT to additional agencies, Schools, Law Enforcement, Other youth-serving agencies |
| Implement Sexual Exploitation Identification Tool for in-depth screening (CSE-IT) | Met | CSE-IT integrated as practice with: Juvenile Hall & Child Welfare | Expanding use and increasing sustainability. |
| Increase identification of youth at-risk for or with clear concern of Commercial CSECY. | Met | Agencies have identified 430 youth, some duplicated—far more than ever identified. | Broader implementation with more agencies and unduplicated counts. |

The RISE Project partnered with the Santa Barbara County District Attorney’s Human Trafficking Task Force (HTTF) to develop and implement a countywide First Responder Identification Tool (FRIT). The
FRIT includes indicators of suspected commercial sexual exploitation (CSE) and instructions to make a suspected child abuse report (SCAR). In addition, the RISE Project was key in adopting the WestCoast Children’s Clinic Commercial Sexual Exploitation Identification Tool (CSE-IT) for use in service delivery systems. The CSE-IT guides a structured interview to determine if a person has possible or clear concern of CSE. The RISE Project helped county agencies institute CSE protocols. For example, Santa Barbara County Behavioral Wellness implemented screening questions and a response protocol with their 24/7 toll-free crisis response and service “Access” line.

### Evaluation Goal #2: Impact of RISE for Young Women Vulnerable to or Involved in CSECY

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met?</th>
<th>Evidence</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage participants in services that address their needs</td>
<td>Met</td>
<td>A total of 163 unique participants were engaged in services specifically tailored to build on their strengths and address their needs.</td>
<td>The RISE Project was in high demand for providing training, outreach, and direct services throughout a geographically large county. A more coordinated effort across agencies would support more survivors.</td>
</tr>
<tr>
<td>Increase engagement for LGBT/GNC CSEC youth.</td>
<td>Partially Met</td>
<td>Developed and pilot tested the LGBTGNC Tool</td>
<td>Consistent implementation with participants who identify as LGBTGNC</td>
</tr>
<tr>
<td>Increase attention to race, ethnicity, culture, and discrimination.</td>
<td>Partially Met</td>
<td>Developed and pilot tested the Race, Culture, and Discrimination Tool</td>
<td>Consistent implementation with all participants.</td>
</tr>
<tr>
<td>Increase participant strengths</td>
<td>Met</td>
<td>Participants’ strengths were higher at later assessments; most strengths showed more positive than negative growth at 12 months for matched participants.</td>
<td>Some participants showed negative growth at 12 months. Without an experimental design and control group it is impossible to know how participants would have functioned without intervention. Moreover, staff felt that CANS were challenging to rate at intake and results may have been more accurate over time.</td>
</tr>
<tr>
<td>Reduce participant needs</td>
<td>Met</td>
<td>Participants’ highest needs were lower at later assessments; most needs showed more positive than negative growth at 12 months for matched participants.</td>
<td></td>
</tr>
<tr>
<td>Achieve participant satisfaction</td>
<td>Met</td>
<td>Clients provided anonymous feedback about RISE and it was very strongly positive.</td>
<td>Obtaining consistent feedback from all participants.</td>
</tr>
</tbody>
</table>

The RISE Project provided bio-psycho-social support to children and youth exposed to or at risk of sexual exploitation and trafficking. The approach relied on interagency collaboration and multi-layered treatment, training, and education that included partners throughout the community. A comprehensive female specific and trauma-informed model of services, resources, protocols, education, and training was developed, implemented, and tested for efficacy.

The RISE Project approached intervention within stages, recognizing that clients have different needs as they progress through engagement and treatment. Each stage may take days, weeks, or years, depending on each individual’s journey. At the onset of treatment, when clients are in the engagement and stabilization stages, the focus is on developing rapport and gaining trust before implementing relatively invasive assessment protocols. Participants typically cycle between stages, often returning to “stabilization” several times before more consistently advancing into “coping strategies” or “maintenance.” Thus, few clients reached the “leadership” stage of the RISE Project, which is a journey that takes several years.
Overall, demographic data were collected for 163 RISE Project participants in the Behavioral Wellness data system although not all clients received all assessments. Most participants received a diagnosis of Post-Traumatic Stress Disorder (57.7%) followed by Major Depressive Disorder (17.1%). ACEs scores were available for 51 clients with an average of 5 to 6 ACEs. Common ACEs were sexual abuse, emotional abuse, witness to community violence, witness of family violence, disruption to caregiving/attachment losses, and victim witness to criminal activity. A lifetime history of prior Behavioral Wellness services provided to clients in RISE was available for 159 RISE Project participants. Only 9% of clients referred to Behavioral Wellness entered the RISE program at their first admission. More common pathways into the Behavioral Wellness system were through children and youth outpatient (32%), Crisis Services (26%), Alcohol and Drug Prevention (15%), and juvenile justice (10%).

The RISE Project developed and piloted two smart tools to enhance the assessment of youth needs to more effectively support them starting with program engagement. The LGBT/GNC Tool was developed because youth with minority sexual orientation or gender identity are common within the CSECY population and may require specialized treatment to process experiences of discrimination and/or support identity development. The Race, Culture, and Discrimination Tool was developed because youth from certain racial/ethnic groups—including African American, Asian Pacific Islander, Hispanic/Latino(a), and indigenous Native Americans—have been historically underrepresented in mental health treatment and in the research and evaluation of evidence-based treatments.

RISE administered the CANS as a multi-purpose tool used across systems of care to identify participant strengths and needs. The most common strength at intake was Educational (54.8%) followed by Talents and Interests (45.2%), Natural Supports (37%), Family Strengths (28.1%), Spiritual Religious (24.4%), Community Life (23.7%), and Interpersonal (17.8%). At subsequent CANS time points, more participants were rated with having most strengths. The most common need at intake was Social Functioning (66.6%) followed by Family Functioning (64.4%), Depression (61.5%), Adjustment to Trauma (60.7%), School Achievement (55.5%), Anxiety (54.8%), and Living Situation (54.8%). Social Functioning, Family Functioning, Depression, School Achievement, and Living Situation saw large decreases in the percentage of youth with these needs at 12 months. Participants were asked to provide feedback about the RISE Project and related services, confidentially. Results indicate that clients really enjoy RISE because they enjoy being able to talk to people they trust, they get the things they need, they express their emotions, they get support, they learn coping skills, and they are monitored.

| Evaluation Goal #3: Interagency Collaboration and Impacts on Improved Recognition and Response |
|---|---|---|---|
| Objective | Met? | Evidence | Barriers |
| CSECY Interagency MOU | Met | An MOU was developed and executed. | Maintaining trust and collaboration over time. |
| Participant referrals and interagency collaboration | Met | Multidisciplinary Teams included RISE; HART Court was developed, approved, and functioning. | Engaging schools, medical professionals, and additional service providers in the MDTs. |
| Increased public awareness of CSECY | Met | Media coverage, consultation requests, & county partner resources | Continuing to address myths and sustain trainings |
Central to RISE Project success was the pre-planning process and ongoing collaboration between all partners. These collaborative partnerships have been key in shifting the community toward a CSE– or Trauma–Informed Lens and changing the culture from criminalization to treatment and support. Evidence of such collaboration is found in media reports as well as RISE staff interviews regarding referrals and interagency collaboration. Identification and reporting protocols, multidisciplinary teams, and the Helping to Achieve Resiliency Treatment Court for CSE children (HART Court) are all new and formalized methods of interagency collaboration established in partnership with RISE. Media coverage and newly developed partner resources about CSECY are evidence of the improved recognition and response to CSECY achieved since the RISE Project was implemented.

### Evaluation Goal #4: Increases in Funding and other Public Support

<table>
<thead>
<tr>
<th>Objective</th>
<th>Objective Met?</th>
<th>Evidence</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countywide CSECY Toolkit developed and published</td>
<td>Met</td>
<td>The Toolkit is posted on the Behavioral Wellness Website</td>
<td>Dissemination.</td>
</tr>
<tr>
<td>RISE Project Public Support</td>
<td>Met</td>
<td>RISE documentary; media coverage</td>
<td>Updating the documentary and sustaining media coverage.</td>
</tr>
<tr>
<td>RISE Project Professional Support</td>
<td>Met</td>
<td>RISE was designated as a promising practice; has been presented about at professional conferences; and is published in a peer-reviewed journal</td>
<td>Funding is needed to support the full spectrum of services the RISE Project was able to deliver that TAY-FSPs cannot.</td>
</tr>
<tr>
<td>Increased funding for CSECY</td>
<td>Partially Met</td>
<td>Santa Barbara County District Attorney and Sheriff have been awarded six-years of funding for human trafficking work</td>
<td>Countywide coordination is needed, alongside additional dedicated funding, to support survivors outside the parameters of full-service partnerships.</td>
</tr>
</tbody>
</table>

The RISE Project has been a key partner within the Human Trafficking Task Force (HTTF) to support survivors once identified. Together, partners have provided trainings including developing a documentary that summarizes CSECY in Santa Barbara County. Media coverage demonstrates public support and funding including nonprofit partnerships. The RISE project has been designated as a promising program, been presented about at professional conferences, and has been documented in peer-review publication. These collaborations have supported additional grant funding to the county and efforts to sustain the wide array of programming offered by the RISE Project.

**CONCLUSION**

The RISE Project had a positive impact on awareness of CSECY and the identification, screening, and intervention with survivors of CSECY. Moreover, the RISE Project supported dozens of identified survivors previously served within juvenile justice systems including juvenile detention. The RISE Project was instrumental in radically shifting the perspective that services need to be provided in communities to youth wherever they are most comfortable. CSECY is a lucrative, hidden, and pervasive problem that needs ongoing innovative work to address in Santa Barbara County and beyond. The RISE Project provided Santa Barbara County with the resources and a toolkit to serve as a road map for continuing this important work.

Moving forward, a key to engaging all survivors of CSECY, regardless of their readiness for participation in a TAY-FSP, will be coordinating across the county with other agencies and nonprofit organizations to develop continuum of care to efficiently prevent, identify, engage, house and fully support CSECY. The
MHSA Innovations funding accelerated Santa Barbara County’s understanding of what innovations it takes within the mental health system of care to accomplish this and found that a) it takes specialized training in CSECY in order to do this work and b) no one agency can tackle this alone. Institutional partners including the district attorney, department of social services, schools, law enforcement, and nonprofit agencies must work together to establish a continuum of care and build capacity until it is possible to eradicate CSECY and identify and serve all children and youth survivors of CSECY.
INTRODUCTION

The Resiliency Interventions for Sexual Exploitation (RISE) project aimed to empower and support youth, ages 10 to 28, who were at risk or exposed to sexual exploitation or trafficking. RISE collaborated with several partner agencies across Santa Barbara County to offer a multi-faceted approach that addressed participants’ needs and also built on their strengths. Given the diversity of need in this target population, a comprehensive trauma-informed screening process identified the youth’s past trauma experiences, trauma-related symptoms, risk and protective factors, substance use prevention and support, vocational and educational support, and medical needs. Specifically, the RISE Project increased accessibility to those who were most at risk, such as youth who: had previously survived sexual exploitation or sexual trauma, were in foster care, resided in group homes, identified as “runaway youth,” and/or resided in Juvenile Hall. Additionally, the team designed and tailored the program to work with previously underserved populations, including youth of color and LGBTQ youth. This screening considered a hierarchy of needs, by centering their basic living needs, housing support, and current level of safety. Lastly, RISE fostered each participants’ sense of purpose and goals for the future. Promoting self-care and teaching advocacy was designed to build the self-esteem of the youth, and encourage the use of the offered services.

The RISE projects’ mission to provide multifaceted and strengths-based support for commercial sexual exploited children and youth (CSECY) is highlighted in work across the county. Working with this population offers unique considerations to the program. CSECY are at higher risk for medical and psychiatric problems, such as depression, PTSD, STIs, and malnutrition (Hossain et al., 2010). They are also more likely to experience other at-risk events, such as homelessness, foster care placement, and other forms of childhood abuse (Macias-Kostantopouos et al., 2015). These past experiences and situational circumstances could lead to a different set of needs and strengths than experienced by other children and youth.

Maslow’s hierarchy of needs suggests that certain needs, such as physiological and safety needs, should be met to be able to address higher processing needs, such as belonging and self-actualization (Maslow & Lewis, 1987). Youth with multiple trauma experiences may also have multiple high competing needs. An assessment of the level of these needs can help illuminate which the program should be tackled first. Understanding levels of needs and strengths can help better provide guidance to the types of services that will most benefit youth.

The core principles of the RISE Project are EMPOWERMENT and RESTORATION achieved through a non-judgmental/non-shaming “survivor-driven”, community- and system-based service delivery program. Simply put, the RISE Project was designed to meet youth where they are, both figuratively and literally. Each youth’s unique strengths, needs, and preferences were assessed through a comprehensive trauma-informed screening process designed to identify several biopsychosocial and “hierarchy of needs” factors including, trauma related symptoms, risk/protective factors, safety, socioeconomic/cultural/spiritual background, natural supports, education, AOD supports, medical/reproductive needs, housing/placement, vocational/pro-social, legal restoration and readiness for engagement. The RISE Project worked toward supporting each youth to identify their own sense of self, hope, purpose and belonging so she/he/they could become empowered in their own destiny.
COMPONENTS OF THE RISE PROJECT

- An extensively CSECY–trained trauma–informed culturally–aware team
- Client/Family Driven goal identification and treatment planning
- Clinical Lead: Licensed behavioral health clinician who has received training to work with sex trauma and sexual exploitation survivors/victims
- System Navigator: A member of RISE who has built rapport with each youth to ensure consistent and easy access to services through providing transportation, “warm handoffs”, and advocacy within the child welfare, juvenile justice, educational, medical and mental health systems
- Health and Wellness Advocate: A licensed medical professional to attend to medical, reproductive, AOD and overall physical wellness. Physical health is greatly impacted by childhood trauma and attending to the biological health needs is paramount to assist in restoration
- Rehabilitation Specialist: An experienced practitioner that conducts extensive outreach and engagement and will work with each youth on developing a plan which includes numerous community-based resources/supports to address vocational, pro-social and educational restoration and reintegration
- Peer/Survivor Support: A trained peer or survivor that can provide a unique parallel and empathetic perspective as well as act as a role model and advocate
- Biopsychosocial Treatment Model focused on wellness, resilience and recovery supports which attend holistically to each youth through a biological, social, psychological, spiritual, cultural, and strengths-based approach
- CSECY Hierarchy of Needs to address environmental needs, basic necessities and inalienable human rights i.e., food, clothing, shelter, safety, love, belonging, purpose, self-esteem and self-actualization
- Coercion Resiliency through Runaway Youth/Ending the GameTM program
- Comprehensive Assessment, Screening and Identification Tools that are culturally sensitive and trauma-informed. RISE helped to create a Santa Barbara County multi-collaborative “First Responder CSECY Identification Tool”
- Non-Traditional and Easy Access to services, providers and supports through 24/7 crisis hotlines, mobile intake/treatment, flexible scheduling, transportation to and from appointments/supports, “warm hand-offs” and welcoming intake process
- Non-Judgmental and Non-Shaming: RISE will provide a “safe haven” for trauma exposed and exploited youth where they feel free to express themselves in an environment free of shame or judgment
- RISE Center: Outside of scheduled classes, groups, wellness activities and counseling, RISE provides a welcoming home-like setting for our youth to come and rest, make a meal, talk to their support team, work on projects, listen to music or obtain reproductive/hygiene/educational supports even if they do not have an appointment.
- Outcome Measures and ongoing multi-agency CQI/QA (Continuous Quality Improvements/Quality Assurance). RISE Project will also collect data on service delivery fidelity and outcomes to test for programmatic efficacy. We believe RISE can be used as a learning tool for providers to develop more effective ways of successfully treating this high-risk population and provide insight into preventative measures
- Early Intervention to address ways to make our youth more resilient and knowledgeable in order to make them less susceptible to victimization (early social emotional skills training, social media awareness for youth and parents)
- Outreach for unidentified and underserved trauma exposed youth
- Shelter/Placements: RISE works with the Human Trafficking Task Force to seek out ways to
fund and furnish temporary housing to longer term shelter/placements for sexually exploited girls and women

- **Flexible Funds** effort to create a way to support non-traditional needs for CSECY that are not typically funded through other resources
- **Psycho-education and Trainings** to improve CSECY identification and Trauma/CSECY informed interventions and protocols county wide
- **Multi-Disciplinary Teams**: RISE regularly facilitates or participates in MDT’s and is an active member in SB County District Attorney’s HART Court ("Helping Achieve Resiliency Treatment"); a multi-disciplinary treatment team for CSECY youth involved in the Juvenile Justice system. These inter-agency collaboration efforts have become integrated into the county’s response to youth engaged in CSEC.
- **Human Trafficking Task Force (HTTF)**: RISE staff and the evaluator are members of the Human Trafficking Task Force. RISE provides training and guidance to HTTF members to improve and sustain protocols (e.g., shared screening tool) within the county. RISE also collaborates with HTTF members to increase funding and public support for services to prevent and support survivors of CSECY.

**KEY RISE PROJECT AREAS**

The RISE Project Evaluation is based on four key project areas:
1. Effectiveness and impact of using a shared screening tool;
2. Effectiveness of the adapted treatment approach for young women who are vulnerable to or involved in sex trafficking, including mental health and substance-use outcomes, as well as related behavioral and social outcomes such as reduction in further sexual exploitation;
3. Whether and how the Program enhances inter-agency collaboration and the resulting effects in improved recognition and response to victims’ mental health issues; and
4. Whether the program contributes to increases in funding and other public support for improving mental health outcomes for girls who are victims of sexual exploitation.

This report provides summaries of what was accomplished in each of the four key project areas.

**EVALUATION DESIGN**

The RISE Project evaluation includes detailed RISE Project participant need, service provision, client need, and participant outcome data to better understand the strengths and needs of the CSECY population and how they are being addressed by RISE. The logic model pictured below details how the evaluation is embedded in a system with infrastructure; identification of participant strengths and needs, services, and outcomes; and community impacts. This is a descriptive evaluation, which shows whether a program is operating as planned, provides feedback about services, and determines if desired outcomes are being addressed and accomplished. Outcomes to track include a focus on building participant strengths as a priority focus while also addressing needs and risks. Each component of the evaluation is detailed in a separate section that will include methods.
RISE PROJECT LOGIC MODEL

**Infrastructure**
- Agency Partnerships
- Behavioral Wellness
- District Attorney
- Law Enforcement
- Child Welfare
- Probation
- Schools
- Community-Based Organizations
- Human Trafficking Task Force
- Evaluation
- Memorandum of Understanding

**Participant Strengths & Needs**
- Race, Ethnicity, Culture, and Discrimination Tool
- LGBT/GNC Tool
- ACEs
- CoVitality
- Service History
- Level of Care and Recovery

**Participant Services**
- The RISE Project:
  - Outreach & Engagement
  - Stabilization
  - Coping Strategies
  - Maintenance
  - Leadership

**Participant Outcomes**
- Child & Adolescent Needs and Strengths
- Consumer Feedback

**Community Impacts**
- Multidisciplinary Teams
- HART Court
- Identification Tool: FRIT
- Screening Tool: CSE-IT
- Improved Recognition & Response
- Funding & Public Support
- RISE Project Dissemination
#1: EFFECTIVENESS AND IMPACT OF USING A SHARED SCREENING TOOL

This evaluation goal focused on establishing shared screening tools for all personnel working with vulnerable youth in Santa Barbara County to know how to recognize signs of CSECY and help identified youth become engaged with CSECY specific services. Over the course of the project period, RISE Project personnel were engaged in interagency collaboration and advocacy to establish shared screening tools and procedures to identify and respond to sexually exploited youth. The following is a summary of the screening efforts that were accomplished.

<table>
<thead>
<tr>
<th>Evaluation Goal #1: Effectiveness and Impact of Using a Shared Screening Tool</th>
<th>Objective</th>
<th>Met?</th>
<th>Evidence</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement Countywide First Responder Identification Tool (FRIT)</td>
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<td>Broader implementation with more agencies and unduplicated counts.</td>
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</tbody>
</table>

**FIRST RESPONDER IDENTIFICATION TOOL**

The primary shared screening tool, developed for first responders including law enforcement and educators, is the First Responder Identification Tool (FRIT). Members of Santa Barbara Human Trafficking Task Force including representatives from Santa Barbara County District Attorney and Santa Barbara County Behavioral Wellness developed the FRIT for CSECY. The FRIT was designed for use by professionals classified as first responders (e.g., law enforcement, social workers, teachers, medical personnel, mental health professionals) when they suspect possible CSECY. Some indicators alone trigger referral (e.g., has been missing and traveled out of county without guardian consent). Others require a total of three in order to trigger referral (e.g., tattoos representing exploitation, runaway history, truancy). The one-page tool includes instructions for responders to complete a Suspected Child Abuse Report (SCAR) for Child Welfare Services (CWS) and includes suspected CSECY and related identifiers. The RISE Project collaborates with Child Welfare Services, District Attorney/Victim Witness Advocate, and community-based organizations to obtain referrals for clients. The RISE Project has provided training directly to first responders and to members of the Human Trafficking Task Force (HTTF). Training on the FRIT continues to be a need that is met by RISE staff and a variety of partners through the HTTF. The Santa Barbara County FRIT is linked in the Appendix.
WESTCOAST CHILDREN’S CLINIC CSE-IT TOOL

WestCoast Children’s Clinic developed a commercial sexual exploitation identification tool (CSE-IT) that is more in-depth than the FRIT. The CSE-IT must be completed by a professional trained in its administration and is completed based on information gleaned from an interpersonal interaction between the trained professional and a client. There are ten categories of questions (e.g., relationships, finances and belongings, use of technology) that are rated on a scale of 0=no concern, 1=possible concern, and 2=clear concern. Item scores are added together and are considered No Concern if they total 0-4 points, Possible Concern if they total 5-10 points, and a Clear Concern if they total 11-20 points. The tool provides ten possible actions to take (e.g., mandated report to authority, develop a safety plan, refer to mental health services). The CSE-IT is an open domain tool for use in service delivery systems that serve children and youth. The RISE Project consulted with WestCoast Children’s Clinic to develop the CSE-IT tool and successfully implement it in Santa Barbara County.

INCREASED IDENTIFICATION: SANTA BARBARA COUNTY CHILD WELFARE SERVICES CSEC PROTOCOLS

Child Welfare Services (CWS) provided the RISE Project with data regarding their hotline reports related to CSEC. Over time the number of SCAR reports (duplicated) to CWS with CSEC allegations has fluctuated. This may reflect fluctuating levels of training and awareness amongst mandated reporters and first responders. Overall, referrals increased from the inception of the RISE Project through 2019. Data from 2020 are incomplete and, in the final quarter, services were significantly impacted by COVID-19.

Suspected Child Abuse Reports (SCAR) to CWS Hotline with CSEC Allegations, Quarterly

CWS also reports results of CSE-IT screenings gathered and reported by the WestCoast Children’s Clinic. CWS referrals are screened when the referral is flagged as potential CSEC at the hotline or when the investigator determines that there are risk factors present during the course of the child abuse/neglect investigation. For active cases, CWS policy is to screen all children age 10 years and older with the CSE-IT tool within 30 days of case opening and every 6 months thereafter. Children are also screened when they return from an absence from placement. Since these procedures were implemented, from
December 2015 through June 2020, 674 youth were screened by CWS. Of these, 63% (424) resulted in “no concern,” 20% (134) resulted in “possible concern,” and 17% (116) resulted in “clear concern.” This means that 37% of CWS cases age 10 years or older have had a possible or clear concern for CSEC.

**INCREASED IDENTIFICATION: SANTA BARBARA COUNTY BEHAVIORAL WELLNESS CSECY PROTOCOLS**

Santa Barbara County Department of Behavioral Wellness regularly takes calls from potential clients and referring agencies seeking mental health (MH) or drug and alcohol treatment (ADP). This 24/7 toll-free crisis response and service “Access” line added a CSECY screening protocol.

The following are the three screening questions that Access asks a guardian or provider when they call to obtain services for a potential client under 25 years of age.

1. Does the youth have a history of running away or being kicked out of the home?
2. Does the youth engage in risky sexual behaviors, or in relationships that are abusive, controlling, or dangerous?
3. Is the youth involved in a friendship or intimate relationship with someone much older, either in person, online, or on social media?

Through June 30, 2020, a positive response to any question initiated the following protocol:
1. Administration of an adapted FRIT.
2. Completion of a SCAR with the Department of Social Services if the potential client is under the age of 18 years old.
3. Notify the RISE Project via email that the FRIT and SCAR have been completed.
4. The RISE Project is in the Department of Behavioral Wellness and works closely to the Access line to obtain referrals of children identified as CSECY.
Calls for Mental Health Services

Between October 2016, when the protocol was initiated, through June 30, 2020, of the callers who sought mental health services, a total of 3,276 people were given screening questions. Of these, 614 (18.7%) endorsed a “yes” to one of the three screening questions, yet only 16 (.5%) subsequently endorsed any of the FRIT questions.

Calls for Substance Use Treatment Services

The Drug Medi-Cal Organized Delivery System (DMC-ODS), went “live” in Santa Barbara County in December 2018, and at that time the Access line also began screening callers for referral to substance use treatment. From December 1, 2018 through June 30, 2020, 874 callers were screened with the three screening questions; of these, 262 (30%) responded “yes” to at least one question and 46 (5%) subsequently endorsed any of the FRIT questions.

Results have multiple implications. First, compared to youth with mental health concerns, youth with alcohol and drug use concerns had higher rates of behavior that placed them at-risk for CSECY. Second, while screening questions identified a large proportion of Access Line callers as at-risk for CSECY, subsequent use of the FRIT did not. The use of the FRIT as a screener over the phone should be further investigated. It is possible that the Access Line questions are too broad leading to overidentification of youth as at-risk for CSECY and/or that the use of the FRIT as an over-the-phone screener is under-identifying youth in this particular context.

INCREASED IDENTIFICATION: SANTA BARBARA COUNTY PROBATION CSEC PROTOCOLS

The RISE Project and the Behavioral Wellness Juvenile Justice Mental Health Services (JJMHS) team collaborated with Probation to implement CSEC screening and tracking. The RISE Project and the JJMHS team collaborated with Probation to standardize implementation of the FRIT. As a result, Santa Barbara County Probation entered required CSEC information into the CWS case management system for youth in foster care. Effective Friday March 10, 2017, Probation began capturing FRIT results in IMPACT, their case management system. All youth who are booked into juvenile hall are screened with the First Responder tool. The indicator is a required field and must be answered in order to complete a booking in IMPACT. The results from the First Responder screening tool are entered as follows: If determined to be at risk of being CSEC – “Completed: At Risk.” If determined NOT to be at risk of being CSEC – “Completed: NOT at Risk.”
Data show the declining population of youth in the juvenile hall over the past four years, which is the results of a concerted effort by the Probation Department to limit the number of youth in juvenile hall combined with additional programming, such as the RISE Project, offered in the community. Of all the youth screened from March 2017 through June 2020 most (74%) were male. A much higher percentage of females (17.9%) than males (1.2%) who were screened fell in the at-risk range. A much higher percentage of White (11.3%) versus Hispanic (4.8%) or Other (4.7%) youth who were screened fell in the at-risk range. White females (50%) were the most likely subgroup to be identified as at-risk for CSEC within the juvenile hall population. Such a discrepancy in rates bears further investigation as, for example, the screening tool may be under-identifying males at-risk for CSEC.

### Summary and Future Directions

Overall, evidence for the effectiveness and impact of using a shared screening tool has included the development of effective screening measures to identify youth at-risk for or involved with CSECY, implementation of training and new protocols within key agencies, and increasing identification of youth at-risk for or involved with CSEC by multiple coordinating agencies. Across the agencies who work with Santa Barbara County’s most vulnerable children (Child Welfare, Probation, and Behavioral Wellness), a total of 430 children, some duplicated, were identified as at-risk for or clear concern for CSECY. It is likely that with additional key agencies adopting identification and screening protocols–such as schools and non-profit agencies serving children and older youth–significantly more youth would be identified as at-risk or clear concern for CSECY.

Next steps to increase the impact of shared screening tools include engaging even more first responders including school administrators and additional law enforcement and public health and safety partners. There is an ongoing need to provide CSECY awareness trainings while also working with the Human Trafficking Task Force and other partners in these efforts. For example, it is important to continue working with student attendance review boards (SARB) in multiple school districts to help them implement screening protocols to identify youth who are truant as they too are at-risk for CSECY. Ultimately, a county-wide data tracking system that allows multiple agencies to gain access to a shared database, with appropriate login credentials and access permissions, would allow the county to identify unduplicated counts of the prevalence of CSECY and–most importantly–provide a streamlined continuum of services that avoids duplicating assessments and interventions.
#2: IMPACT OF RISE FOR YOUNG WOMEN VULNERABLE TO OR INVOLVED IN CSECY

The RISE Project empowered and supported youth ages 10-28 years old and their families living in Santa Maria, Lompoc, Carpinteria, and Santa Barbara regions of Santa Barbara County. The RISE Project aimed to improve treatment for historically underserved populations (African American, Asian/Pacific Islander, Latinx, Native American/Tribal, and LGBTQ) who may be at increased risk for sexual exploitation across various Santa Barbara County regions. Specifically, the focus was on:
- Youth 18 and older at risk of or who are survivors of sexual exploitation or trauma (CSEY);
- Youth identified as Commercially Sexually Exploited Children (CSEC);
- Transition age youth (TAY) who have been sexually exploited;
- Youth who are at risk for out-of-home placement, residing in Juvenile Hall, in foster care or group homes, as well as any “runaway youth.”

| Evaluation Goal #2: Impact of RISE for Young Women Vulnerable to or Involved in CSECY |
|------------------------------------------|---------------------------------|-------------------|-------------------------|
| Objective | Met? | Evidence | Barriers |
| Engage participants in services that address their needs | Met | A total of 163 unique participants were engaged in services specifically tailored to build on their strengths and address their needs. | The RISE Project was in high demand for providing training, outreach, and direct services throughout a geographically large county. A more coordinated effort across agencies would support more survivors. |
| Increase engagement for LGBT/GNC CSEC youth. | Partially Met | Developed and pilot tested the LGBTGNC Tool | Consistent implementation with participants who identify as LGBTGNC |
| Increase attention to race, ethnicity, culture, and discrimination. | Partially Met | Developed and pilot tested the Race, Culture, and Discrimination Tool | Consistent implementation with all participants. |
| Increase participant strengths | Met | Participants’ strengths were higher at later assessments; most strengths showed more positive than negative growth at 12 months for matched participants. | Some participants showed negative growth at 12 months. Without an experimental design and control group it is impossible to know how participants would have functioned without intervention. Moreover, staff felt that CANS were challenging to rate at intake and results may have been more accurate over time. |
| Reduce participant needs | Met | Participants’ highest needs were lower at later assessments; most needs showed more positive than negative growth at 12 months for matched participants. | |
| Achieve participant satisfaction | Met | Clients provided anonymous feedback about RISE and it was very strongly positive. | Obtaining consistent feedback from all participants. |
PARTICIPANT DEMOGRAPHICS: ALL RISE PARTICIPANTS

Behavioral Wellness participant data were available for 163 participants in the RISE Project at any level, including pre-consumer. Gender (missing for 3) was primarily female (98.8%) with an additional 2 participants who were male. Racial/ethnic data indicated a diverse group including Mexican American (39.9%), White (19.6%), Other Hispanic Latino (17.8%), Unknown (7.4%), Black or African American (6.1%), Mixed Race (4.9%), Asian or Pacific Islander (2.5%), American Indian (1.2%), and Mixtec (0.6%). Language (missing for 16) was primarily English (78.2%) with some participants speaking Spanish (21.8%). Residential living arrangements (missing for 17) included in a house or apartment (56.8%), house or apartment with supervision (22.6%), group home (8.2%), foster family (2.1%), house or apartment with support (3.4%), homeless (2.7%), or other (2.1%). Demographic data are also provided for individual measures when they were included in the data.

PARTICIPANT DEMOGRAPHICS: RISE ADMISSIONS

A total of 111 RISE Participants were formally admitted to the RISE Project. Additional data are available for these participants. They ranged in age from 12 to 24 years old at first admission to the RISE Project ($M = 15.6$, $SD = 1.5$). Most lived in North County (51.4%; e.g., Santa Maria) or West County (29.7%; e.g., Lompoc).

<table>
<thead>
<tr>
<th>Diagnosis Description</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>57.7</td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>17.1</td>
</tr>
<tr>
<td>Anxiety Related</td>
<td>9.0</td>
</tr>
<tr>
<td>Unspecified Mood Disorder</td>
<td>6.3</td>
</tr>
<tr>
<td>Missing or Expired</td>
<td>5.4</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>1.8</td>
</tr>
<tr>
<td>Dysthymic Disorder</td>
<td>.9</td>
</tr>
<tr>
<td>Other Stimulant Abuse</td>
<td>.9</td>
</tr>
<tr>
<td>Mental Disorder not otherwise specified</td>
<td>.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The majority of RISE Participants received diagnoses of Post-Traumatic Stress Disorder (57.7%). When trauma symptoms go unrecognized and untreated, they may be mistaken for a disruptive behavior disorder including conduct disorder and oppositional defiant disorder. This can have devastating effects for survivors of trauma as treatment for disruptive behavior disorders assumes that the person has a fundamental disregard for other people and doesn't care about consequences of behavior. Children who exhibit externalizing behaviors in response to trauma are often thought of as bad because their behavior threatens others around them. On the other hand, trauma symptoms that include internalizing behaviors such as depression and anxiety often garner more sympathy because the person exhibiting such behaviors is only harming themselves. To help all survivors of sexual exploitation, diagnoses should be made with care, carefully considering trauma histories and the resulting courses of treatment. When evidence-based treatments are used to positively address behavioral, cognitive, emotional, or interpersonal areas, survivors can be resilient to their traumatic histories and develop the skills they need to be successful.
PARTICIPANT DEMOGRAPHICS: ADVERSE CHILDHOOD EXPERIENCES

Data about the adverse childhood experiences (ACEs) of participants were gathered at intake through the CANS. Responses are “No” for no evidence of trauma and “Yes” for suspicion or confirmation of a trauma. All of the traumatic/adverse childhood experiences indicate whether or not a youth has experienced a particular trauma. If they have ever had one of these experiences it would always be rated in this section, even if the experience was not currently causing problems or distress in the youth’s life. Thus, these items are not expected to change except if the youth has a new trauma experience or a historical trauma is identified that was not previously known.

The data demonstrate that the majority of RISE participants experienced a significant number of ACEs (76-83% report four or more ACEs) and are at high risk of poor health outcomes without intervention. Very common ACEs were sexual abuse (71.4%), emotional abuse (71.4%), disruptions in caregiving or a loss of caregiver (66.7%), witnessing criminal behavior (66.7%), witnessing community violence (66.7%), and witnessing family violence (61.9%). Medical trauma was rare (19%). No participant experienced war or terrorism and no participant experienced natural or manmade disasters. Additional details related to the data collection and results are provided in the Appendix.

This pattern of ACEs suggests attachment is a major factor in treatment since attachment for CSECY survivors is significantly harmed due to the nature of the multiple traumas they have typically experienced at the hands of their caregivers, including the exploiter(s). By approaching practitioner service provision through a “caretaker” lens, effective approaches would need to consider attachment style, counter-transference and transference, attend to basic needs, and provide an understanding, flexible, non-judgmental, non-pathologizing, bio-psycho-social strengths-based empowerment approach in order for their CSECY participants to achieve full therapeutic benefit.
PARTICIPANT DEMOGRAPHICS: BEHAVIORAL WELLNESS SERVICES HISTORY

When clients are admitted to services with Behavioral Wellness, they enter a system of care (i.e., managed care, mental health, or alcohol and drug) and begin to receive a variety of services until they are discharged. Each period of “admission” includes a beginning and end date along with services such as assessments, plan development, targeted case management, individual therapy, family therapy, group therapy, crisis intervention, and medication support. Each psychiatric intervention, medical support appointment, or day in the hospital is counted as a new/single service.

A lifetime history of prior Behavioral Wellness services provided to participants in the RISE Project was available for 159 participants for all admissions that began prior to June 30, 2020. The earliest date of admissions for a RISE Project participant into the Behavioral Wellness system was December 2, 2004. Individuals receive treatment services during admission periods bounded by intake and discharge dates; they can have multiple admissions if they are discharged and later admitted again. Participants had an average of 8.8 admission periods (range from 1 to 43) and an average of 42.6 services (services include all billed activities and/or days in the hospital) across all admissions.

A comprehensive understanding of participants’ first admission may be helpful for improving attention to CSECY prevention and identification within the Behavioral Wellness System. The following chart displays which system of care the participant was admitted into. RISE Project participants experienced their first admission into the Behavioral Wellness system primarily through the Mental Health system (81.2%). However, a few entered through Alcohol and Drug (14.1%) or Managed Care (4.7%).

**Client System of Care at First Admission to Behavioral Wellness Services (n=159)**

- Mental Health: 81.2%
- Alcohol and Drug: 14.1%
- Managed Care: 4.7%
The following chart displays the first admission primary referral source, available for 98 participants. The most common referral sources were schools/educational programs (28%) and juvenile probation (20%).

**Client Referral Source at First Admission (n=98)**

The following table provides information about the programs RISE Project participants \((n=159)\) received when they first received Behavioral Wellness services. Only 9% of participants were first admitted into Behavioral Wellness for the RISE Project. More common pathways into the Behavioral Wellness system were through children and youth outpatient (32%), Crisis Services (26%), Alcohol and Drug Prevention (15%), and juvenile justice (10%). As the issue of CSECY becomes recognized by more and more first responders, first admissions for participants who are at-risk for or engaged with CSECY may shift to programs that serve children earlier in their lives including community-based services, managed care, and school-based programs.

<table>
<thead>
<tr>
<th>First Admission Program Name</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Youth Outpatient</td>
<td>51</td>
<td>32</td>
</tr>
<tr>
<td>Crisis Services</td>
<td>42</td>
<td>26</td>
</tr>
<tr>
<td>Alcohol and Drug Prevention</td>
<td>24</td>
<td>15</td>
</tr>
<tr>
<td>Juvenile Justice</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>RISE</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>School-Based Programs</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Transitional Age Youth Services</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Adult Access/Assessment</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
ENGAGING PARTICIPANTS: OVERVIEW OF THE RISE PROJECT

The RISE Project intentionally designed the program to work with previously underserved populations, including youth of color and Gender or Sexual Minority (GSM) youth. The low barrier/no barrier philosophy of the RISE Project meant that youth could access services anytime, anywhere, by any method, without navigating challenging location, transportation, appointment, and assessment barriers required of standard behavioral health programs funded by Medicare, Medicaid, and the Children’s Health Insurance Program.

Through MHSA funding, the RISE Project was able to work with multidisciplinary partners to develop a comprehensive identification, screening, and assessment process to inform the referral, engagement, and treatment of youth impacted by CSECY. The First Responder Identification Tool (FRIT) helps professionals who regularly interact with children and youth (e.g., law enforcement officers, juvenile hall staff, probation officers, medical staff, teachers) identify the warning signs of CSECY and make a referral to Child Welfare with a Suspected Child Abuse Report (if under 18) and/or other supports (i.e., 911, mobile crisis teams, or the Behavioral Wellness Access line for service referral) depending on the urgency of concerns. Reports triggered a Multi-Disciplinary Team (MDT) meeting and a referral to the RISE Project for survivor engagement and supports.

Once youth were referred to the RISE Project, staff engaged them in formal and informal screening and assessments designed to identify the youth’s past traumatic experiences; trauma-related symptoms; risk and protective factors; substance use prevention and support; social, vocational and educational support; and physical health needs. The screening and assessment process adapted Maslow’s Hierarchy of Needs (see CSECY Hierarchy of Needs Matrix) to promote a true biopsychosocial treatment model. As such, the RISE Project attended to each girl’s physiological, safety, social, and esteem needs while simultaneously providing intensive victim centered, trauma-focused and CSECY specific therapeutic interventions. Focus on the CSECY Hierarchy of Needs fulfills previously unmet basic necessities, which reduces the ability for exploiters to use those unmet gaps to exploit children and youth. Moreover, the RISE Project aimed to support and empower participants to advocate for their own lives in order to reach self-actualization and fortify/reinforce their complete exit from a life of sexual exploitation, trauma, and unbalanced relationships.

The RISE Project model differs from standard mental health provision in many key ways by incorporating innovations that were critical to engaging and sustaining relationships and healthy
outcomes with participants. Children and youth with past abuse, neglect, or trauma are targeted by exploiters who take advantage of their vulnerability and cause compound, complex trauma for survivors. Survivors have been extraordinarily resilient to survive their abuse, and often present as very high functioning and capable of taking care of themselves. They may have profound symptoms of PTSD and trauma but have often developed skills for coping with and adapting to stress. Thus, they may not conform to the diagnostic criteria that typically guide mental health treatment. In addition, survivors of CSECY are not “perfect victims” in that they may present as angry and aggressive instead of sad and withdrawn. Because of their externalizing symptom presentation, survivors often end up in the juvenile justice setting instead of receiving the intensive, specialized treatment they need.

Core principles of the RISE Project are empowerment and restoration achieved through a non-judgmental/non-shaming “survivor & youth -driven” community and system-based service delivery program. Simply put, the RISE Project met youth where they were, both figuratively and literally. The RISE Project highlighted the unique needs and strengths of each participant to encourage agency, autonomy, and “voice and choice” designed to support survivors in coming up with their own solution in collaboration with RISE Project staff. Dialectical Behavior Therapy (DBT) was integrated into treatment because it does not require participants to over-process their circumstances or reveal their past histories. DBT is grounding and stabilizing, there is coaching in between planned sessions, and the focus is on validation and radical acceptance without moral judgement. RISE Project staff worked collaboratively with participants and their social supports to identify their needs, strengths, and goals. RISE Project staff inspired and invited youth to participate by weaving lessons, coping skills, and therapy into every day social interactions rather than implementing formal and restrictive sessions. Thus, activities were often conducted in tandem with another activity focused on building the relationship such as a hike, meal, or other outdoor/community excursion.

Survivors of CSECY have experienced severe disruptions to their caregiving relationships as their exploitation often starts as abuse or neglect by parents or other caregivers. Exploiters take advantage of youth’s’ need for love, belonging, and purpose, and provide these along with other basic needs (e.g., food, clothing, shelter) to secure a relationship with youth who have not experienced acceptance by their families and/or communities. Youth will run from their families seeking love, acceptance, and belonging even if it puts their food, clothing, and shelter needs at risk. Thus, exploiters recruit youth by forming a “loving” relationship with them and making the youth feel accepted. Once this relationship has been developed, exploiters start to manipulate youth by controlling their access to food, clothing, and shelter. This type of abuse causes disrupted attachments that can only be healed through restorative relationships with a new caregiver (e.g., therapist, counselor, other support person) who can remain stable. Thus, rapport and trust building with survivors of CSECY is of paramount importance and teams must remain stable and open to a years-long relationship with each participant in order to maintain the secure attachment relationship that is so critical for healing and personal development.

Survivors of CSECY are more likely to be vulnerable within their own families and communities. That is, youth with nonconforming racial/ethnic or sexual/gender identities are less likely to have needs of love, belonging, and acceptance met and are therefore more likely to be targeted by traffickers. Thus, youth who are multiracial or gender and/or sexual minorities (GSM) are disproportionately represented amongst survivors of CSECY. RISE Project programming includes social enhancements designed to help participants work through issues related to their intersecting identities and build self-awareness including classes in yoga; meditation; intentional thinking; interpersonal skill-building; artistic self-expression; self-care through hygiene, diet, exercise and cosmetology; vocational skill-building and spiritual awareness; and psychosocial education on gender oppression, the impact of cultural norms, emotional/social/biological effects of trauma, socioeconomic inequalities, racism and sexual health.
Throughout your journey with RISE Project, we will support you to uncover and live your “true self;” the YOU that has always been there wisely waiting for a safe space to be the “Real Me”. There were reasons why you needed to protect yourself and survive the way you did. Those choices you made were based on what you believed you needed to do to survive in the moment...you are here now and safe so those choices worked. Now we invite you to practice “Being the Real Me” so you can take the “Leadership” role in your own life and break the chains of abuse, exploitation, pain, broken relationships, incarceration and addiction that kept you from creating the life you want...to become a "Thriver"!
ENGAGING PARTICIPANTS: OVERVIEW OF SERVICES PROVIDED

After extensive planning and pilot testing, on July 1, 2017, the RISE Project implemented a detailed daily service provision tracking process aligned with their triage system of intervention. From July 1, 2017 to June 30, 2019, the RISE Project implemented the daily triage system with an Excel form to bring attention to each the RISE Project participant and identify their needs at that moment. The RISE Project staff set immediate, short-term, and longer-term goals after reviewing the triage system. As each goal was met, the RISE Project staff logged the activity. First and foremost, tracking assisted RISE in meeting the needs of their participants. In addition, the tracking assisted with billing and understanding the frequency and duration of various RISE Project services. Finally, these detailed data are ideal for in-depth understanding of what services and activities RISE Project staff offered and provided to participants.

The RISE Project tracking system consists of ten services categories (therapy, rehabilitation, medication support, rehabilitation health and wellness, plan development, assessment, case management, participant support, crisis intervention, and pre-consumer). Within each category are detailed subcategories. Each service for each girl is tracked on a daily to weekly basis during team meetings.

In 2018-2019 the RISE Project transitioned to a web-based database, Vertical Change, to more efficiently track triage data and readily report results. Staff continued to complete the Excel tracking sheet while the database was being contracted and developed. With feedback during the process of evaluation, the RISE Project team streamlined and updated the triage categories to make sure they best reflect the RISE Project model moving forward. This process of continual program improvement based on evaluation and feedback is critical to optimizing services. Once the database was developed, all historical triage data were uploaded into the system. Results reported in this report are based on the uploaded and entered data reflecting services assigned from July 1, 2018 to June 30, 2020.

**Services**

The RISE Project offered a wide range of services to respond to the high level of need among their participants. Therapy and rehabilitation services are offered to address mental health and developmental needs. To respond to basic living needs, the RISE Project also offered medical, legal, and housing support. To assure that participants receive adequate, appropriate, and accessible services, they offered many supportive services, such as transportation. Services were selected based on participants’ goals, needs, strengths, and stage in life.

Overall, triage reporting captured 6,165 activities over the two-year period. The following chart displays the number of each broad service category provided to RISE participants. As displayed, participant support (e.g., transportation, scheduling, housing support, legal support, educational support) were by far the most commonly provided at 38.7%. Other key services unique to the CSEC survivor population that provide a therapeutic benefit include removing tattoos or other scars and visual disfiguration that exploiters used to “brand” the girls or providing dental work to help girls have confidence in their smile. While these services are not all traditional therapeutic interventions, they are critical for restoring health and wellness for CSECY survivors.
Broad Service Category | Category Description as Implemented
--- | ---
Client Support | These activities facilitate access to assessment and treatment and include transportation, scheduling, parent/family support, and interpretation.
Plan Development | Services that consist of development of client plans, approval of client plans, and/or monitoring of client’s progress including consultations, treatment meetings, and case conferences.
Case Management | Case management services support the accessibility and fit of services.
Rehabilitation | Rehabilitation includes, but is not limited to, assistance in improving, maintaining, or restoring a client or group of clients’ functional skills, daily living skills, social and leisure skills, personal hygiene skills, meal preparation skills, and support resources.
Assessment | Assessments determine participant’s mental health needs and diagnoses, past traumas, medical conditions, life circumstances, and strengths.
Rehabilitation | Health & Wellness activities include yoga, linking to alcohol/drug support, medical appointments, meditation, and reproductive health.
Therapy | Therapy sessions are face-to-face services designed to respond to the mental health and substance abuse needs of participants and their families.
Pre-Consumer | Clients are still in engagement and have not been opened or had an intake.
Medication Support | All medical support services are done with a RISE advocate involved to ensure participant’s comfort and trust.

The RISE Project team adjusted the categories to reduce redundancies across and within domains. Triage data tracking helped RISE Project staff manage caseloads and attend to outstanding needs. The data also helped identify what configuration of services were needed for participants over time so appropriate staffing levels could be determined.
INCREASE ENGAGEMENT FOR LGBT/GNC CSEC YOUTH

One of the goals of the Innovations extension is to “increase outreach and engagement efforts for LGBT/GNC CSECY youth.” The LGBT/GNC (Lesbian, Gay, Bisexual, Transgender, Gender Non-Conforming) Tool aims to better understand the sexual orientation, gender identity, and gender expression of RISE participants. This tool is important because youth with minority sexual orientation or gender identity are common within the population of youth at-risk for CSECY. For example, research of girls in the juvenile justice system have found that compared with one, White, straight girl from the general population, a White LGQ girl is eight times more likely, a Black LGB girl is 71 times more likely, and a mixed racial identify LGB girls is 265 times more likely to be incarcerated (Reclaiming Future, 2017). Youth who identify as LLGBT/GNC may require specialized treatment to process experiences of discrimination and/or support identity development.

The LGBT/GNC Tool asks participants to provide their sex assigned at birth and then rate their gender identity, gender expression, sexual attraction, and emotional attraction on a scale from 0 to 10 for Female/Woman/Girl, Male/Man/Boy, and Other Gender(s). The survey also allows for any notes about a participant’s gender identity or sexual and emotional attraction. Overall, this tool allows program staff to address gender identity and expression with youth consistently and without bias. This tool, and results of the pilot implementation can be found in the Appendix. In the future, we recommend that clinicians implement the LGBT/GNC tool to facilitate the incorporation of key identity factors in the therapeutic process. Additional use of this tool will help understand its utility as a clinical tool.

INCREASE ATTENTION TO RACE, ETHNICITY, CULTURE, AND DISCRIMINATION

Youth from certain racial/ethnic groups have been historically underrepresented in mental health treatment and in the research and evaluation of evidence-based treatments including African American, Asian Pacific Islander, Hispanic/Latino(a), and indigenous Native Americans. To better attend to race, ethnicity, and culture in providing services to RISE Project participants, the evaluator worked with the clinical team to develop the Race, Ethnicity, Culture, and Discrimination Tool. This semi-structured interview, administered by a clinician as they get to know a client, asks participants to report their racial/ethnic background and what racial/ethnic background other people thing they are. It also asks open-ended questions about cultural traditions, family roles, birth location of family members including parents and grandparents, experiences of discrimination due to racial/ethnic background, information about languages spoken, immigration, and legal status (in confidence, if appropriate). The tool also includes measures of racial socialization, ethnic identity, and experiences of discrimination including what the client felt was the main reason for experiences of discrimination (e.g., gender, race, age, religion). This tool, and results of the pilot implementation can be found in the Appendix. We recommend clinicians adopt this tool in their clinical practice when working with youth from backgrounds that have been historically underserved and discriminated against. Additional use of this tool will help understand its utility as a clinical tool.
INCREASE PARTICIPANT STRENGTHS

The CANS identifies youth’s strengths, which are the areas of life where they are doing well or have interest or ability. A rating of “0” indicates a “centerpiece strength” and a rating of “1” indicates a “useful strength.” The following table displays the percentage of RISE Project participants who was rated with a “0” or “1” at intake, six months, 12 months, and 24 months. Each time point includes all youth who were given a CANS at that time point.

% Youth with Strengths at Each Time Period

The most common strength at intake was Educational (54.8%) followed by Talents and Interests (45.2%), Natural Supports (37%), Family Strengths (28.1%), Spiritual Religious (24.4%), Community Life (23.7%), and Interpersonal (17.8%). At subsequent CANS time points, more participants were rated with having most strengths. Educational, Natural Supports, and Interpersonal Strengths had the biggest change in percent of participants with these strengths. Talents and Interests, Family Strengths, Spiritual Religious, and Community Life had smaller changes in the percent of participants with these strengths.
CANS Strengths Domain Change from Intake to 12 months

A crosstab visualizes change between CANS assessments administered at two time points. Each cell shows how many times a pre-post score pair occurred. Green indicates positive change, grey indicates no change, and red indicates negative change. The boldness of the color indicates how prevalent the change was. The following tables depict change for each RISE Project participant with matched intake and 12-months CANS.

Change in Strengths from Intake to 12 Months (n = 67)

<table>
<thead>
<tr>
<th>Interpersonal (32.8% positive; 23.9% negative)</th>
<th>Family Strengths (29.9% positive; 43.2% negative)</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Interpersonal Table" /></td>
<td><img src="image2" alt="Family Strengths Table" /></td>
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</table>

<table>
<thead>
<tr>
<th>Educational (44.8% positive; 20.9% negative)</th>
<th>Talents &amp; Interests (38.8% positive; 35.8% negative)</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image3" alt="Educational Table" /></td>
<td><img src="image4" alt="Talents &amp; Interests Table" /></td>
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<table>
<thead>
<tr>
<th>Spiritual Religious (31.3% positive; 31.3% negative)</th>
<th>Community Life (25.4% positive; 41.8% negative)</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image5" alt="Spiritual Religious Table" /></td>
<td><img src="image6" alt="Community Life Table" /></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Natural Supports (29.9% positive; 35.8% negative)</th>
<th>Note: Without an experimental design including a control group it is impossible to know how these strengths would have increased or decreased without intervention.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image7" alt="Natural Supports Table" /></td>
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</table>

At a program level, results suggest that RISE Project participants had the most positive growth in Educational, followed by Talents and Interests and Interpersonal. Strengths that were more likely to be lower one year after intake for matched participants included Family and Community Life.
DECREASE PARTICIPANT NEEDS

The CANS identifies youth’s needs to help with level of care and service planning. A rating of “3” indicates that the youth needs immediate or intensive services, a rating of “2” indicates that the youth needs help, a rating of “1” indicates monitoring, and “0” indicates that nothing is needed at the moment. The following table displays the percentage of RISE Project participants who was rated with a “0” or “1” at intake, six months, 12 months, and 24 months for the highest needs indicated at intake (above 50% of participants). Each time point includes all youth who were given a CANS at that time point.

The most common need at intake was Social Functioning (66.6%) followed by Family Functioning (64.4%), Depression (61.5%), Adjustment to Trauma (60.7%), School Achievement (55.5%), Anxiety (54.8%), and Living Situation (54.8%). Social Functioning, Family Functioning, Depression, School Achievement, and Living Situation saw large decreases in the percentage of youth with these needs at 12 months. Adjustment to Trauma and Anxiety had smaller changes in the percent of participants with these needs. Charts of the additional CANS needs are provided in the Appendix.
CANS Highest Needs Domain Change from Intake to 12 months

A crosstab visualizes change between CANS assessments administered at two time points. Each cell shows how many times a pre-post score pair occurred. Green indicates positive change, grey indicates no change, and red indicates negative change. The boldness of the color indicates how prevalent the change was. The following tables depict change for each RISE Project participant with matched intake and 12-months CANS.

Change in Highest Needs from Intake to 12 Months (n = 67)

Social (32.8% positive; 28.4% negative)

<table>
<thead>
<tr>
<th>Initial CANS Score</th>
<th>12-Months CANS Score</th>
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<tbody>
<tr>
<td>0</td>
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Family (40.3% positive; 25.4% negative)

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<tr>
<th>Initial CANS Score</th>
<th>12-Months CANS Score</th>
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Depression (35.8% positive; 35.8% negative)

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<tr>
<th>Initial CANS Score</th>
<th>12-Months CANS Score</th>
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<td>0</td>
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Adjustment to Trauma (34.3% positive; 29.9% negative)

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<tr>
<th>Initial CANS Score</th>
<th>12-Months CANS Score</th>
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Anxiety (23.9% positive; 20.1% negative)

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<th>Initial CANS Score</th>
<th>12-Months CANS Score</th>
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School Achievement (35.8% positive; 34.3% negative)

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<thead>
<tr>
<th>Initial CANS Score</th>
<th>12-Months CANS Score</th>
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Living Situation (37.3% positive; 20.9% negative)

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<tr>
<th>Initial CANS Score</th>
<th>12-Months CANS Score</th>
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Note: Without an experimental design including a control group it is impossible to know how these needs would have increased or decreased without intervention.

At a program level, for the highest percentage needs at intake, results suggest that RISE Project participants had the most needs reduction in the areas of Family, Living Situation, School Achievement, Depression, Adjustment to Trauma, and Social. Anxiety had less change, either positive or negative.
A consumer survey was developed by the RISE program developer to obtain detailed information from RISE participants about their perspectives about themselves and the services they are receiving. In addition to open-ended feedback, the RISE Consumer Survey asked participants questions designed to quantify their satisfaction with RISE and related services. The first set of questions asked RISE girls several questions about RISE and how well they feel supported by various aspects of their treatment. The second set of questions asked RISE girls if they had received a particular service and if so, how supported they felt on a five-point scale from Strongly Disagree to Strongly Agree.

RISE Program staff administered 59 consumer surveys to 48 RISE participants between December 2016 and June 2020. Girls were asked to provide feedback about the RISE Project and related services. They were assured that their responses would be confidential; only a number was used to track their surveys, not their names.

The first question was, “As a survivor of many challenges, please give us 3 words to describe yourself.” The following figure presents the words girls selected, with the size of word related to how often it was selected and the color randomly applied. For example, strong, the most frequently endorsed self-description, was mentioned in 19 of 59 (32%) surveys. Other particularly common words were nice (17%) and caring (15%).
Qualitative Feedback
The following open-ended questions were posed for participant feedback. Two questions were added in 2020-2021 and have fewer responses ($n=10$; What can Medical Professionals do so they can help you do better? and What can Victim Witness Advocates do so they can help you do better?). This feedback is important to incorporate in program improvement efforts. For example, one RISE participant expressed the desire to be allowed to speak at her court hearings, which was feedback given back to the judges. Responses were grouped by major themes, which are reported here for each question along with one example.

**What has been the MOST helpful part of the RISE Project?**
- Being able to talk to and trust people (“they actually talk to us and show they care”)
- Getting things I need (“The resources they had for me, when I needed it”)
- Expressing emotions (“They help me when I am mad”)
- The support (“They make me feel I’m worth it and can do anything I want”)
- Learning coping skills (Learning new coping skills and helping me get on track…”)
- Monitoring (“…no matter what, someone is always checking up on you”)
- Safety (“…helping me be safe”)

**What has been the LEAST helpful part of the RISE Project?**
- Overprotective (“When they get overprotective, scared, and fearful”)
- Need more RISE (“They’re not located in SB”)
- It’s all helpful (“It’s all helpful and I appreciate the RISE program very much”)
- Access (“I never get to see the RISE program on the outs because I’m never home”)
- When staff leave (“Ally leaving”)
- None (“Nothing”)
- I don’t know (“I don’t know”)

**What do you see as the biggest obstacle to reaching your goals or dreams?**
- Negative peer influences (“Staying away from bad people”)
- Education & Employment (”Not graduating;” “Get a job”)
- Myself (“My bad habits and procrastination”)
- System involvement (“Being on probation;” “Jail/being incarcerated;” “My social worker”)
- Drugs (“Staying sober”)
- Family (“Not having a home for me and my daughter”)
- Documentation status (“I’m worried about becoming documented”)
- Need structure (“Lack of structure”)

**What can RISE do to help you reach your goals and dreams?**
- Maintain support (“Continue to be there for me when I’m doing good or bad”)
- Provide support (“Come with me to do new things”)
- Help with schoolwork (“Support with my homework if they can”)
- More programs (“Having more things/programs available”)
- Advocate more (“Advocate more often in court”)
- Help get jobs (“Help me look for a job”)
- Family help (“Wants to spend more time with family”)
- Documentation (“If there is anything they can do to get documented”)
- I don’t know
What is the best way RISE can encourage participation of your family and/or other supportive individuals to help you reach your goals?

- Tell them about RISE (“Tell them about RISE”)
- Meet with family (“Have a meeting with my family or call my family”)
- Family therapy (“Maybe family therapy”)
- Help my family understand me (“Listen to what I want not what they think I need”)
- Encourage family (“Encourage them to come with me to do new things”)
- Rewards (“Small rewards”)
- I don’t want family to be involved (“I don’t want my mom to be involved at the time”)
- Maintain support (“Just keep supporting me”)
- I don’t know
- Nothing (“Nothing”)

What can Law Enforcement do so they can help you do better?

- Don’t manhandle me (“They could try to calm me down instead of provoking me”)
- Help me (“Just be supportive”)
- Be more understanding (“Don’t assume. Don’t accuse.”)
- Get more programs (“The could help me with programs.”)
- Monitor me (“They try to help me by putting me on GPS or EM”)
- Don’t lock me up (“Not lock up people for minor things”)
- Family support (“Let me go with family”)
- I don’t know
- Nothing (“Nothing”)

What can Juvenile Probation do so they can help you do better?

- Be more understanding (“Learn about what I went through!!!”)
- Program referrals (“Help provide drug counseling”)
- Less punishment (“Stop locking me up for dirty tests”)
- It helps me (“It helps me stay on track”)
- Do more (“They should check on me a little bit more…”)
- Leave me alone (“Get me off probation”)
- Be fair (“Treat us fairly”)
- I don’t know

What can Juvenile Court do so they can help you do better?

- Be more understanding (“See how hard I am trying”)
- Better interventions (“Give programs that help…”)
- Not put me on probation (“Not put me on probation”)
- Treat us better in court (“Give us a chance to speak!”)
- More time between court (“Just extend my date to going to court…”)
- Leave me alone (“Leave me alone”)
- Not much (“Not much”)
- I don’t know (“IDK”)
- Not take long for placements (“Not take long for placements”)
- I don’t know
What can Medical Professionals do so they can help you do better?  
- Offer additional support (“braces, etc.;” “not just medication”)
- Nothing
- I don’t know

What can Victim Witness Advocates do so they can help you do better?
- I don’t have one
- I don’t know
- Nothing

What can RISE do to help you if you feel like running away or already “on the run?”
- Helping others understand (“Talk to probation about why I run away or want to run”)
- Talk me through it emotionally (“Talk to me and calm me down”)
- Talk me through it rationally (“They give me the pros & cons & alternatives”)
- Help my living situation (“Talk to us & try to figure out family situations…”)
- Distract me (“Help them find fun programs to get their mind distracted from running…”)
- Help me with food and shelter (“Take us to a shelter”)
- Unconditional support (“Don’t tell! And just give me your # so if I need help…”)
- Turn me in (“To encourage me to turn myself in or to tell on me”)
- Not sure (“I can’t think of anything”)

What would you say to someone who has very little knowledge or understanding of what it’s like to be a survivor or a young woman who has faced many difficult or painful experiences?
- Share experience (“Explain to them maybe my story…”)
- I would not share (“Let them be. They’ll never know why I am the way I am…”)
- Understand (“Don’t judge a book by it’s cover, you don’t know what it’s like…”)
- Encourage (“You are not what happened to you”)
- Instruct (“Don’t go on the run, it’s not worth it”)
- I don’t know (“I don’t know”)

Survey Scale Questions Part 1
In addition to open-ended feedback, the RISE Consumer Survey asked questions to quantify participant satisfaction with RISE and related services. The response options were changed in 2019-2020 to ease clarity of options for participants. Instead of “strongly disagree,” “disagree,” “neither disagree or agree,” “agree,” and “strongly agree” the survey offered “yes,” “unsure,” and “no.” All previously administered surveys were translated into this response scale such that “yes” was inputted for all responses of “strongly agree” and “agree,” “unsure” was inputted for all responses of “neither disagree or agree,” and “no” was inputted for all responses of “strongly disagree” and “disagree.”

The first set of questions asked participants questions about RISE and how well they feel supported by various aspects of their program. As can be seen in the table, the majority of RISE participants were positive about RISE; for example, 91% agreed that “yes” they have a good relationship with all or most RISE Staff, 95% agreed that they feel RISE tries to be responsive to what they need, and 96% agreed that they feel heard by RISE. Moreover, only 6% of participants felt that “yes” RISE Staff are judgmental. In contrast, only 71% responded “yes” I feel supported by my family to reach my goals.

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2 This item was introduced in 2019-2020 and has a small number of respondents.
and dreams” and 46% responded “yes” “I feel supported by my community to reach my goals and dreams.” Detailed results are displayed on the following page.

**Survey Scale Questions Part 2**
The second set of questions asked participants if they had received a particular service (% of participants who had contact with each organization is reflected in parenthesis next to each program name) and if so, how supported they felt. The questions and the percentage agreement are presented in the following table. Several items were added in 2019-2020 (medical provider, Runaway Girl, hospital, mental health provider, substance abuse provider, and Victim Witness Advocate; thus, these items have very few responses). Participants were most likely to feel supported by RISE (100%), Rape Crisis (95%), HART Court (89%), or SB163/WRAP (88%). Detailed results are displayed on the page following results of the first set of questions.
RISE Project Feedback

- I have a good relationship with all or most RISE staff: 71% Yes, 19% Unsure, 10% No
- I feel RISE tries to be responsive to what I need: 93% Yes, 7% Unsure, 0% No
- I feel supported by my community to reach my goals: 46% Yes, 26% Unsure, 29% No
- I feel RISE would advocate for me with Probation: 98% Yes, 0% Unsure, 2% No
- RISE has helped me with managing my emotions: 91% Yes, 0% Unsure, 0% No
- RISE has helped me work towards my goals: 91% Yes, 7% Unsure, 2% No
- I feel RISE tries to be available when I need them: 95% Yes, 5% Unsure, 0% No
- I feel heard by RISE: 96% Yes, 4% Unsure, 0% No
- RISE Staff are judgmental: 6% Yes, 7% Unsure, 87% No
- I feel RISE tries to be responsive to what I need: 95% Yes, 5% Unsure, 0% No
- I have a good relationship with all or most RISE staff: 91% Yes, 9% Unsure, 0% No
Note: In parenthesis next to each program name is the % of participants who had contact with each organization.
#3: INTER-AGENCY COLLABORATION AND IMPACTS ON IMPROVED RECOGNITION AND RESPONSE

Central to RISE Project success was the pre-planning process and ongoing collaboration between all partners including: Law Enforcement, Juvenile Probation, Juvenile Courts, Public Defender, District Attorney, Rape Crisis, DSS, Victim Witness, Santa Barbara County Human Trafficking Task Force, Department of Behavioral Wellness, Local Schools, UCSB, Medical Community, EMTs, Community Based Organizations, Guardians, Foster Parents, Peers/Mentors/Survivors, Spiritual Community and others. These collaborative partnerships have been key in shifting the community toward a CSEY or Trauma Informed Lens and changing the culture from criminalization to treatment and support.

Survivors were referred to the RISE Project primarily through Child Welfare Services (CWS) based on suspected child abuse reports and/or survivor Commercial Sexual Exploitation-Identification Tool (CSE-IT) screening. Identification of risk or experience with CSECY results in a referral. The RISE Project also received referrals from the Juvenile Hall through the Probation Department’s screening process with the First Responder Identification Tool (FRIT). The Probation Department also completes a Suspected Child Abuse Report (SCAR).

Multidisciplinary Teams (MDTs) are staffed by CWS to engage various agencies in youth treatment. MDTs may result in a referral from CWS or Probation to the RISE Project. MDT meetings are conducted over the phone to problem solve. MDT agreements include multiple half-hour slots open every week for any case that comes up. There is an open invitation to all partners including Sheriff, Probation, police departments and nonprofits focused on rape crisis.

Santa Barbara County District Attorney Joyce Dudley established Santa Barbara’s Human Trafficking Task Force (HTTF) in 2013 and the first local conviction of a human trafficker occurred in 2015. The goal of the HTTF is to assess the scope of the problem locally, offer access to training opportunities, develop protocols, and improve law enforcement and victim service response. The task force is comprised of state, and federal law enforcement agencies, as well as non-profit and faith-based organizations. RISE has been a key member of the HTTF since its inception.

<table>
<thead>
<tr>
<th>Evaluation Goal #3: Interagency Collaboration and Impacts on Improved Recognition and Response</th>
<th>Objective</th>
<th>Met?</th>
<th>Evidence</th>
<th>Barriers</th>
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<tbody>
<tr>
<td>CSECY Interagency MOU</td>
<td>Met</td>
<td>An MOU was developed and executed.</td>
<td>Maintaining trust and collaboration over time.</td>
<td></td>
</tr>
<tr>
<td>Participant referrals and interagency collaboration</td>
<td>Met</td>
<td>Multidisciplinary Teams included RISE; HART Court was developed, approved, and functioning.</td>
<td>Engaging schools, medical professionals, and additional service providers in the MDTs.</td>
<td></td>
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<tr>
<td>Increased public awareness of CSECY</td>
<td>Met</td>
<td>Media coverage, consultation requests, &amp; county partner resources</td>
<td>Continuing to address myths and sustain trainings</td>
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DEVELOPING A CSECY INTER-AGENCY PROTOCOL MOU

Prior to 2015, the need to develop a CSECY protocol arose in Santa Barbara County in part when it was discovered that many youth impacted by CSECY were being arrested and detained in Juvenile Hall, both because they were considered to be engaging in prostitution and because this was the only place where they could be kept safe from their exploiters. Simultaneously, the Department of Behavioral Wellness (Behavioral Wellness) decided to apply for Mental Health Services Act (MHSA) Innovation funding to create a program dedicated to serving the unique mental health needs of youth that had been sexually exploited, reflecting the findings at Juvenile Hall. To substantiate what was mostly anecdotal at that time, Behavioral Wellness began conducting mental health assessments of all Juvenile Hall female inmates, and the assessments determined that a high percentage of survivors had been sex trafficked/sexually abused. Potential CSECY victims were identified through Juvenile Hall or through reports to Child Welfare Services. Less often, youth first would come to Behavioral Wellness for children’s services, where it was determined that they had been sexually abused or exploited. Fortunately, the MHSA Innovation funding was awarded and the RISE Project was implemented.

In addition, the work of the District Attorney’s Office (DA) and its Victim Witness Unit helped coordinate the Human Trafficking Task Force, a joint effort between law enforcement, the DA’s Office, Victim-Witness Unit, and Child Welfare Services to proactively investigate and prosecute those engaging in sex trafficking activities. Recognizing the overlap of these efforts was the first step in determining that a systematic, coordinated effort to combat CSECY was needed in Santa Barbara County.

BARRIERS AND CHALLENGES
A key to overcoming impasses in creating an MOU was to assure each participating department that they would not have to do more than they already did in providing support to Survivors. Establishing robust inter-department communications facilitated trust, a key operational change.

Regular meetings between the parties, including the Triage Team meetings, provided a platform to discuss specific cases, learn how to problem solve together, and build relationships. Each time a CSECY survivor was provided support by these collaborative efforts, parties gained more trust in the process. A common phrase for characterizing the development of this program was “trying to fly the plane while building it.” The parties to the MOU learned that they did not have all of the answers, but by collaborating, they could reach a better decision for the youth than they could alone. Willingness to discuss how to continue to improve the program led to trust.

SUCCESSES
The Santa Barbara County Protocol MOU was executed in 2016 and has undergone a number of revisions. Although some of the initial members of the effort continue to support the CSECY Program, there has been significant turnover at the executive, program manager, and staffing levels. With department responsibilities clearly outlined in the protocol MOU, the departments remain clear on their respective performance expectations to sustain the MDTs. Consequently, the collaborative work continues as new staff step into defined roles.

The protocol MOU called for the development of a Steering Committee composed of representatives from each of the member departments. The role of the Steering Committee is to provide oversight and leadership for the CSECY Program and to ensure that the MDTs and other collaborative efforts are working as intended. This Steering Committee meets quarterly with an agenda dedicated to updates, addressing challenges and determining priorities. Action items are assigned after each meeting so that progress can be tracked at the next regular meeting.
Santa Barbara County Department of Behavioral Wellness had to establish that multidisciplinary work with added value to the team. It did this by taking responsibility for some of the difficult and uncomfortable work tied to bringing the survivors in to care, coordinating the services that the survivors needed, initiating necessary MDTs, and reaching out to the various agencies asking them for their respective supportive services, as needed. Santa Barbara County Department of Behavioral Wellness took the lead on amending the CSECY MOU and working toward building trust.

After the first year of operations, the Steering Committee agreed that it would be a wise investment to hire a CSECY Coordinator, employed by the Department of Social Services. The job of the Coordinator is to facilitate the implementation of MDTs and assist with linking Survivors to recommended services and supports; provide outreach to other CSECY related organizations such as community-based organizations, advocacy groups, and families; participate in various County CSECY meetings; monitor program performance; and plan and implement CSECY related trainings. Having an individual dedicated to these functions relieved other CSECY department members from doing these tasks. This decision further improved trust between the parties since State money had been invested in a manner that benefited all CSECY partners, not just one or two.

LESSONS LEARNED

- Multi-agency collaborations span disparate geographical regions, personalities, and organizational cultures. The single greatest impediment to success is a lack of consistent protocols, policies, and procedures.
- Even though all the legally-specified parties were unable to join the initial protocol MOU, the group proceeded with creating the MOU with the parties that were interested. By launching the MOU with the engaged parties, the effort is more likely to be a success. Once the other parties understand how the MOU works, and that the collaboration is effective, they will be more willing to join. Trying to get everyone to the table initially would have resulted in the MOU effort being scrapped.
- Organizing department representatives around their tasks was an effective way to get buy-in, since it provided departments with assurances that they were not being asked to take on more work than they already were doing.
- Define departmental responsibilities in a clear, detailed manner that will ensure that as program and staff changes occur, the key responsibilities under the protocol MOU may be maintained.
- Meet regularly to discuss MDT cases, what is working, and what may be done better. Regular meetings with an agenda and clear purpose help improve working relationships, leading to increased trust among the parties.
- Don’t wait to finalize the protocol MOU simply because every detail is not in place. It is better to keep things simple at the outset, knowing operations can expand later. In fact, the MOU should be considered a living document that is reviewed regularly and updated as needed. The work being performed by the group will change, and the MOU should be kept up to date to reflect those changes.
- Invest in the collaboration overall and not just in one Department. Come to consensus and invest in solutions that help all of the departments.
- To the fullest extent possible, all first responders should be on the same page regarding key issues like confidentiality, release of information, and information-sharing.
PARTICIPANT REFERRALS AND INTERAGENCY COLLABORATION

Interviews with RISE Staff provided details, summarized below, about how inter-agency collaboration impacts work to recognize and respond to CSECY.

Participants are referred to RISE primarily through CWS based on suspected child abuse reports (SCAR) and/or participant CSE-IT screening. Identification of risk for or experience of CSECY results in a referral to RISE. RISE also receives referrals from the juvenile hall through probation’s screening process with the FRIT; probation also completes a SCAR.

Multidisciplinary Teams (MDTs) are staffed by CWS to engage various agencies in youth treatment. MDTs may result in a referral from CWS or Probation to RISE. MDTs are conducted over the phone to problem solve. MDT MOUs include multiple half-hour slots open every week for any case that comes up. There is an open invitation to all partners including Sheriff, Probation, Police Department, and Rape Crisis. The MDT flow chart is available on the following page.

The Helping to Achieve Resiliency Treatment Court for Commercially Sexually Exploited Children (HART Court) was developed in 2017 and provides referrals to RISE. HART Court was developed to address the needs of the youth instead of detaining and locking them up. The District Attorney, Public Defender, Probation, Behavioral Wellness, and Rape Crisis staff the HART Court. HART Court is designed for participants in the criminal justice system who have experienced CSECY. HART has mandatory treatment; thus, RISE Participants will occasionally decline HART Court services to work directly with a probation officer. The benefit to participants is that they have a treatment team regularly reviewing their case. HART Court also prevents detention at juvenile hall.

RISE staff note that they are starting to receive referrals from schools, which demonstrates the extent to which RISE services have been made known to partners who focus on all students and not just those students who are system involved. RISE staff have started to participate in Student Attendance Review Board hearings to engage youth at-risk for CSECY in services before they become system involved. RISE staff note that screening amongst the special education population is important due to their risk for CSEC and would like to see more formal screening occur in alternative schools and diversion settings.

RISE staff noted the need for consistent screening and protocols in hospitals and medical settings. They noted that some hospitals in our region have structured response tools and others do not. For example, a youth in one emergency room was in foster care, yet hospital staff allowed her trafficker to come visit her multiple times (he said he was her uncle) and she still had her cell phone. This participant had a 5585 psychiatric hold for harm to self, harm to others, or grave disability. A consistent protocol would have enhanced the likelihood that this girl was protected from further exploitation.
INCREASED PUBLIC AWARENESS OF CSECY

Media Evidence of Recognition and Response to CSECY
There has been a significant increase in response to CSECY since the inception of RISE and the HTTF continues to be leader alongside RISE in recognizing and responding to CSECY. The following media coverage provides examples of recent responses:

Yamamura, J. (November 5, 2019). Santa Barbara Awarded $1.5 Million to Fight Human Trafficking: Grants to Help Hunt Down and Prosecute Perps and Provide Services for Victims

Texas Governor’s Office Consultation
After presenting at the H.E.A.T. (Human Exploitation and Trafficking) Institute in 2016, the Texas Governor’s Office was impressed and requested consultation the RISE Project and a site visit. The RISE Project shared program materials and evaluation protocols through phone consultation and a one-day site visit.

County Partners Build Resources about Child Trafficking
Office of the Santa Barbara County District Attorney Human Trafficking Task Force
Santa Barbara County Child Welfare Services Website about Child Trafficking
Santa Barbara Hope Refuge is dedicated to seeing that every sex trafficking survivor has a place of refuge where they can transition from slavery to freedom. Their mission is to provide a retreat center where programs and services can be offered and to address the trauma, abuse, abandonment, and neglect of a sex trafficking survivor.

The Junior League of Santa Barbara, in partnership with 4 Kids 2 Kids, announced the official opening of S.A.F.E. House Santa Barbara (Saving At-risk Youth from Exploitation) in May 2018. S.A.F.E. House is dedicated to improving the lives of at-risk young women by educating & empowering them to reach their full potential while working to prevent exploitation and injustice in our community.
The RISE Project has been a key partner within the Human Trafficking Task Force (HTTF) to support survivors once they have been identified. The following resources are listed as evidence for funding and other public support for CSECY that has resulted from the partnerships facilitated by RISE. Together partners have provided trainings including developing a documentary that summarizes CSECY in Santa Barbara County. Media coverage demonstrates public support and funding including nonprofit partnerships such as with the Junior League of Santa Barbara. The RISE project has been designated as a promising program, has been presented about at professional conferences, and has been documented in peer-review publication. These are significant accomplishments given the lack of attention to and community awareness of CSECY prior to 2015, when the RISE Project was initially funded.

### Evaluation Goal #4: Increases in Funding and other Public Support

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met?</th>
<th>Evidence</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countywide CSECY Toolkit was developed and published</td>
<td>Met</td>
<td>The <a href="#">Toolkit</a> is posted on the Behavioral Wellness Website and represents a collaborative effort.</td>
<td>Dissemination.</td>
</tr>
<tr>
<td>RISE Project Public Support</td>
<td>Met</td>
<td>RISE documentary; media coverage</td>
<td>Updating the documentary and sustaining media coverage.</td>
</tr>
<tr>
<td>RISE Project Professional Support</td>
<td>Met</td>
<td>RISE was designated as a promising practice; has been presented about at professional conferences; and is published in a peer-reviewed journal</td>
<td>Funding is needed to support the full spectrum of services the RISE Project was able to deliver that TAY-FSPs cannot.</td>
</tr>
<tr>
<td>Increased funding for CSECY</td>
<td>Partially Met</td>
<td>Santa Barbara County District Attorney and Sheriff have been awarded six-years of funding for human trafficking work</td>
<td>Countywide coordination is needed, alongside additional dedicated funding, to support survivors outside the parameters of full service partnerships.</td>
</tr>
</tbody>
</table>

### COUNTYWIDE CSECY TOOLKIT

Santa Barbara County Department of Behavioral Wellness (2020). *Developing an Effective Multidisciplinary Response to Serve Exploited Youth: A Toolkit for Counties, Behavioral Health Departments, and Community-Based Organizations.* Funded by the Mental Health Services Act.
RISE PROJECT PUBLIC SUPPORT

Documentary Developed
Our kids: Sexual Exploitation in Santa Barbara County.

Media Coverage of The RISE Project
Payne, J. (September 7, 2016). Out of the shadows: As human trafficking becomes more visible on the Central Coast, authorities are collaborating in an unprecedented way to prosecute abusers, help victims, and end the cycle. Santa Maria Sun, 17(27) Cover Story. (Appendix E).

Related Media Coverage of Child/Youth Sex Trafficking
HOPE Refuge. (September 13, 2016). Group Offering Refuge from Sex Trafficking to Screen Documentary on Friday. Noozhawk.

RISE PROJECT PROFESSIONAL SUPPORT

RISE Project as a Promising Practice

Examples of Trainings provided by RISE Project and collaborators
Sharkey, J.D., & Conn Akoni, L. (September, 2020). Commercial Sexual Exploitation of Children & Young Adults. A training, with CEUs, tailored for the Santa Barbara County Psychological Association to meet licensure requirements. Delivered via a Zoom Meeting.
Sharkey, J. D., Conn, L., Adam, C. (2018, April). *Our Kids...Our Responsibility: Sexual Exploitation in Santa Barbara County.* Presentation for social workers and psychological staff at Cottage Hospital. Santa Barbara, CA


**Conference Presentation provided by RISE Project and collaborators**


**RISE Evaluation Reports**


Sharkey, J. D. (2018). *RISE Participant Consumer Survey Report* funded by a Mental Health Services Act Innovations Grant to Santa Barbara County Department of Behavioral Wellness. SB, CA


**Peer-Reviewed Publication about RISE**

INCREASED FUNDING FOR CSECY

Grants to Santa Barbara County for CSEY
In October 2019, Santa Barbara County District Attorney and Sheriff were awarded a $1.2 million three-year extension of funding for their human trafficking work.
In September 2016, Santa Barbara County District Attorney and Sheriff were awarded a 1.3-million-dollar three-year grant focused on human trafficking.

Trafficking Action Group is an action oriented, research-driven & strategic work group, catalyzing prevention & intervention efforts to end Commercial Sexual Exploitation of Children & Youth in Santa Barbara County. Developed to fill in gaps with the sunsetting of the RISE Project, TAG seeks to bolster, expand upon and/or accelerate SB Co’s efforts to eradicate sexual exploitation and support victims/survivors compassionately, swiftly and effectively. TAG’s mission is to ensure that all CSE Children & Youth have immediate access to research validated, trauma informed, and survivor driven innovative supports
DISCUSSION

The RISE Project, along with the Santa Barbara County Human Trafficking Task Force, have been leaders in addressing CSECY in Santa Barbara County.

ACCOMPLISHMENTS

The RISE Project provided training to community members and key professional groups such as law enforcement, medical providers, and nonprofit agencies. The RISE Project was critical in developing the infrastructure and maintenance of multidisciplinary team meetings (MDTs) and HART Court (a CSECY-specific treatment court for youth in the juvenile justice system). The RISE Project was also instrumental in developing the FRIT identification tool and the CSE-IT screening assessment and advocating with key agencies (i.e., CWS, Probation, and Behavioral Wellness) to implement identification and screening policies. These protocols were implemented successfully because community agencies were able to refer identified survivors to the RISE Project and know the survivors would receive immediate outreach and engagement. Moreover, the RISE Project provided consultation to other municipalities (e.g., Ventura, Texas Governor’s Office) and local, state, and national audiences (documentary, press releases, conference presentations and peer-reviewed publication) to highlight the hidden and pervasive issue of CSECY and identify and disseminate ways to prevent, identify, screen, and support youth who have been impacted by CSECY. As such, the RISE Project has had a deep and permanent impact on knowledge related to CSECY with numerous lessons learned and future directions generated to continue to build resources and expertise in this area.

The RISE Project developed and implemented new smart tools to better support gender- and cultural-specific goals of services. The LGBTQ/GNC tool helped clinicians open up a conversation about gender identity, sexual orientation, and related topics. While most participants in the pilot study identified as cisgender and heterosexual, the conversations allowed them to express their identities in a nurturing way that acknowledges the many ways gender and sexuality can be felt and expressed. Similarly, the Race, Ethnicity, Culture, and Discrimination Tool helped bring up these topics for discussion and provide psychoeducation to their participants, many of whom have expressed that they are not sure what race, ethnicity, and culture mean. This tool also helped staff proactively discuss experiences of discrimination.

The RISE Project recognized the importance of tracking services and assessments in a nimble database that can link data to participants over time, allow participants to access their own data via a client portal, and provide access levels based on ability to access personal health information (PHI). This is optimal for any evaluation and particularly due to the unique challenges posed by programs that serve CSECY-impacted participants. The RISE Project invested in a flexible and adaptive data collection system, Vertical Change. Although using Vertical Change added another data entry platform for RISE Project staff to use that required a steep learning curve, the goal was to reduce workload due to the ease of collecting data from participants remotely, the availability of immediate reports and data dashboards, the ability of the external evaluator to access the data directly without staff assistance, and the ability to upload data from other sources and have the data linked to participants with a unique identifier. While this process was underway in the final year of the RISE Project, use of the database was still gaining traction when the project ended.

Data from assessments with RISE Project participants indicate that they enter the program with a long history of prior admissions to mental health services and a significant history of adverse childhood experiences. RISE services are heavily focused on participant engagement and outreach as well as
client services. Given their risks and needs, participants are likely to need a long time to engage and benefit from intervention. Fortunately, RISE Project participants also present with a lot of strengths they can build on, and have demonstrated extraordinary resilience.

RISE Consumer Surveys revealed that RISE Project participants tend to be very highly satisfied with RISE Project services and feel supported by the RISE Project staff. This was in contrast to their ratings of other agencies they have interfaced with such as Child Welfare Services. Results provided evidence that the RISE Project was experienced as a safe and supportive program that provided meaningful support and opportunities to participants.

**BARRIERS**

Conducting an evaluation of services for CSECY-impacted youth is essential yet challenging for many reasons. First and foremost, it is impossible to conduct an experimental design with random assignment to treatment modalities as the needs of survivors eclipse any evaluation protocol that requires a wait-list or control group. Moreover, the needs of CSECY-impacted youth are diverse and ever changing. Thus, no participant receives a standard protocol. As programs build capacity, they are likely to add on services and new partnerships to meet the evolving needs of their participants. As CSECY-impacted youth often come in and out of treatment, adhering to regular assessment protocols at standard intervals is challenging. Moreover, survivors may need 3-5 years of treatment before progress stabilizes; thus, longitudinal tracking of participants is critical.

The CANS is a multi-purpose tool used by child-serving agencies to identify and track needs and strengths over time. Moreover, the CANS has developed and implemented a CSEC module. Thus, the CANS may be useful to implement across agencies to track outcomes for all youth (especially when agencies have data sharing agreements with release of information protocols) and also for survivors of CSECY. However, the CANS may be challenging for staff to implement in reliable ways and is a lengthy assessment. Staff reported that the CANS was difficult to rate at intake making comparisons to later assessments potentially unreliable. Thus, caution should be used when interpreting CANS change scores.

**SUSTAINABILITY**

The MHSA Innovation Grant was instrumental to launching the RISE Project but its time limited nature meant that the Department of Behavioral Wellness would need to identify longer term sources of funding to sustain RISE Project services. RISE Project leadership decided this could be accomplished in two ways. First, some of the RISE Project services are reimbursable under Medi-Cal, including assessments, treatment planning, psychotherapy, case management and medication services. Nearly all of the youth the RISE Project encountered were Medi-Cal beneficiaries who were eligible for treatment in our system of care. However, the challenge here was that the majority of RISE Project participants required a great deal of outreach and engagement before they would agree to services, and these activities are not generally reimbursable under Medi-Cal. Second, as the Department was also in the process of launching a Transitional Aged Youth (TAY) Full-Service Partnership (FSP) program under MHSA funding, Behavioral Wellness determined this would provide another source of funding to sustain RISE Project services. FSP programs provide intensive, often field-based services, and have low client to staff ratios and 24-hour availability. Many of the youth served by the RISE Project would qualify for this level of services, and the FSP structure provides funding for much of the outreach and engagement that is necessary to link survivors to longer term care. The RISE Project transition to a TAY-FSP program began in FY 2019-2020.
As a TAY FSP, the RISE Project equivalent will be partially funded by MHSA, which allows a “whatever it takes” approach. This funding source allows money to be used for emergency hotel/accommodation charges, clothes, food, and other basic needs. Moreover, FSPs provide many of the same services offered through the RISE Project (e.g., counseling and psychotherapy, medication and physical care, educational opportunities, treatments for addiction, transportation) and can also provide these services in the youth’s home or community.

On the downside, an FSP is an enrollment-based program and clients must be referred to the program. In order to receive these benefits, survivors will need to be admitted to the program, consent to treatment, and receive mental health services (assessment, treatment plan, rehabilitation, case management, etc.). In addition, if the youth qualifies for Medi-Cal, they will need to be enrolled so that qualified services can be billed to Medi-Cal. What is unknown is how many identified survivors of CSECY will engage in mental health services without the intensive period of rapport and trust building that was found necessary with the RISE Project. As part of the Innovations program, Behavioral Wellness and the RISE Project were able to invest a lot of time in non-clinical activities. The RISE Project team focused on outreach and engagement, and were not always able to determine whether the youth would qualify for or consent to mental health services. Some youth who engaged with the RISE Project and benefited from the outreach efforts of the program (food, clothes, housing, mental wellness services, yoga, meditation, group counseling, and access to the RISE Project space) without ever enrolling in Behavioral Wellness.

Moving forward, a key to engaging all survivors of CSECY, regardless of their readiness for participation in a TAY-FSP, will be coordinating across the county with other agencies and nonprofit organizations to develop continuum of care to efficiently prevent, identify, engage, house and fully support CSECY. The MHSA Innovations funding accelerated Santa Barbara County’s understanding of what innovations it takes within the mental health system of care to accomplish this and found that a) it takes specialized training in CSECY in order to do this work and b) no one agency can tackle this alone. Institutional partners including the district attorney, department of social services, schools, law enforcement, and nonprofit agencies must work together to establish a continuum of care and build capacity until it is possible to eradicate CSECY and identify and serve all children and youth survivors of CSECY.

FUTURE DIRECTIONS

CSECY Earlier Identification
It is critical to provide training and further engage additional partners (e.g., schools and medical providers) in using the FRIT and associated protocols. Existing protocols need to be examined as to the ease and frequency of implementation as well as the number of children and youth who are identified as at-risk or confirmed CSECY. Protocols need to be adjusted to improve procedures as necessary.

CSECY Prevention
A gap in Santa Barbara County prevention remains in providing the required human trafficking education and training; in October 2017, AB 1227, the Human Trafficking Prevention Education and Training Act was passed making California the first state to require human trafficking prevention education training for teachers and students. In addition, this legislation includes educational agencies as eligible to serve on multidisciplinary teams serving CSECY. PROTECT represents a non-profit collaborative that developed materials for teachers of students in grades 5, 7, 9, and 11 to incorporate human trafficking education. This legislation should help promote attention to CSECY in schools and provide critical exploitation prevention education.
**CSECY Intervention**
Santa Barbara County District Attorney and Sheriff continue to work to arrest and prosecute traffickers and buyers while engaging survivors in system supports. In addition, Santa Barbara County Behavioral Wellness has transitioned CSECY services to their TAY-FSP programs. A dedicated CSECY coordinator, who can navigate between systems, and support warm hand-offs between referring agencies (e.g., CWS, Probation), TAY-FSP programs, and non-profit agencies who can provide outreach and engagement services, would fill a gap left in the transition from the specialist RISE Project to a broader-focused TAY-FSP program.

**CSECY Evaluation**
Developing a countywide shared database would allow providers to track survivors across agencies and systems to identify their service history, benefit from past assessments, and identify current and ongoing strengths, needs, and outcomes. Survivors rarely have stable housing and may move frequently; it is not optimal for a survivor to have to start the intake and assessment process over again with each new agency they encounter. Evaluation designs also need to be flexible to track survivor needs, strengths, and outcomes over time while also addressing survivor experiences in the moment. Action research, in combination with standard assessments, may be optimal to help address survivor needs and provide immediate feedback to providers.

**Action research** is designed to continually improve the quality of implementation and effectiveness of the programming. By collecting regular feedback directly from participants about their experiences with various agencies and programs, CSECY programs can make immediate program adjustments, and also advise other agencies to do the same. The RISE Project developed a Consumer Survey. Such a tool should be implemented regularly along with other program measures and periodically reviewed to address results. Feedback to other organizations based on the results should also be scheduled proactively.

Another way to take immediate action with youth participant feedback is to conduct regular focus groups with participants. While program staff or external evaluators could conduct these focus groups (Whaling et al., 2020), an innovative approach that includes youth leadership development is to teach survivor leaders or survivor mentors to run participant focus groups themselves. These survivor leaders/mentors would be trained in focus group methodology and develop the questions they would want to ask. After running focus groups with current youth participants, the leader/mentors would write up the results and provide the feedback to staff in aggregate to keep individual responses private. This provides valuable training to the leader/mentor in giving feedback while allowing the youth participants to potentially feel more secure than they would with a staff member or evaluator.

Finally, Youth Participatory Action Research (YPAR) is a method of research that centers the youth participants as the researchers. YPAR includes youth researchers in every step of the research process and therefore brings forward youth voices and youth expertise to inform the research process (Ozer, 2016). At the same time, YPAR empowers participants and equips participants with valuable knowledge about the research and evaluation process. Youth build skills in research, teamwork, and communication skills. The Institute for Community Research has provided YPAR curriculum. YPAR would be a particularly empowering method of action research to implement with survivors of CSECY.

**Identifying and Tracking Outcomes**
Identifying accurate assessments to assess and track the needs and strengths of survivors is key. An alternative to the CANS, RTI International, has a focus on human trafficking research and prevention. Published in 2020, they developed an easy to use and freely available evaluation instrument called Outcomes for Human Trafficking Survivors (OHTS). This tool is designed to be completed by service providers.
providers about their clients and measures safety, well-being, social connectedness, and self-sufficiency. A webinar about implementing this tool in order to measure outcomes for survivors is available at the Center for Victim Research.

Existing data collected by county agencies may also improve evaluation efforts. For example, Behavioral Wellness collects data on patient acuity: the level and intensity of care required by a participant. A goal might be to reduce the number of psychiatric hospital admissions needed to support participant needs. Behavioral Wellness gathered data related to patient acuity for 110 RISE Project participants. Few had psychiatric hospital admissions six months prior to their admission to the RISE Project (n=9; 8.2%). As displayed in the following chart, psychiatric hospital admissions decreased significantly during RISE Project admission, which was sustained well after RISE Project discharge.

CONCLUSION

Overall, evidence indicates that the RISE Project had a positive impact on awareness of CSECY and the identification, screening, and intervention with survivors of CSECY. Moreover, the RISE Project had a positive impact on dozens of identified survivors who had previously received services primarily within juvenile justice systems including juvenile detention. The RISE Project was instrumental in radically shifting the perspective that services need to be provided in communities to youth wherever they are most comfortable. Unfortunately, CSECY is a lucrative, hidden, and pervasive problem that needs ongoing innovative work to address in Santa Barbara County and beyond. Fortunately, the RISE Project provided Santa Barbara County with the resources and a toolkit to serve as a road map for continuing this important work. The following table
APPENDICES

- Glossary
- First Responder ID Tool
- CSEC Hierarchy of Needs
- LGBT/GNC Tool and Pilot Results
- Race, Ethnicity, Culture, and Discrimination Tool and Pilot Results
- Definition of ACES Categories
- CANS Longitudinal Methodology and Additional Results
GLOSSARY

AOD – Alcohol and other drugs

CBT – cognitive behavioral therapy, a structured form of psychotherapy that creates awareness of negative thinking to help cope with challenging situations more effectively.

CSE – Child sexual exploitation

CSE-IT – Commercial Sexual Exploitation Identification Tool

CSEC – Commercially sexually exploited children or commercial sexual exploitation of children. CSEC is the sexual abuse of a child under the age of 18 years, for the financial benefit of any person, or in exchange for anything of value, including monetary or non-monetary benefits. All commercially sexually exploited minors are victims, regardless of the presence of force, fraud, or coercion. CSEC includes selling/trading a child for economic gains, child pornography, child sex tourism, street prostitution, stripping, phone sex lines, interfamilial sexual exploitation of children, survival sex (e.g., exchanging sex for food or shelter), and other forms of transactional sex like arranged marriages.

CSEY – Commercially sexually exploited youth or commercial sexual exploitation of youth. CSEY has a similar definition as CSEC but of youth between the ages of 18 and 25. Youth 18 years and older do not have the same legal protections, resources, and reporting requirements as minors.

CSECY – Commercial sexual exploitation of children and youth or commercially sexually exploited children and youth

DBT – Dialectical Behavioral Therapy, a type of cognitive behavioral therapy first used to treat borderline personality disorder and subsequently used to treat other behavioral disorders.

FRIT – The First Responder Identification Tool (FRIT) helps professionals who regularly interact with children and youth (e.g., law enforcement officers, juvenile hall staff, probation officers, medical staff, teachers) identify the warning signs of CSECY and make a referral to Child Welfare with a Suspected Child Abuse Report (if under 18) and/or other supports (i.e., 911, mobile crisis teams, or the Behavioral Wellness Access line for service referral) depending on the urgency of concerns.

GSM – Gender or Sexual Minority, which is inclusive of anyone who does not identify as cisgender or heterosexual.

Harm Reduction - Policies and practices aimed at reducing the negative consequences of drug and alcohol use.

HART Court – The Helping to Achieve Resiliency Treatment (HART) Court for Commercially Sexually Exploited Children was established in Santa Barbara County in November 2015 to increase strategic collaboration and ongoing communication between all stakeholder agencies working directly with children who have been commercially sexually exploited.

Hierarchy of Needs – Maslow’s Hierarchy of Needs comprises a five-tier framework of human needs. Basic needs include physiological needs (food, water, shelter) and safety needs (security, safety). Psychological needs include love needs (friends and belongingness) and esteem needs (feeling of accomplishment). Self-fulfillment involves self-actualization, which is achieving full potential. Youth are at-risk for CSECY if their love needs are not being met; youth will leave food and shelter to seek love and belonging.

HTTF – Santa Barbara County Human Trafficking Task Force (HTTF) was founded by the Santa Barbara District Attorney in 2013 in recognition that an interdisciplinary, collaborative, and victim-centered effort is needed to combat human trafficking.

Human Trafficking – Human trafficking involves the use of force, fraud, or coercion to obtain a labor or commercial sex act. Traffickers use force, fraud, or coercion to lure victims and force them into labor or commercial sexual exploitation.

LGBTQ – Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning

MDT – A multidisciplinary team includes a range of professionals from one or more organizations working together to provide comprehensive care to clients/patients.
**MHSA** – California’s Mental Health Services Act (MHSA). The MHSA is funded by a one percent income tax on personal income in excess of $1 million per year and is designed to expand California’s behavioral health system to better serve individuals with, and at risk of, serious mental health issues, and their families.

**MOU** – A memorandum of understanding is an agreement as to the roles and responsibilities of and between two or more parties outlined in a formal document.

**The RISE Project** – Resiliency Interventions for Sexual Exploitation, a Project of the Santa Barbara County Department of Behavioral Wellness.

**Runaway Girl** – Carissa Phelps’s 2012 memoir that cast light on sex trafficking in the United States.

**SCAR** – A suspected child abuse report

**Survival Sex** – Exchanging sex for basic subsistence needs like food, clothing, and shelter.

**Trafficking** – Trafficking means the recruitment, harboring, transportation, provision, or obtaining of a child for the purpose of a commercial sex act

**Victim Witness** – Victim witness programs provide comprehensive and coordinated services to victims of crimes.
FIRST RESPONDER ID TOOL

Youth’s Name:  DOB:  Reporter’s Name:  Date:

FIRST RESPONDER ID TOOL for COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN & YOUTH (CSECY)

- This tool is NOT to be given to the youth or the family to complete.
- To be completed in private by reporting party (not with youth present).
- Do NOT to conduct lengthy interviews w/youth to gather information—all you need is SUSPICION of sexual exploitation.

**Automatic Referral Identifiers** (Only 1 is needed for referral):

- Self or other report of commercial sexual exploitation—includes survival sex (sex acts in exchange for basic necessities, drugs, travel, protection, etc.)
- Picked up, reports or found in motel or known area of prostitution & exploitation
- Using lingo associated with sexual exploitation (see below)
- Older person engaging in “grooming” or “recruiting” tactics (purchasing items, making promises of job/money, offering place to stay/roles/drugs/alcohol, inappropriate social media contact/pictures, etc.)
- Listed on Backpage, Craigslist, Tinder, “dating” sites or other social media for purpose of sex acts
- Has been officially reported as a “Missing Person”, BOL and/or has a Special Pop CSEC Flag within the last 12 months
- Has been missing for extensive periods (more than 24 hours) or traveled out of county without guardian consent or knowledge (even if youth states they went willingly)
- §653.22 PC—type behavior (Law Enforcement only)

**Referral Identifiers** (3 are needed for referral):

- Associating with others involved in sexual exploitation (exploitation victims or traffickers/perpetrators/pimps)
- Brands or tattoos representing CSEC/Exploitation
- Runaway History for shorter periods of time (under 24 hours & runs to a non-familial home or unknown/unsafe place)
- Homeless w/o parent/guardian (couch surfing)
- Under the influence of or known to use controlled substances (meth, cocaine, heroin, prescription pain medication, etc.)
- Allegations of current or past sexual abuse, physical abuse or neglect (regular reporting mandates apply here—also report any suspicions of non-CSEC related abuse to CWS immediately)
- Has money or items that guardians or family did not purchase or give to youth
- In a controlling relationship with an older partner or domestic violence
- Bruises/explaned marks
- Chronic Truancy
- In relative placement, foster or group home care
- Possession of more than 2 cell phone
- Charges for survival crimes or youth has engaged in the following behaviors:
  - Shoplifting/theft of basic necessities (food, clothing, hygiene items, health items etc)
  - Trespassing
  - Panhandling

You must complete a Suspected Child Abuse Report if:

- If youth is under 18 yo
- You identified at least one of the criteria noted in section 1 and/or;
- You identified three or more criteria noted in section 2
- Please identify that you suspect CSEC when making the report and list any statements made by youth, known history or identifiers above that lead to suspected CSEC: Child Welfare Hotline: (800) 367-0166
- If you feel youth is in Immediate danger, please call 911 and request a Welfare Check then complete steps above

Terminology/Warning Signs of Sexual Exploitation:

- Out of pocket
- Bottom
- Bitch/Girl
- Quote
- Stable
- Out
- Daddy
- Ho
- Square
- Track/Glade
- Standing/Hustle
- Pimp
- Drug
- Willy/Thief Family/Sister Wife
- The Life or “The Game”
- Trade Up/Trade Down
- Automatic
- Knock
- Choose Up
- Swag
- Diamond/dollar sign, crown, “property of” tattoo

REMEMBER, ALL YOU NEED IS SUSPICION!
# CSEC HIERARCHY OF NEEDS

## RISE Project Phases-CSEC Hierarchy of Needs

**BIO PSYCHO SOCIAL MODEL**

<table>
<thead>
<tr>
<th>PHYSIOLOGICAL</th>
<th>SAFETY</th>
<th>LOVE/BELONGING</th>
<th>ESTEEM</th>
<th>SELF-ACTUALIZATION</th>
<th>TOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food and clothing</td>
<td>Self care safety plan</td>
<td>Rapport building with first responder</td>
<td></td>
<td>First Responder CSEC ID Tool, SEHS Self Care Safety Plan</td>
<td></td>
</tr>
<tr>
<td>Higienic</td>
<td>Suicide intervention</td>
<td>What makes me shine?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate medical care</td>
<td>Daily Check-In</td>
<td>Assign systems Navigator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynecological care</td>
<td>Trauma-Informed DBT Crisis Interventions</td>
<td>Welcoming intake process into RISE program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate sexual trauma support</td>
<td>Self-soothing supports and tools</td>
<td>Begin to create sense of belonging</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>Short-term goals and initial treatment planning</td>
<td>Identify primary care providers (i.e. therapist, counselor, peer advocate, family, teacher, friend, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuse intervention</td>
<td>“Warm handoffs”</td>
<td>“Warm handoffs”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate placement and planning</td>
<td>Moving On: Am I ready for the next step?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STABILIZATION: “Out of the Fire”**

**COPING STRATEGIES: “Rise and Shine”**

1. Physiological needs: food, clothing, shelter, water, and homeostasis.
2. Safety needs: security of body, employment/education, resources, morality, family, health, environment.
3. Love and Belonging needs: friendship, family, intimacy, connections to others or group.
5. Self-Actualization is the need to “become the most one can be” through mastering how to meet all previous levels of need.
<table>
<thead>
<tr>
<th>MAINTENANCE-Practice Being the &quot;REAL ME&quot;:</th>
<th>LEADERSHIP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Walking in my new shoes&quot;</td>
<td>&quot;Don't talk about it, be about it&quot;</td>
</tr>
<tr>
<td>- Psychosocial education: Reconnecting with the body</td>
<td></td>
</tr>
<tr>
<td>- Assign Health and Wellness advocate</td>
<td></td>
</tr>
<tr>
<td>- Mind/Body/Spirit Wellness</td>
<td>- Mind/Body/Spirit Wellness</td>
</tr>
<tr>
<td>- Meditation</td>
<td>- Ongoing trauma-focused counseling</td>
</tr>
<tr>
<td>- Trauma-informed group therapy activities</td>
<td>- Seeking Safety</td>
</tr>
<tr>
<td>- Family therapy</td>
<td>- New healthy and markedly improved relationships</td>
</tr>
<tr>
<td>- &quot;warm handoffs&quot;</td>
<td>- Increased opportunities to participate in the facilitation of BRF services</td>
</tr>
<tr>
<td>Individual and group counseling</td>
<td>- Strong rapport with treatment team</td>
</tr>
<tr>
<td>Emotional regulation skills development</td>
<td>- Has specific leadership role within BRF and the community</td>
</tr>
<tr>
<td>- Interpersonal skills building and repairing relationships</td>
<td></td>
</tr>
<tr>
<td>- Group and individual counseling</td>
<td>- Leadership roles within BRF and own life</td>
</tr>
<tr>
<td>- Group therapy activities</td>
<td>- Mentoring other survivors or those in need</td>
</tr>
<tr>
<td>- &quot;warm handoffs&quot;</td>
<td>- Vocational/educational/financial life skills</td>
</tr>
<tr>
<td>- Trauma-focused family therapy</td>
<td>- Employment/Education attainment</td>
</tr>
<tr>
<td>- Practice being the REAL ME</td>
<td>- Fine tuning coping strategies and skill development</td>
</tr>
<tr>
<td>- Building positive self-regard</td>
<td>- Life Skills</td>
</tr>
<tr>
<td>- Reframing life story</td>
<td>- Wellness-Mind-Body-Spirit</td>
</tr>
<tr>
<td>- Radical acceptance</td>
<td>- Leadership and advocacy</td>
</tr>
<tr>
<td>- Reframing life story</td>
<td>- Self-efficacy and advocacy</td>
</tr>
<tr>
<td>- Radical acceptance</td>
<td>- Self-acceptance</td>
</tr>
<tr>
<td>- Psychosocial education: gender, age, race, economic, inequalities, effects of trauma, co-morbidity, resiliency</td>
<td></td>
</tr>
<tr>
<td>- Sharing testimonies</td>
<td>- Starting to experience internal validation</td>
</tr>
<tr>
<td>- Group therapy activities</td>
<td>- Automatic Pilot</td>
</tr>
<tr>
<td>- Reproductive/wellness education and counseling</td>
<td></td>
</tr>
<tr>
<td>- Short and long term goal attainment</td>
<td>- Moved from external validation to internal validation</td>
</tr>
<tr>
<td>- Moving On: Am I ready for the next step?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Reality testing and resolving goals</td>
</tr>
<tr>
<td></td>
<td>- Identifying skills that need strengthening or patch work</td>
</tr>
<tr>
<td></td>
<td>- Discharge Planning/Referrals</td>
</tr>
<tr>
<td></td>
<td>- Graduation Certificate</td>
</tr>
<tr>
<td></td>
<td>- Moving On: Am I ready for the next step?</td>
</tr>
</tbody>
</table>

1 Physiological needs: food, clothing, shelter, water, and homeostasis.
2 Safety needs: security of body, employment/education, resources, morality, family, health, environment.
3 Love and Belonging needs: friendship, family, intimacy, connections to others or group
4 Esteric needs: purpose, confidence, self-efficacy, positive self-regard and self-esteem.
5 Self-Actualization is the need to “become the most one can be” through mastering how to meet all previous levels of need.
**LGBT/GNC TOOL AND RESULTS**

<table>
<thead>
<tr>
<th>Assignment</th>
<th>Female</th>
<th>Male</th>
<th>Intersex (born with both female and male characteristics)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex at birth? (circle one)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender Identity</td>
<td>What is your internal sense of being female, male, or another gender?</td>
<td>Female/Woman/Girl</td>
<td>Male/Man/Boy</td>
</tr>
<tr>
<td>Gender Expression</td>
<td>How do you express yourself through clothing, hairstyle, etc.?</td>
<td>Feminine</td>
<td>Masculine</td>
</tr>
<tr>
<td>Sexually Attracted To</td>
<td>Who do you want to have sexual interactions with?</td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>Emotionally Attracted To</td>
<td>Who do you want to spend time with and form romantic relationships with?</td>
<td>Women</td>
<td>Men</td>
</tr>
</tbody>
</table>

Write here any notes about your gender identity or sexual and emotional attraction:
The LGBT/GNC tool was implemented between February and May 2020 with eight RISE Project participants, who all reported that they were identified as female at birth. In the following tables, results are depicted with each response placed in a bubble; the more participants who marked a response, the larger the bubble is.

The following table provides a visual depiction of responses to each item about gender identity (internal sense of being female, male, or other). Although there was some diversity in responses, most identified as a “10” for female and a “0” for male and other.

<table>
<thead>
<tr>
<th>What is your internal sense of being female, male, or another gender?</th>
<th>Female/Woman/Girl (n=8)</th>
<th>Male/Man/Boy (n=8)</th>
<th>Other Gender (s; n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

The following table provides a visual depiction of responses to each item about gender expression (how you express yourself through clothing, hairstyle, voice, body shape, etc). Participants varied in how much they rated their gender expression as female or male but all participants rated other gender expression as “0.”

<table>
<thead>
<tr>
<th>Gender Expression</th>
<th>How do you express yourself through clothing, hairstyle, etc.?</th>
<th>Feminine (n=8)</th>
<th>Masculine (n=8)</th>
<th>Other (n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

The following table provides a visual depiction of responses to each item about sexual attraction. It was most common to report sexual attraction to men but not women or other.

<table>
<thead>
<tr>
<th>Sexually Attracted To</th>
<th>Who do you want to have sexual interactions with?</th>
<th>Women (n=8)</th>
<th>Men (n=8)</th>
<th>Other Gender(s; n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7</td>
<td>1</td>
<td>7</td>
<td>1</td>
</tr>
</tbody>
</table>

The following table provides a visual depiction of responses to each item about emotional attraction (who you want to spend time with and form close relationships with). Responses varied widely between participants; most rated their emotional attraction to women as “0,” men as “10,” and other as “0.”

<table>
<thead>
<tr>
<th>Emotionally Attracted To</th>
<th>Who do you want to spend time with and form romantic relationships with?</th>
<th>Women (n=8)</th>
<th>Men (n=8)</th>
<th>Other Gender(s; n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
RACE, ETHNICITY, CULTURE, AND DISCRIMINATION TOOL AND RESULTS

Sometimes peoples’ background or identity influences their experiences of illness and the type of care they receive. In order to better help you, I would like to understand your own background or identity. By background or identity, for example, the communities you belong to, the languages you speak, where you or your families are from, and your racial or ethnic background.

1. What is your racial/ethnic background? (mark all that apply; it may help to read the response options out loud or show the list to the client)

   African/American/Black (non-Hispanic)
   African American/Black
   Haitian
   Caribbean, not Puerto Rican or Cuban [e.g., Jamaican, Dominican Republic]
   African Black
   All Other non-Hispanic Black

   Asian/Pacific Islander
   Chinese
   Japanese
   Korean
   South Asian [e.g., Indian, Pakistani, Sri Lankan]
   Southeast Asian [e.g., Filipino, Indonesian, Vietnamese]
   Pacific Islander [e.g., Hawaiian, Guamanian, Somoan]
   Other Asian/Pacific Islander

   Hispanic/Latino
   Mexican/Mexican American
   Cuban
   Puerto Rican
   Central American [e.g., Guatemalan, Nicaraguan, Panamanian]
   South American [e.g., Brazilian, Colombian, Ecuadorian]
   Spanish, Portuguese, Cape Verdean
   Other Caribbean
   Other Latino

   Other
   White (non-Hispanic), including Caucasian, North African
   American Indian, Aleutian, Native Alaskan or Eskimo
   Arab American
   Middle Eastern
   Other, please specify________________________
2. What race/ethnicity do other people think you are? (mark all that apply; it may help to read the response options out loud or show the list to the client)

* African/American/Black (non-Hispanic)
  * African American/Black
  * Haitian
  * Caribbean, not Puerto Rican or Cuban [e.g., Jamaican, Dominican Republic]
  * African Black
  * All Other non-Hispanic Black, please list ________

* Asian/Pacific Islander
  * Chinese
  * Japanese
  * Korean
  * South Asian [e.g., Indian, Pakistani, Sri Lankan]
  * Southeast Asian [e.g., Filipino, Indonesian, Vietnamese]
  * Pacific Islander [e.g., Hawaiian, Guamanian, Somoan]
  * Other Asian/Pacific Islander, please list ________

* Hispanic/Latino
  * Mexican/Mexican American
  * Cuban
  * Puerto Rican
  * Central American [e.g., Guatemalan, Nicaraguan, Panamanian]
  * South American [e.g., Brazilian, Colombian, Ecuadorian]
  * Spanish, Portuguese, Cape Verdean
  * Other Caribbean
  * Other Hispanic, please list ________

* Other
  * White (non-Hispanic), including Caucasian, North African
  * American Indian, Aleutian, Native Alaskan or Eskimo
  * Arab American
  * Middle Eastern
  * Other, please specify________________
3. In the environment where you grew up, what cultural traditions and values do you have, for example, the holidays you celebrate, the food you eat, and your spiritual beliefs?

INTERVIEWER: From your knowledge of the client, describe the environment the client grew up in (home with their family, foster care, etc.) before asking

4. What is or was your role where you grew up?

5. What are the expected roles you had in terms of responsibilities? Did you have any particular roles because of your age, gender, or other factor?

[National, Ethnic, Racial Background]

6. Where were you born?

7. Where were your parents and grandparents born?

8. How would you describe your family’s national, ethnic, and/or racial background?

9. Do you experience any difficulties such as discrimination, stereotyping, or being misunderstood because of your background?

[Language]

10. What languages do you speak fluently?

11. What languages are spoken at home? Which of these do you speak?

12. What language would you prefer to use in getting health care?

[Migration] [SKIP TO NEXT PAGE IF THE CLIENT WAS BORN IN THE UNITED STATES]

13. When did you come to this country?

14. What are your concerns for your own and your family’s future here?

This next question asks, “What is your current status in this country?” This question may feel uncomfortable and you do not have to answer it. I want to let you know that your response is confidential (it will be kept private) and will not be used to investigate your status in this country. I am asking this question because many children and families come to this country without legal documentation. The process of coming to the United States can cause a lot of stress and we want to help you with any types of stresses you are experiencing.

15. What is your current status in this country (e.g., refugee claimant, citizen, student visa, work permit)?

16. How has migration influenced your health or that of your family?
### Racial Socialization

17. As you were growing up, how often...

<table>
<thead>
<tr>
<th></th>
<th>All the time, like daily</th>
<th>Sometimes, like monthly</th>
<th>Rarely, like yearly</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you encouraged to be proud of your ethnicity?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Were you told about your culture and history?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Did you talk about the value of diversity?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Did you talk about ethnic and cultural bias?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### Ethnic Identity

18. How much is your ethnicity a part of your identity?

<table>
<thead>
<tr>
<th></th>
<th>A lot</th>
<th>A little</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much is your ethnicity a part of your identity?</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>How close are your ideas and feelings to others with the same ethnicity?</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>How much do you want to spend time with people sharing your ethnicity?</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### Experiences of Discrimination

19. In your day-to-day life, how often do any of the following things happen to you?

<table>
<thead>
<tr>
<th></th>
<th>All the time, like daily</th>
<th>Sometimes, like monthly</th>
<th>Rarely, like yearly</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are treated with less courtesy than other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>You are treated with less respect than other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>You receive poorer service than other people at restaurants or stores.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>People act as if they think you are not smart.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>People act as if they are afraid of you.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>People act as if they think you are dishonest.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>People act as if they’re better than you are.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>You are called names or insulted.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>You are threatened or harassed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

INTERVIEWER, ask this only if the client answered more than “never” to any discrimination.

20. What do you think is the main reason for these experiences? (Check all that apply).
1. Your Ancestry or National Origins, Explain:
2. Your Gender Identity, Explain:
3. Your Race, Explain:
4. Your Age, Explain:
5. Your Religion, Explain:
6. Your Physical Appearance, Explain:
7. Your Sexual Orientation, Explain:
8. Your Education Level, Explain:
9. Your Income Level, Explain:
10. The people you are hanging out with, Explain:
11. Another reason, Explain:
Race, Ethnicity, Culture, And Discrimination Tool Pilot Results

This tool was developed and pilot-tested during the 2018-2019 fiscal year and implemented for pilot testing in 2019-2020 with a total of 10 youth. Results are described by item in the following paragraphs.

What is your racial/ethnic background vs. What race/ethnicity do other people think you are?
The first questions ask participants about their racial/ethnic background and identity and what other people assume about their racial/ethnic identity. During their conversation with participants, clinicians are able to mark as many detailed racial/ethnic backgrounds (e.g., Mexican American, Haitian, Pacific Islander) as apply to each participant. These questions help clinicians open up a conversation about racial/ethnic background and how youth are perceived by others. While most participants identified and were perceived as Mexican/Mexican American, three participants experienced a mismatch in perceived racial/ethnic identity. This is important because experiences of discrimination are frequently based in perceived racial/ethnic background and because such a mismatch may cause identity confusion or distress for youth. Bringing this conversation up within a therapeutic context may help bring experiences to light for further conversation and insight.

In the environment where you grew up, what cultural traditions and values do you have, for example, the holidays you celebrate, the food you eat, and your spiritual beliefs?
This question is designed to help the clinician understand the extent to which someone’s racial/ethnic identity is congruent with their cultural traditions and values and to help the clinician avoid stereotypes and assumptions and get to know the client in more depth. Responses included those reflecting standard American values and traditions as well as American values and traditions integrated with some Mexican American traditions as well as more specific religious beliefs.

What is or was your role where you grew up?
This question helps the clinician gain a broader sense of the participant’s identity and open up a conversation about family dynamics. Frequently responses provided useful information about the participant’s place in their family (e.g., “oldest daughter and parttime babysitter”). Others simply wrote their relationship to others in their family (e.g., “big sister”).

What are the expected roles you had in terms of responsibilities? Did you have any particular roles because of your age, gender, or other factor?
This question is designed to help the clinician understand the cultural and familial role expectations influencing a participant. Some participants mentioned chores (e.g., “clean the house and other chores”). Several participants noted that they had role expectations due to being a girl (e.g., “I had to cook, clean, stay in the house, and do what girls do.”) or the oldest sibling (“I had to be more responsible, because I was older than my siblings”). One participant noted, “I don’t want to talk about it.”

Where were you born?
This question was designed to start to understand a participant’s migration history and if they were born locally, in state, in country, or internationally. These questions can open up a conversation about moving and transitions, which can be stressful. This can also help clinicians approach the more sensitive conversation of immigration and address any additional supports that may be needed for youth who are undocumented or in mixed documentation families. Most participants were born in Santa Barbara County.
Where were your parents and grandparents born?
Most participants reported that their parents and grandparents were born in Mexico (80%). One participant noted a city in California and the other participant reported “don’t know.”

How would you describe your family’s national, ethnic, and/or racial background?
Responses focused on regional heritage or racial/ethnic group (e.g., “Hispanic,” “Very White”). One respondent wrote, “I don’t talk to them.” Another wrote more specific information about values and traditions that would be useful in treatment.

Do you experience any difficulties such as discrimination, stereotyping, or being misunderstood because of your background?
Most participants (70%) indicated that they do not experience discrimination. Others wrote about specific experiences of discrimination based on expectations that they might steal or do something else wrong.

What languages do you speak fluently? What languages are spoken at home? Which of these do you speak?
Youths reported speaking English, Spanish, Mixteco or a combination of two or three. Most youths (90%) reported that they speak one or more, if not always all, of the languages spoken at home.

What language would you prefer to use in getting health care?
Most participants (80%) responded that they would prefer to get their health care in English. One wrote they would prefer to receive care in Spanish if their mom was there and English if “by myself.” One wrote “Spanish.”

Immigration History
There is a set of questions for participants who were not born in the United States that can be asked to identify documentation status and any other concerns about the impact of immigration on the family’s health. Only one participant was born outside the United States and these questions were not completed, perhaps because they were too sensitive and the timing was not appropriate. Due to the sensitivity of immigration and legitimate fears of deportation, clinicians proceed with care and do not ask these questions if they risk making the participant uncomfortable.

Racial Socialization and Ethnic Identity
This section provided response options to several questions designed to understand racial socialization and ethnic identity. Youths who report low levels of racial socialization and ethnic identity may benefit from exploring this within a youth group or therapeutic context. Youths who have high levels may be able to draw from these strengths and be leaders in group contexts when discussing and processing how racial socialization and ethnic identity contribute to their own identities.
**Racial Socialization**

As you were growing up, how often...

- **Did you talk about ethnic and cultural bias?**
  - 30% Never
  - 10% Rarely
  - 40% Sometimes
  - 20% All the Time

- **Did you talk about the value of diversity?**
  - 50% Never
  - 0% Rarely
  - 20% Sometimes
  - 30% All the Time

- **Were you told about your culture and history?**
  - 40% Never
  - 20% Rarely
  - 30% Sometimes
  - 10% All the Time

- **Were you encouraged to be proud of your ethnicity?**
  - 40% Never
  - 10% Rarely
  - 10% Sometimes
  - 40% All the Time

---

**Ethnic Identity**

- **How much do you want to spend time with people sharing your ethnicity?**
  - 30% Not at all
  - 30% A little
  - 40% A lot

- **How close are your ideas and feelings to others with the same ethnicity?**
  - 30% Not at all
  - 30% A little
  - 40% A lot

- **How much is your ethnicity a part of your identity?**
  - 20% Not at all
  - 20% A little
  - 60% A lot
Experiences of Discrimination

Youth are frequently discriminated against for a variety of reasons and such experiences can be discussed within a therapeutic context to provide insight and empowerment. Common experiences of discrimination were “people act as if they’re better than you are” and “people act as if they think you are not smart.”

What do you think is the main reason for these experiences?
Participants were asked to check any of 11 reasons (including “other”) that they experience discrimination and then to explain their response. Seven of the ten participants answered this question and example responses are provided in the following table.

<table>
<thead>
<tr>
<th>Type of discrimination</th>
<th>#</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>6</td>
<td>Because I hang out with older folks so I get talked down to because of my age; I just barely turned 18 and people think that is when people turn bad</td>
</tr>
<tr>
<td>The People you are Hanging out with</td>
<td>5</td>
<td>Because we hang out in big groups and then we get recognized; never really hung out with nice people</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>4</td>
<td>Because I’m female</td>
</tr>
<tr>
<td>Race</td>
<td>3</td>
<td>Because some places being White isn’t okay</td>
</tr>
<tr>
<td>Education Level</td>
<td>3</td>
<td>Because I haven’t graduated</td>
</tr>
<tr>
<td>Physical Appearance</td>
<td>2</td>
<td>Because I dress like a guy sometimes</td>
</tr>
<tr>
<td>Income Level</td>
<td>1</td>
<td>(Explanation blank)</td>
</tr>
</tbody>
</table>
PARTICIPANT INFORMATION: ADVERSE CHILDHOOD EXPERIENCES

Research has demonstrated that ACEs such as emotional, physical, or sexual abuse and domestic violence are challenging to overcome, and without help, survivors are at increased risk for poor health outcomes (Felitti et al., 1998). Felitti et al. (1998) screened 13,494 adults in the healthcare system for ACEs including abuse, violence against mother, living with people who abuse substances, and living with people who have mental illness, are suicidal, or have been in prison. In this population, experiencing ACEs was common (52%), however, experiencing four or more ACEs was rare (6.2%; Felitti et al.). People with four or more ACEs, compared to people with none, experienced much higher risk for health risk (e.g., 12.2 times more likely to ever have attempted suicide), health problems (e.g., 10.3 times more likely to have ever injected drugs), and disease conditions (e.g., 2.2 times more likely to have experienced heart disease). In follow-up research, Brown, Anda, Tiemeier, and Felitti (2009) found that participants with six or more ACEs died nearly 20 years earlier than those without ACEs (60.6 years versus 79.1 years). Thus, it is important to understand the ACEs of RISE participants in order to help provide them with the help and resources they may need to overcome the traumatic events they have experienced.

Prior to July 1, 2018, the 10-item ACEs Questionnaire (Felitti et al., 1998) was implemented by clinicians as a standalone assessment. When implementing this version of the ACEs, clinicians noted only the total ACEs score and did not track individual items. As of July 1, 2018, a new ACEs module was added to the CANS allowing ACEs to be collected regularly through the standard CANS process. This 12-item ACEs includes many, but not all, of the original 10 ACEs with an additional focus on community violence and natural disaster. The CANS assessed individual ACEs as well as total ACEs scores.

A comparison of CANS items between the two surveys and response data are summarized in the following table.

<table>
<thead>
<tr>
<th>ACES Scores</th>
<th>ACES Implemented</th>
<th>Felitti et al.</th>
<th>CANS</th>
<th>Years Implemented</th>
<th>2017-2018</th>
<th>2018-2020</th>
<th>Number of Participants</th>
<th>30</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td></td>
<td>5.4</td>
<td></td>
<td></td>
<td>5.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td></td>
<td>5.5</td>
<td></td>
<td></td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mode(s)</td>
<td></td>
<td>4, 7</td>
<td></td>
<td></td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4+</td>
<td></td>
<td>83%</td>
<td></td>
<td></td>
<td>76%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6+</td>
<td></td>
<td>50%</td>
<td></td>
<td></td>
<td>56%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Items Compared</td>
<td></td>
<td>Physical abuse</td>
<td>Physical Abuse</td>
<td>Verbal Abuse</td>
<td>Emotional Abuse</td>
<td>Sexual Abuse</td>
<td>Sexual Abuse</td>
<td>Physical Neglect</td>
<td>Neglect</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Having a Parent who is an Alcoholic</td>
<td></td>
<td>Mother Victim of Domestic Violence</td>
<td>Witness of Family Violence</td>
<td></td>
<td></td>
<td>Family Member in Jail</td>
<td>Parental criminal behavior</td>
</tr>
</tbody>
</table>
Results of individual ACEs reported on the CANS (2018-2020) are charted in the figure below.
Definition of ACES Categories

- **Sexual Abuse**: whether or not the child/youth has experienced sexual abuse.
- **Physical Abuse**: whether or not the child/youth has experienced physical abuse.
- **Emotional Abuse**: whether or not the child/youth has experienced verbal and nonverbal emotional abuse, including belittling, shaming, and humiliating a child/youth, calling names, making negative comparisons to others, or telling a child/youth that he or she is “no good.” This item includes both “emotional abuse,” which would include psychological maltreatment such as insults or humiliation towards a child/youth and “emotional neglect,” described as the denial of emotional attention and/or support from caregivers.
- **Neglect**: whether or not the child/youth has experienced neglect. Neglect can refer to a lack of food, shelter or supervision (physical neglect), lack of access to needed medical care (medical neglect), or failure to receive academic instruction (educational neglect).
- **Medical Trauma**: whether or not the child/youth has experienced medically-related trauma, including inpatient hospitalizations, outpatient procedures, and significant injuries.
- **Witness of Family Violence**: whether or not the child/youth has witnessed violence within the child/youth’s home or family.
- **Witness to Community/School Violence**: whether or not the child/youth has witnessed incidents of violence in his/her community. This includes witnessing violence at the child/youth’s school or educational setting.
- **Natural or Manmade Disaster**: describes the child/youth’s exposure to either natural or manmade disasters.
- **War Terrorism Affected**: describes whether or not the child/youth has been exposed to war, political violence, torture or terrorism.
- **Victim/Witness to Criminal Activity**: describes whether or not the child/youth has been exposed to criminal activity. Criminal behavior includes any behavior for which an adult could go to prison including drug dealing, prostitution, assault, or battery.
- **Disruptions in Caregiving/Attachment Losses**: describes whether or not a youth has had one or more major changes in caregivers, potentially resulting in disruptions in attachment.
- **Parental Criminal Behaviors**: describes whether or not the child/youth has had caregivers involved in criminal behavior. This includes both biological and stepparents, and other legal guardians, but not foster parents.
CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS): METHODOLOGY AND ADDITIONAL RESULTS

CANS data are administrated and tracked through the Behavioral Wellness system by programs including the RISE Project. The CANS is a multi-purpose tool developed to identify strengths and needs. Strengths are the youth’s assets, which are the areas of life where they are doing well or have interest or ability. Needs are potential areas that require intervention or care. The CANS is administered by care provider by selecting the best description of the youth’s functioning level for each item. The level is chosen collaboratively with the youth, family, and all other stakeholders. To use the CANS as a fidelity model approach, the program marks items rated at a “2” or “3” as areas that should be targeted in services or in the treatment plan. A rating of “0” or “1” in a strength-based item suggests that this area should be used for strength-based intervention planning.

The CANS was updated in 2018 and this new version was implemented midway through implementation of The RISE Project. While this impeded the ability to compare complete subscales over the entire grant period, many of the CANS items remained the same. In order to maintain the largest sample size possible within the longitudinal repeated-measures design, only items that were in both CANS were included in the CANS analyses and results.

A challenge of the longitudinal design was adhering to a strict assessment protocol. As the CANS is administered throughout the Behavioral Wellness system, the CANS was completed multiple times for RISE Project participants across different services they received. Behavioral Wellness queried all available CANS for each participant during the RISE Project period. To identify CANS at each time period, an intake CANS date was identified. A new variable was created for each subsequent CANS that provided length of time, in months, since the intake CANS. Then, the CANS was fit within the 6 mos, 12 mos, 18 mos, 24 mos, 36 mos, 48 mos, and 60 mos assessment periods. The following table provides details regarding the actual month range and mean for each assessment period along with how many matched surveys were identified at that time period.

<table>
<thead>
<tr>
<th>Time Period Coded</th>
<th>Intake</th>
<th>6 mos</th>
<th>12 mos</th>
<th>18 mos</th>
<th>24 mos</th>
<th>36 mos</th>
<th>48 mos</th>
<th>60 mos</th>
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</thead>
<tbody>
<tr>
<td>Number Completed</td>
<td>135</td>
<td>88</td>
<td>67</td>
<td>35</td>
<td>40</td>
<td>29</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Range &amp; (Mean) of actual mos</td>
<td>1-1 (1)</td>
<td>3-10 (6.4)</td>
<td>8-16 (12.2)</td>
<td>15-22 (18.1)</td>
<td>20-32 (25.0)</td>
<td>29-42 (35.2)</td>
<td>42-48 (44.5)</td>
<td>54-63 (59.3)</td>
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<tr>
<td>N=88</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=56</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=22</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=17</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=12</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=6</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>N=67</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=40</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=29</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
In addition to the primary results that were described in the main body of the report, the following two pages depict results of the remaining needs. These charts show that fewer RISE Project participants were rated as having needs the farther the time point was from intake. These charts also show that there are several needs that are extremely uncommon, or nonexistent, for RISE Project participants. These include, at intake, Sexual Aggression (0%), Psychosis (2.9%), Developmental/Intellectual (3%), Medical/Physical (3.7%), and Danger to Others (3.7%). Given the sum total of strengths and needs, it is clear that RISE Project participants differ from other high-need clients of the Behavioral Wellness system.

Overall, although the CANS was identified as a key evaluation tool to track participant changes over time, there were barriers to implementation. Ratings are completed by a service provider based on information gathered from a variety of sources. Feedback from clinical supervisors has suggested that CANS results may be skewed for RISE Project participants because needs and strengths are relative and this group of participants has extremely high needs. Overall, the CANS provides helpful identification of areas of strengths and needs and indicates that RISE Project participants improve in these areas over time but should be interpreted with caution when used as an evaluation tool.
% of Participants with Somewhat Common Needs (25-50%) at Intake

- School Behavior
  - 24 Months (n=40): 2.5%
  - 12 Months (n=67): 26.9%
  - 6 Months (n=88): 19.3%
  - Intake (n=135): 27.4%

- Oppositional
  - 24 Months (n=40): 17.5%
  - 12 Months (n=67): 17.9%
  - 6 Months (n=88): 22.8%
  - Intake (n=135): 31.1%

- Sexual Development
  - 24 Months (n=40): 27.5%
  - 12 Months (n=67): 31.4%
  - 6 Months (n=88): 25%
  - Intake (n=135): 34.8%

- Impulsivity/Hyperactivity
  - 24 Months (n=40): 27.5%
  - 12 Months (n=67): 28.4%
  - 6 Months (n=88): 41%
  - Intake (n=135): 38.5%

- Runaway
  - 24 Months (n=40): 20%
  - 12 Months (n=67): 28.4%
  - 6 Months (n=88): 31.8%
  - Intake (n=135): 38.5%

- Sleep
  - 24 Months (n=40): 17.5%
  - 12 Months (n=67): 25.4%
  - 6 Months (n=88): 22.7%
  - Intake (n=135): 40.8%

- Substance Use
  - 24 Months (n=40): 30%
  - 12 Months (n=67): 32.9%
  - 6 Months (n=88): 39.8%
  - Intake (n=135): 41.5%

- School Attendance
  - 24 Months (n=40): 25%
  - 12 Months (n=67): 34.3%
  - 6 Months (n=88): 37.5%
  - Intake (n=135): 43.7%

- Anger Control
  - 24 Months (n=40): 30%
  - 12 Months (n=67): 25.4%
  - 6 Months (n=88): 29.6%
  - Intake (n=135): 45.2%
### % of Participants with Less Common Needs (<25%) at Intake

<table>
<thead>
<tr>
<th>Category</th>
<th>Intake (n=135)</th>
<th>6 Months (n=88)</th>
<th>12 Months (n=67)</th>
<th>24 Months (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Aggression</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Intake (n=135)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medical/Physical Development</td>
<td>2.5</td>
<td>6</td>
<td>0</td>
<td>2.9</td>
</tr>
<tr>
<td>Intake (n=135)</td>
<td>2.5</td>
<td>6</td>
<td>0</td>
<td>2.9</td>
</tr>
<tr>
<td>Intellectual Delinquency</td>
<td>1.5</td>
<td>1.1</td>
<td>3</td>
<td>3.7</td>
</tr>
<tr>
<td>Intake (n=135)</td>
<td>1.5</td>
<td>1.1</td>
<td>3</td>
<td>3.7</td>
</tr>
<tr>
<td>Other Self-Harm</td>
<td>2.5</td>
<td>4.5</td>
<td>19.3</td>
<td>13.4</td>
</tr>
<tr>
<td>Intake (n=135)</td>
<td>2.5</td>
<td>4.5</td>
<td>19.3</td>
<td>13.4</td>
</tr>
<tr>
<td>Non Suicidal Self-Injurious</td>
<td>9.1</td>
<td>13.4</td>
<td>16.6</td>
<td>13.4</td>
</tr>
<tr>
<td>Intake (n=135)</td>
<td>9.1</td>
<td>13.4</td>
<td>16.6</td>
<td>13.4</td>
</tr>
<tr>
<td>Conducting Conduct</td>
<td>5</td>
<td>13.4</td>
<td>16.6</td>
<td>13.4</td>
</tr>
<tr>
<td>Intake (n=135)</td>
<td>5</td>
<td>13.4</td>
<td>16.6</td>
<td>13.4</td>
</tr>
<tr>
<td>Delinquent Behavior</td>
<td>10</td>
<td>16.4</td>
<td>15.9</td>
<td>17.7</td>
</tr>
<tr>
<td>Intake (n=135)</td>
<td>10</td>
<td>16.4</td>
<td>15.9</td>
<td>17.7</td>
</tr>
<tr>
<td>Social Behavior</td>
<td>10</td>
<td>16.4</td>
<td>15.9</td>
<td>17.7</td>
</tr>
<tr>
<td>Intake (n=135)</td>
<td>10</td>
<td>16.4</td>
<td>15.9</td>
<td>17.7</td>
</tr>
<tr>
<td>Suicide Risk</td>
<td>4.5</td>
<td>12.5</td>
<td>19.2</td>
<td>19.5</td>
</tr>
<tr>
<td>Intake (n=135)</td>
<td>4.5</td>
<td>12.5</td>
<td>19.2</td>
<td>19.5</td>
</tr>
</tbody>
</table>