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A New Model of Foster Care for Youth Impacted by Commercial Sexual Exploitation in San Francisco

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Final Evaluation Report | December 2022

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FAMILY AND ME (FAM)

Family and Me (FAM) is a component of the San Francisco Safety, Opportunity, and Lifelong Relationships (SF SOL) Collaborative, a project funded by the California Department of Social Services and the City and County of San Francisco's Department on the Status of Women.

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ACRONYMS

BIPOC	Black, Indigenous, and People of Color
CDSS	California Department of Social Services
CSE	Commercial sexual exploitation
CSEC	Commercial sexual exploitation of children
DOSW	Department on the Status of Women (City of San Francisco)
FAM	Family And Me
FFA	Foster family agency
HART	Huckleberry Advocacy and Response Team
HSA	Human Services Agency (San Francisco)
HRC	Human Rights Center, University of California, Berkeley
HYPE	Helping Young People Elevate
ISFC	Intensive Services Foster Care
PSA	Public service announcement
RFA	Resource family approval
STRTP	Short-term residential therapeutic program
SF SOL	San Francisco Safety, Opportunity, Lifelong relationships

EXECUTIVE SUMMARY

CHILDREN AND YOUTH experiencing commercial sexual exploitation (CSE) often have some form of engagement with the child welfare system.[1,2,3] Safe and stable housing is vital to minimize vulnerability to CSE, help survivors recover, and reduce revictimization.[4,5] Yet housing and shelter are among the top service gaps reported by agencies serving trafficking survivors in San Francisco,[6] a high density area for CSE.[7]

To address this disparity, in 2019, a coalition of agencies developed Family And Me (FAM),[8] a new model of foster care designed to meet the needs of youth who have experienced or are at risk of CSE in the San Francisco Bay Area. The goal was to establish an evidence-based, youth-centered model of care that could be scaled throughout the State of California and beyond. The 3.5-year FAM pilot aimed to improve the health, safety, and well-being of youth affected by CSE and to increase the knowledge, capacity, and retention rates of the caregivers who support them by offering a range of enhanced support services for both youth and their caregivers. However, due to numerous challenges, such as COVID-19 restrictions and recruitment barriers, the FAM collaborative was only able to implement a portion of the original FAM model.

1 Walker, Kate and Fiza Quraishi. "From Abused and Neglected to Abused and Exploited: The Intersection Between the Child Welfare System and Child Sex Trafficking." National Center for Youth Law, Thorn Digital Defenders, 2014.

2 Gragg, Frances, Ian Petta, Haidee Bernstein, Karla Eisen, and Liz Quinn. "New York Prevalence Study of Commercially Sexually Exploited Children: Final Report." Rensselaer, NY: New York State Office of Children and Family Services, 2007.

3 Polaris. "Child Trafficking and the Child Welfare System." 2014.

4 Dierkhising, Carly B., Kate Walker Brown, Mae Ackerman-Brimberg, and Allison Newcombe. "Recommendations to Improve Out of Home Care From Youth Who Have Experienced Commercial Sexual Exploitation." *Children and Youth Services Review* 116 (2020): 105263.

5 Groton, Danielle B., and Tomi Gomory. "Improving Housing Services for Youth Survivors of Sexual Exploitation: An Exploratory Study." *National Youth-At-Risk Journal* 4, no. 2 (2021): 44–64.

6 San Francisco Mayor's Task Force on Anti-Human Trafficking. "Human Trafficking in San Francisco: 2017 Data." 2019.

7 Jones, Nikki, and Joshua Gamson, with Brianne Amato, Stephanie Cornwell, Stephanie Fisher, Phillip Fucella, Vincent Lee, and Virgie Zolala-Tovar. "Experiences of Youth in the Sex Trade in the Bay Area." New York: Center for Court Innovation, 2016.

8 FAM was developed by Freedom Forward in collaboration with the San Francisco Department on the Status of Women, Huckleberry Youth Programs, WestCoast Children's Clinic, and Family Builders. FAM is one component of San Francisco Safety, Opportunity, Lifelong relationships (SF SOL), a 3.5 year initiative funded by the California Department of Social Services (CDSS) to develop a continuum of care options for youth impacted by CSE and trafficking in San Francisco.

EVALUATION

The Human Rights Center (HRC) at the University of California, Berkeley partnered with the FAM Collaborative to conduct an in-depth evaluation of the pilot. The FAM evaluation was designed as a quasi-experimental, longitudinal, mixed-methods study with regular cycles of data collection and analysis which partners used to adapt and improve the FAM pilot over time. Due to the challenges in pilot implementation, the evaluation focus shifted to an in-depth, process-oriented assessment identifying implementation successes, challenges, and lessons learned in three programmatic areas: youth identification and engagement, caregiver recruitment and training, and collaboration, coordination, and referral among service providers. Four rounds of data collection were undertaken between 2019 and 2022; data were thematically analyzed. Methods included:

- 49 semi-structured interviews with 25 direct and indirect service providers
- 7 semi-structured interviews with 5 caregivers
- Pre- and post-training surveys completed by 10 caregivers
- Baseline survey and follow-up interview with 1 youth
- Analysis of case notes from 14 youth referrals

KEY ACHIEVEMENTS

Youth

- 16 youth identified and referred to FAM for services and support (14 during the evaluation period)
- 12 youth engaged in permanency services (10 during the evaluation period)
- 7 youth supported with discretionary funds for food, school supplies, and other needs
- 1 youth placed in FAM caregiver home with supportive secondary caregiver for short-term placement

Caregivers

- 15 caregivers completed FAM training
- 4 caregivers supported with discretionary funds for housing, food, and other needs
- 2 potential caregivers completed RFA process: 1 primary and 1 secondary

KEY FINDINGS

Youth Identification and Engagement

Strengths and Successes

FAM partners and external service providers gained knowledge and tools to support and refer youth at risk of, or experiencing, CSE. Collaboration and knowledge-sharing among FAM partners with differing expertise in CSE, as well as training and advocacy materials, helped to expand their knowledge and skills. Further, the expansion of FAM criteria, such as including youth up to age 21 and referrals for expecting and/or parenting youth, increased the number of vulnerable youth eligible for FAM services.

Challenges

FAM focused on permanency services and was not designed as an emergency placement model. However, youth in this population often need a place to stay immediately. Family-based placements were unavailable during the pilot, primarily because FAM did not have caregivers ready for youth due to caregiver recruitment and retention challenges. Few service providers referred youth to FAM services for various reasons, including a lack of familiarity with FAM services, the referral process, or the value-add of FAM. Service providers struggled to engage youth in this community, and youth away from placement were difficult to contact. Additional challenges included the COVID-19 pandemic, staff burnout and turnover, and differing capacity and approaches among some service providers to effectively support youth who have experienced CSE.

YOUTH REFERRALS

Fourteen youth referrals, between the ages of 13–21, were received during the FAM pilot: 12 girls/women, one boy/man, and one non-binary youth. Analysis of referral case notes found the following:

- **Housing stability** — Two youth had stable housing placements during the referral period. Two more were away from placement, one of whom was living with her exploiter. The remaining youth each had two to four different placements during this time, and were often away from placement.
- **Permanency efforts and challenges** — Ten youth received permanency services. For three, no potential caregivers were identified from among family and adult friends. For seven, though suitable caregivers were identified, just one led to a successful placement.
- **Family-based placement challenges** — Even if suitable caregivers were identified, youth were often unavailable for placement. Three spent time in juvenile detention and four experienced health challenges that delayed placements, including two pregnancies and one psychiatric hospitalization.
- **Reasons youth referrals closed** — Of 14 youth, one was effectively placed in FAM housing (albeit short-term), and two cases were ongoing at the end of the evaluation. Among remaining youth, case workers determined two were not at risk of CSE, two required higher levels of care than FAM could provide, two were ineligible for FAM because they were seeking placement with siblings, one was out of the coverage area, one was reunified with a parent, and three chose to pursue transitional housing opportunities.

Caregiver Recruitment, Engagement, and Training

Strengths and Successes

A total of 15 caregivers attended three training sessions during the pilot. Pre- and post-tests from ten participants revealed improved understanding of CSE and trauma-informed care among caregivers. A multi-pronged outreach strategy also helped to recruit caregivers, such as the development of a Caregiver Recruitment Workgroup, a caregiver recruitment toolkit, digital advertising campaign strategies, and a public service announcement. In addition, multiple efforts helped to improve engagement and communication with potential caregivers, including streamlining the caregiver recruitment workflow and revising the caregiver signup website.

Challenges

Few people who expressed interest in becoming a caregiver followed through to complete the training. Even though FAM provided discretionary funding to support caregivers' home set-up, housing requirements, such as a spare bedroom for the youth, were a significant barrier to caregiver retention and resource family approval (RFA). The RFA process, which involves extensive training, home inspections, and background checks, was prohibitively time-consuming, and sometimes took more than a year to complete. Stigma and fears regarding FAM youth also inhibited caregiver recruitment, with some potential caregivers worried that these youth might have unmanageable behavioral issues.

Collaboration, Coordination, and Referral

Strengths and Successes

Communication and coordination among FAM partners generally improved over time. Factors that supported interagency cohesion and accountability included a new FAM Director, consistent meetings and working groups, and collectively developed resources. Collaboration between FAM implementing partners and government agencies, including DOSW and HSA, was also strengthened over time. FAM partners demonstrated deep commitment to youth affected by CSE and to the mission of the pilot. They worked together to try to meet the urgent

needs of CSE-affected youth and have them placed in safe, supportive, and loving homes.

Challenges

Despite some notable strengths and improvements in interagency collaboration, relationship-building and trust among partner organizations was an ongoing challenge due to various factors, including unrealistic expectations of partners and perceptions that others were not fulfilling their responsibilities. Developing agreed roles, responsibilities, and goals across so many organizations was difficult. Staff turnover and overwhelming workloads also undermined interagency cohesion and hindered implementation. Referral processes required further clarity, agreement, and strengthening. Additional challenges included difficulties in coordinating with government organizations and frustrations with data collection.

RECOMMENDATIONS

Youth Identification and Engagement

1. Engage youth who have previously experienced CSE in assessing and redesigning the FAM model to ensure it meets the needs of CSE-affected youth.
2. Develop an emergency placement model, or partner with other service providers to offer emergency placement options, for CSE-affected youth.
3. Consider extending FAM components to youth who are already in placements.
4. Expand direct outreach efforts to youth, particularly in-person.
5. Offer permanency and community housing options in tandem.
6. Develop creative solutions to engage CSE-affected youth who face increased barriers to engagement and family-based placement.

Caregiver Recruitment, Engagement, and Training

7. Expand caregiver outreach and work to destigmatize CSE.
8. Identify key reasons why potential caregivers withdraw during the recruitment and RFA processes and develop strategies to strengthen retention.
9. Explore ways to streamline the RFA process and further support caregivers to complete requirements.
10. Develop strategies to address housing barriers to caregiver participation.
11. Continue to expand FAM services to caregivers outside of FAM who are already serving CSE-affected youth.
12. Consider advocating for more flexible requirements for secondary caregivers.

Collaboration, Coordination, and Referral

13. Simplify the FAM model, reduce the number of implementing organizations, and streamline service delivery.
14. Further clarify service provider roles and promote consistent communication and trust-building among partners.
15. Promote referrals by expanding outreach efforts with HSA and other referral agencies.
16. Strengthen referral processes to improve service provision for youth.
17. Ensure women of color, youth, survivors of CSE, direct service providers, and other key stakeholders have meaningful roles in high-level decision-making within FAM.
18. Prioritize efforts to reduce burnout and staff turnover.
19. Develop a plan for sustainability from the beginning.
20. Ensure rigorous external evaluation of FAM 2.0.

INTRODUCTION

THE SAN FRANCISCO BAY AREA is considered to be one of the highest density areas for commercial sexual exploitation (CSE) of children[9] in the country.[10,11] The COVID-19 pandemic likely exacerbated CSE of children and youth,[12] with local trafficking[13] organizations reporting an upsurge in demand for services.[14] Commercial sexual exploitation is a profound human rights violation, with multi-dimensional impacts, including unwanted pregnancy, HIV and other sexually transmitted infections, complex post-traumatic stress disorder, depression, and social isolation, among numerous other health, psychosocial, and economic repercussions.

Children and youth experiencing CSE often have some form of engagement with the child welfare system.[15,16,17] For example, in a 2013 nationwide FBI raid of more than 70 cities, 60% of the CSE survivors rescued were children from foster care or residential

9 Commercial sexual exploitation of children refers to "a range of crimes and activities involving the sexual abuse or exploitation of a child for the financial benefit of any person or in exchange for anything of value (including monetary and non-monetary benefits) given or received by any person." Office of Juvenile Justice and Delinquency Prevention. "Sexual Exploitation of Children." Accessed December 12, 2022. https://ojjdp.ojp.gov/programs/sexual-exploitation-children.

10 Jones, Nikki, and Joshua Gamson, with Brianne Amato, Stephanie Cornwell, Stephanie Fisher, Phillip Fucella, Vincent Lee, and Virgie Zolala-Tovar. "Experiences of Youth in the Sex Trade in the Bay Area." New York: Center for Court Innovation, 2016.

11 Corbett, Annie. "The Voices of Survivors: An Exploration of the Contributing Factors That Assisted with Exiting From Commercial Sexual Exploitation in Childhood." *Children and Youth Services Review* 85 (2018): 91–98.

12 Junewicz, Alexandra, Ivt Sohn, and Katherine Walts. "COVID-19 and Youth Who Have Experienced Commercial Sexual Exploitation: A Role for Child Mental Health Professionals During and in the Aftermath of a Pandemic." *Journal of the American Academy of Child and Adolescent Psychiatry*, 61(9) (March 2022): 1071–1073.

13 "Trafficking in persons," "human trafficking," and "modern slavery" are umbrella terms—often used interchangeably—to refer to a crime whereby traffickers exploit and profit at the expense of adults or children by compelling them to perform labor or engage in commercial sex. When a person younger than 18 is used to perform a commercial sex act, it is a crime regardless of whether there is any force, fraud, or coercion involved. The United States recognizes two primary forms of trafficking in persons: forced labor and sex trafficking. U.S. Department of State. "2022 Trafficking in Persons Report." 2022. p. 31.

14 Sierra, Stephanie. "San Francisco FBI Reports 'Concerning Spike' in Child Exploitation Cases across Bay Area." *ABC 7 News*, July 21, 2021, https://abc7news.com/human-trafficking-bay-area-child-antitrafficking-nonprofit/10900375/.

15 Walker, Kate and Fiza Quraishi. "From Abused and Neglected to Abused and Exploited: The Intersection Between the Child Welfare System and Child Sex Trafficking." National Center for Youth Law, Thorn Digital Defenders, 2014.

16 Gragg, Frances, Ian Petta, Haidee Bernstein, Karla Eisen, and Liz Quinn. "New York Prevalence Study of Commercially Sexually Exploited Children: Final Report." Rensselaer, NY: New York State Office of Children and Family Services, 2007.

17 Polaris. "Child Trafficking and the Child Welfare System." 2014.

group homes.[18] Traffickers target youth in the foster care system due to their increased vulnerabilities, such as a lack of permanent home and the absence of familial support and oversight.[19,20] Removal from a home or frequent changes in foster care placements can disrupt protective factors, such as schooling, support services, and social connections.[21] Safe, stable housing is the lynchpin to minimize vulnerability to CSE, help survivors recover, and reduce revictimization.[22,23] Yet housing and shelter are among the top service gaps reported by agencies serving trafficking survivors in San Francisco.[24]

To address this disparity, a coalition of agencies developed Family And Me (FAM), a three and a half year, family-based foster care pilot for youth who have experienced or are at risk of CSE in San Francisco, California. Researchers from the Human Rights Center at UC Berkeley conducted an ongoing evaluation of the pilot with reports issued every six months to adapt and improve the program.[25] This report presents key findings from the final pilot evaluation and offers recommendations for local and state policymakers and practitioners working to better address CSE of children and youth.

18 Hounmenou, Charles, and Caitlin O'Grady. "A Review and Critique of the US Responses to the Commercial Sexual Exploitation of Children." *Children and Youth Services Review* 98 (2019): 188–198.

19 Gluck, Elliot, and Rricha Mathur. "Child Sex Trafficking and the Child Welfare System." First Focus, SPRAC, July 2014.

20 Walker, Kate, and Fiza Quraishi. "From Abused and Neglected to Abused and Exploited: The Intersection Between the Child Welfare System and Child Sex Trafficking." National Center for Youth Law, Thorn Digital Defenders, 2014.

21 Hannan, Madeline, Kathryn Martin, Kimberly Caceres, and Nina Aledort. "Children at Risk: Foster Care and Human Trafficking." In *Human Trafficking Is a Public Health Issue*, edited by Makini Chisolm-Straker and Hanni Stoklosa, 105–21. Cham: Springer International Publishing AG, 2017.

22 Dierkhising, Carly B., Kate Walker Brown, Mae Ackerman-Brimberg, and Allison Newcombe. "Recommendations to Improve Out of Home Care From Youth Who Have Experienced Commercial Sexual Exploitation." *Children and Youth Services Review* 116 (2020): 105263.

23 Groton, Danielle B., and Tomi Gomory. "Improving Housing Services for Youth Survivors of Sexual Exploitation: An Exploratory Study." *National Youth-At-Risk Journal* 4, no. 2 (2021): 44–64.

24 San Francisco Mayor's Task Force on Anti-Human Trafficking. "Human Trafficking in San Francisco: 2017 Data." 2019.

25 See: "Supporting Youth at Risk of Commercial Sexual Exploitation," UC Berkeley, Human Rights Center. Accessed November 14, 2022. https://humanrights.berkeley.edu/programs-projects/health-human-rights-program/supporting-youth-risk-commercial-sexual-exploitation

DATA ON COMMERCIAL SEXUAL EXPLOITATION AND THE CHILD WELFARE SYSTEM

- Of 2,253 commercially sexually exploited children in NYC in 2006, 75% had a history of foster care placement.[26,27]
- Of 88 child survivors of sex trafficking identified in Connecticut in 2011, 98% were involved in the child welfare system in some way.[28]
- In San Diego, local agencies discovered that between 80%–95% of commercially sexually exploited children were known to the child welfare system.[29]
- Of 149 commercially sexually exploited youth in San Francisco, 55% were involved in the foster care system.[30]
- Of more than 100 commercially sexually exploited girls in Los Angeles, almost 80% were involved in the child welfare system.[31]

26 Gragg, Frances, Ian Petta, Haidee Bernstein, Karla Eisen, and Liz Quinn. "New York Prevalence Study of Commercially Sexually Exploited Children: Final Report." Rensselaer, NY: New York State Office of Children and Family Services, 2007.

27 While authors acknowledge that this and the statistics that follow are outdated, they have been included nonetheless as they represent the very limited data that is available on this population.

28 Connecticut Department of Children and Families. "A Child Welfare Response to Domestic Minor Sex Trafficking." 2011.

29 California Child Welfare Council. "Prevalence of Commercially Sexually Exploited Children." n.d.

30 Brantley, Nola. "Framing the issues of commercial sexual exploitation of children." Motivating, Inspiring, Supporting & Serving Sexually Exploited Youth (MISSSEY), 2009. Cited in Chicago Alliance Against Sexual Exploitation. "Know the Facts: Commercial Sexual Exploitation of Children." n.d.

31 Walker, Kate, and Fiza Quraishi. "From Abused and Neglected to Abused and Exploited: The Intersection Between the Child Welfare System and Child Sex Trafficking." National Center for Youth Law, Thorn Digital Defenders, 2014.

FAMILY AND ME (FAM) PILOT

FAMILY AND ME (FAM) is a new model of foster care designed to meet the unique needs of youth who have experienced or are at risk of CSE. The goal of the pilot and evaluation was to establish an evidence-based, youth-centered model of care that could be scaled throughout California and beyond. The pilot aimed to improve the health, safety, and well-being of youth affected by CSE and to increase the knowledge, capacity, and retention rates of the caregivers who support them. To achieve these objectives, FAM offered a range of enhanced support services for both youth and their caregivers, which were underpinned by ongoing evaluation. The FAM model was developed in 2019 under the leadership of Freedom Forward in collaboration with the San Francisco Department on the Status of Women (DOSW), Huckleberry Youth Programs, WestCoast Children's Clinic, and Family Builders. FAM is one component of the San Francisco Safety, Opportunity, Lifelong relationships (SF SOL) Collaborative, a 3.5 year initiative funded by the California Department of Social Services (CDSS) to develop a continuum of care options for youth impacted by CSE and trafficking in San Francisco.

The following outlines the original design of the FAM pilot. However, due to numerous challenges, such as COVID-19 restrictions and recruitment barriers, the organizations involved in FAM were unable to fully implement the original FAM model. Ultimately, only one young person was enrolled in FAM, and two caregivers completed the RFA process. These challenges are further explained in the Limitations, FAM Activities, and Findings sections.

The FAM pilot offered youth family-based placement,[32] case management and transition support, individual and family therapy, and permanency services[33] aimed at strengthening the development of organic relationships with supportive adults. Youth also received support from a secondary caregiver who completed specialized CSE training and Resource Family Approval (RFA)[34] and could serve

32 Placement refers to "the placing of a child in the home of an individual other than a parent or guardian or in a facility other than a youth services center." 42 U.S.C. § 671(a)(19)

33 This includes both legal and relational permanency services. Legal permanency refers to "a legal, permanent family living arrangement, that is, reunification with the birth family, living with relatives, guardianship or adoption." U.S. Department of Health and Human Services, 2005. Relational permanency refers to "youth experiencing a sense of belonging through enduring, life-long connections to parents, extended family, or other caring adults, including at least one adult who will provide a permanent, parentlike connection for that youth." Jones, Annette Semanchin, and Traci LaLiberte. "Measuring Youth Connections: A Component of Relational Permanence for Foster Youth." Children and Youth Services Review 35, no. 3 (2013): 509–517.

34 Resource Family Approval is "a family-friendly and child-centered caregiver approval process that combines elements of the current foster parent licensing, relative approval, and approvals for adoption and guardianship processes and replaces those processes." See: "Resource Family Approval (RFA)." California Department of Social Services.

as another caring adult in their lives. Unlike traditional foster care, youth participants had access to FAM support services if they left their placement and were allowed to return to their placement after periods of absence without permission. Youth eligibility criteria for FAM included:

1. Young people up to age 21. (Age of entry was expanded from 17.5 years of age to 21 in the spring of 2021 to align with California's extended foster care program.)
2. Youth identified as having a Clear CSE Concern score on the CSE-IT assessment tool[35] or other documented clear concerns of CSE such as through calls to San Francisco Human Services Agency's (HSA) child protection hotline.
3. Either child welfare- or probation-supervised foster youth with an out-of-home placement order.

Caregivers in FAM had access to family therapy, peer support groups with other caregivers of youth impacted by CSE, specialized training addressing trauma and CSE, support and mentoring from secondary caregivers who also received this training, and discretionary funding for unexpected and/or commonly unfunded needs. In addition, a broad range of services required the collaboration of numerous organizations with differing areas of expertise. To this end, FAM worked to bolster and streamline coordination and referral systems. The full list of intended services for youth and caregivers are detailed in Table 1.

The organizations involved in the FAM pilot implementation and evaluation included:

- **Family Builders,** a foster family agency managing family-based placements, including providing permanency services, specialized caregiver training and guidance in completing the RFA process, and home-based case management.
- **Freedom Forward,** a nonprofit organization providing oversight and management of the FAM model.
- **Huckleberry Youth Programs,** a nonprofit organization conducting intake through the Huckleberry Advocacy and Response Team (HART) and providing intensive case management and transition support to youth in FAM.
- **The Human Rights Center (HRC) at the University of California, Berkeley,** a research center conducting rigorous, external evaluation of the pilot through the Health and Human Rights Program.
- **San Francisco Department on the Status of Women (DOSW),** a city and county agency funded by the California Department of

RISK FACTORS AND PREDICTORS FOR COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN

- Childhood maltreatment trauma, especially sexual abuse, as well as physical abuse, emotional abuse, and neglect
- Running away and homelessness
- Parental substance abuse
- Chronic hunger
- Juvenile justice and child protection involvement
- Mental health disorders and substance use
- BIPOC youth, particularly Black girls[36]
- Intellectual disability[37]
- LGBTQI+ youth[38]

36 Jaeckl, Simone, and Kathryn Laughon. "Risk Factors and Indicators for Commercial Sexual Exploitation/Domestic Minor Sex Trafficking of Adolescent Girls in the United States in the Context of School Nursing: An Integrative Review of the Literature." *The Journal of School Nursing* 37, no. 1 (2021): 6–16.

37 Buller, Ana Maria, Marjorie Pichon, Alys McAlpine, Beniamino Cislaghi, Lori Heise, and Rebecca Meiksin. "Systematic Review of Social Norms, Attitudes, and Factual Beliefs Linked to the Sexual Exploitation of Children and Adolescents." *Child Abuse & Neglect* 104 (2020): 104471.

38 Fedina, Lisa, Celia Williamson, and Tasha Perdue. "Risk Factors for Domestic Child Sex Trafficking in the United States." *Journal of Interpersonal Violence* 34, no. 13 (2019): 2653–2673.

Accessed November 21, 2022. https://www.cdss.ca.gov/inforesources/resource-family-approval-program.

35 WestCoast Children's Clinic. "Commercial Sexual Exploitation-Identification Tool (CSE-IT)." 2019.

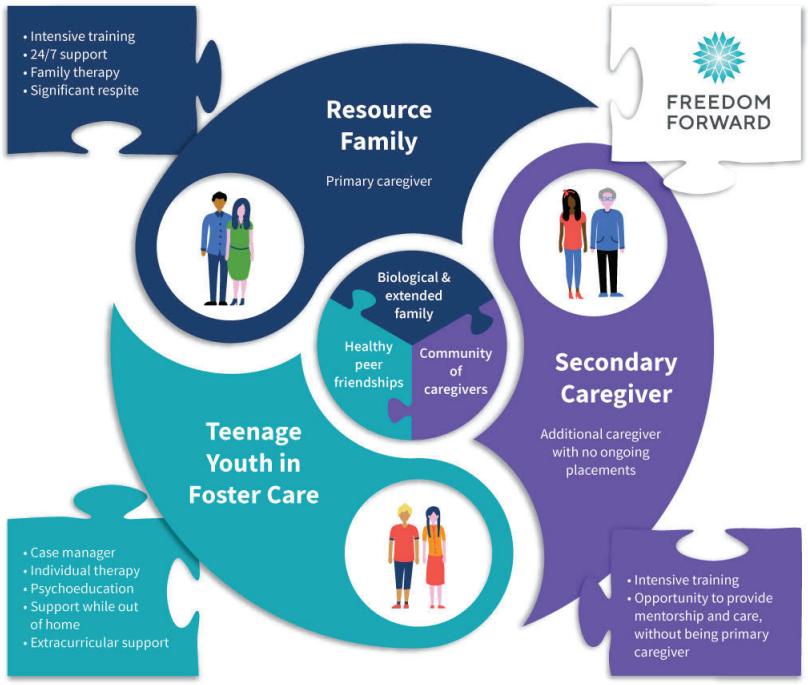

TABLE 1: **INTENDED FAM SERVICES FOR YOUTH AND CAREGIVERS**

FAM Youth Services

- Permanency support to develop and strengthen organic relationships with biological family members, extended family, or other supportive adults
- Intensive case management and transition support
- Placement in a home setting
- Individual and family therapy
- In-home case management
- Support of a secondary caregiver outside of the primary placement who can offer a safe place to stay when needed
- 24-hour crisis support seven days per week
- Access to support while out of home and the ability to return home at any time
- Access to discretionary funding for extracurricular activities and activities to facilitate relationship development

FAM Caregiver Services

- Specialized training on trauma and CSE
- Peer support groups with other caregivers
- In-home case management
- Family therapy
- Support from a secondary caregiver who is available to provide mentoring and respite when needed
- 24-hour crisis support seven days per week
- Additional compensation
- Access to discretionary funding for items to accommodate youth in their homes, interruptions in income if youth leave home for more than two weeks, and any other emergency or unpredicted costs

Social Services to provide oversight of the SF SOL grant and grantees.

- **San Francisco Human Services Agency (HSA),** a city and county child welfare agency identifying and referring youth who have experienced or are at risk of CSE to FAM through the SF SOL Steering Committee.
- **WestCoast Children's Clinic (WCC),** a nonprofit organization providing mental health services for youth in family-based care including individual and family therapy, facilitating caregiver support groups, and providing training for FAM staff.

FAM EVALUATION

OVERVIEW

The Human Rights Center (HRC) at the University of California, Berkeley partnered with the San Francisco DOSW, Freedom Forward, and FAM implementing agencies to conduct an in-depth evaluation of the FAM pilot. The evaluation aimed to support FAM partners in developing an evidence-based, youth-centered intervention model with the potential to be contextualized and scaled to other locations statewide. However, due to numerous external challenges (see Limitations), the original evaluation design had to be significantly modified. This section outlines both the original evaluation design and the necessary modifications.

The HRC team applied a developmental evaluation approach to facilitate adaptive programming. Through regular cycles of data collection and analysis, the team produced evaluation progress reports every six months to provide FAM partners with recommendations to adapt and improve the FAM pilot over time. This approach created an ongoing feedback loop to support partners in identifying and addressing barriers to implementation, and thereby maximize outcomes for youth and caregivers. Throughout the evaluation process, researchers actively worked to elevate youth and caregiver voices and incorporate them into the pilot design.

Original evaluation objectives were to:

1. Understand the feasibility and acceptability of the FAM pilot by youth, caregivers, and service providers.
2. Explore youth and caregiver experiences with various FAM services.
3. Assess the extent to which youth and caregivers are provided with the intensity and types of services and support they need.
4. Understand the influence of the FAM pilot on key outcomes for youth and caregivers over time.

When it became clear that these objectives would not be realized, focus shifted to an in-depth, process-oriented assessment identifying implementation successes, challenges, and lessons learned in three programmatic areas:

1. Youth identification and engagement
2. Caregiver recruitment and training
3. Collaboration, coordination, and referral among service providers

The FAM evaluation was designed as a quasi-experimental, longitudinal, mixed-methods study. Qualitative and quantitative methods were used to assess the implementation process, explore youth experiences, and measure changes in outcomes. Original evaluation design included the following components:

TABLE 2: **OUTCOMES TO BE EVALUATED**

FAM Youth Outcomes	FAM Caregiver Outcomes
• Placement stability • Mental health (trauma symptoms) • Emotional and behavioral well-being (including substance use, sexual risk behavior, and resilience) • Adult and peer relationships • Physical health and safety (including juvenile justice system involvement and experiences of CSE) • School engagement	• Capacity (knowledge and skills) • Sense of support • Sense of fulfillment • Recruitment and retention

- Semi-structured qualitative interviews with youth, caregivers, and service providers
- Quantitative youth surveys
- Pre- and post-training surveys with caregivers
- Service provision data from FAM partners[39]
- Administrative data from San Francisco Juvenile Probation Department and HSA[40]
- Researchers' case notes regarding youth referred to FAM

Outcome categories to be evaluated for youth and caregivers are listed in Table 2. Note that outcomes were not assessed given the lack of youth enrolled in the pilot and limited time frame for follow up. (See Limitations.)

EVALUATION METHODS

Between July 2020 and July 2022, HRC researchers issued three evaluation progress reports.[41] The first report focused on the "pre-enrollment period", which involved preparation for pilot implementation. The next two reports focused on the "service provision period", which commenced once participants were enrolled in FAM. This fourth and final evaluation report synthesizes learning from the previous three reports. It also provides findings from a final round of closing interviews with FAM service providers, conducted in October 2022, and an analysis of research case notes on referrals made throughout the pilot.

Due to the limited number of caregiver and youth participants enrolled in the FAM pilot, the majority

39 Including the Youth Connections Scale to assess the strength and number of relationships with supportive adults and WestCoast Children's Clinic's CSE-It assessment tool to assess changes in risk of CSE every four months.

40 Not collected due to a dearth of youth involved in the pilot. (See Limitations.)

41 Freccero, Julie, and Joanna Ortega. "Family And Me (FAM): A New Model of Foster Care for Youth Impacted by Commercial Sexual Exploitation in San Francisco. Evaluation Progress Report #1." Human Rights Center, UC Berkeley, May 2021. https://humanrights.berkeley.edu/sites/default/files/fam_progress_report_1_v14_final_210716.pdf.

Freccero, Julie, Audrey Taylor, and Joanna Ortega. "Family And Me (FAM): A New Model of Foster Care for Youth Impacted by Commercial Sexual Exploitation in San Francisco. Evaluation Progress Report #2." Human Rights Center, UC Berkeley, November 2021. https://humanrights.berkeley.edu/sites/default/files/fam_evaluation_report_2_v14_211222.pdf.

Taylor, Audrey, Aditi Joshi, Joanna Ortega, and Caroline Eskandar. "Family And Me (FAM): A New Model of Foster Care for Youth Impacted by Commercial Sexual Exploitation in San Francisco. Evaluation Progress Report #3." Human Rights Center, UC Berkeley, May 2022. https://drive.google.com/file/d/1V-gJznMxPXRTEq3Wpoaj430LJVZ8EP_Q/view.

of data collected for the evaluation was from service providers. Caregivers completed a limited number of interviews and pre- and post-training surveys on a rolling basis, and one youth participated in interviews (see Limitations). Following is a summary of the evaluation methods.

Service provider interviews: A total of 49 semi-structured interviews were conducted with 25 direct and indirect service providers during four rounds of data collection. Interviews aimed to gather service providers' reflections on pilot strengths and challenges, suggestions for improvement, and lessons learned. Individuals were selected from FAM partner organizations based on their involvement in FAM implementation. Participants were representatives from the following organizations: DOSW, Family Builders, Freedom Forward, HSA, Huckleberry Youth Programs, and WCC.

Caregiver interviews: A total of five caregivers were interviewed. Three FAM caregivers participated in qualitative interviews, with three completing baselines and one completing two follow-up interviews. Two caregivers outside of FAM who were caring for youth affected by CSE and who had participated in the FAM caregiver training completed baseline interviews. Interviews aimed to gain a deeper understanding of caregiver experiences with FAM services, opinions about the utility of services offered, as well as self-reported changes in their capacity to care for youth impacted by CSE.

Caregiver pre- and post-training surveys: Ten caregivers, both FAM and non-FAM, participated in the FAM caregiver training and completed pre- and post-training surveys during the pilot period. Surveys assessed self-reported changes in knowledge, attitudes, and perceptions following the FAM caregiver training.

Youth interviews: Due to the lack of youth participants in FAM and ongoing challenges to enrollment, just one youth participated in the evaluation and completed a baseline and follow-up interview (see Limitations). Interviews focused on youth service needs, experiences with FAM services, perceptions of the support received, and the impact of FAM services on outcomes, such as their sense of placement stability and adult and peer relationships.[42]

Youth survey: One baseline survey was completed by one youth participant in the evaluation. The survey included validated instruments to assess the influence of the intervention on several outcomes such as trauma symptoms and substance use, and included questions to assess changes in experiences of CSE.[43,44]

Case notes on youth referrals: Every two weeks from July 2019 to July 2022, HRC researchers met with the Family Builders Permanency Worker to discuss the enrollment status of each youth who had been referred to FAM as a potential participant. These youth had been identified by HSA, Huckleberry Youth Programs, or another FAM partner as being a survivor or at risk of CSE and referred to either the SF SOL Collaborative or to Family Builders directly for FAM support. In total, during the pilot, 14 potential youth referrals were actively followed for periods ranging from less than one month to nine months. During these meetings, the Permanency Worker shared details about the circumstances of each youth and their potential caregivers, as well as challenges in engaging with them and enrolling them in the FAM pilot. HRC researchers took detailed case notes which were then analyzed to

42 To protect the anonymity of the youth, findings were not included in this report.

43 Child Report of Post-Traumatic Symptoms (CROPS), California Healthy Kids Survey, Youth Behavior Risk Survey, Youth Quality of Life Scale, and the Brief Resilience Scale.

44 As previously stated, findings were not included in this report to protect the anonymity of the youth.

identify trends in service needs, as well as barriers and strategies in outreach and engagement.

Ethics and Data Analysis

All research procedures and protocols described in this report were approved by the University of California, Berkeley Committee for the Protection of Human Subjects' Institutional Review Board to ensure adherence with all human subjects research protections. Due to the COVID-19 pandemic, all interviews were held by Zoom or phone. Written informed consent was obtained from all adult interview participants. Written informed assent was obtained from the youth participant, as well as written permission from the youth's attorney. Members of the California Child Welfare Council's CSEC Action Team's Advisory Board[45] and Freedom Forward's FAM Youth and Caregiver Advisory Boards reviewed and provided feedback on interview guides, surveys, and consent forms, and their input was incorporated into final study instruments. They also advised on key study procedures such as the evaluation enrollment process, data collection, and participant compensation. Interviews were audio-recorded and transcribed, and detailed notes were taken during the interviews. Two to four research team members coded and thematically analyzed data to identify key patterns in participant responses. An iterative process of open coding was used to identify categories or broad themes that served as a basic framework for analysis. Researchers then inductively identified sub-themes.

LIMITATIONS

The primary limitation of this evaluation is the lack of youth participants. To effectively prevent and respond to the CSE of youth, it is essential to ensure that youth impacted by CSE are actively involved in shaping the policies and programs that aim to support them. Further, one of the core values of the SF SOL Collaborative is to promote youth voice and choice. A developmental evaluation approach was selected to ensure that youth voices are at the center of the pilot's design, implementation, and evaluation. Unfortunately, the pilot and evaluation encountered numerous delays and challenges, including COVID-19 restrictions, recruitment barriers, and coordination difficulties, which are detailed in the FAM Activities and Findings sections. As a result, only one young person was enrolled in the FAM pilot. In order to maximize learning about youth impacted by CSE, the HRC evaluation team adapted the service provider interview guides to explore successes and challenges in identifying and engaging youth in FAM, and analyzed detailed case notes on youth referred to the FAM program from bi-weekly meetings held with the Family Builders' Permanency Worker. In addition, due to the limited number of caregiver participants in the FAM program and FAM caregiver training, data collected from caregivers to inform research findings and recommendations is also limited. Further, COVID-19 and related restrictions delayed the start of pilot implementation and the enrollment of youth and caregivers in FAM was slower than anticipated. In turn, the amount of time for data collection was limited, and follow-up interviews were only possible with one secondary caregiver and one youth participant. Finally, due to a small sample size, particularly of youth and caregiver participants, findings are reported at a broader, thematic level in order to maintain confidentiality and anonymity of research participants.

45 The CSEC Action Team's Advisory Board is composed of adult lived experience experts who have personal experience with CSE as children or youth. For more information, see: https://youthlaw.org/advisory-board-csec-action-team-old

FAM ACTIVITIES

PLANNING AND DESIGN for the FAM pilot began in July 2019. This phase was intended to last six months; however, delays in establishing clear referral pathways, protocols, and memorandums of understanding between the many partners meant that planning was still underway in March 2020 when the COVID-19 pandemic began. After adapting the pilot and its various services as necessary for virtual delivery, the pilot began pre-enrollment activities in July 2020.

The goals for the pre-enrollment period were to establish and develop the collaboration of organizations supporting the FAM pilot, conduct outreach and engagement activities with youth, and recruit and train caregivers, among others. However, complications related to COVID-19 restrictions, high staff turnover, and coordination challenges made this more difficult than expected–particularly with youth engagement and caregiver recruitment–and the phase was prolonged until February 2021.

From March 2021 to July 2022, the FAM pilot focused on service provision. By the beginning of this phase, no youth referrals or potential caregivers had converted into placements. It was clear that FAM needed to adapt several components of the pilot to serve more youth and caregivers. To achieve this, the interagency referral protocol was updated to streamline referrals through SF SOL before youth were further referred to specific services within SF SOL, such as FAM. Youth eligibility criteria were expanded from serving only youth under the age of 17.5 to include youth up to age 21, and permanency services were expanded to youth not planning to live in a FAM home. Later, FAM further extended eligibility criteria to include youth who are expecting and/or parenting. It also expanded access to discretionary funds to youth across SF SOL.

By September 2021, a permanency social worker was onsite at the HYPE Center to offer in-person permanency services to youth. FAM also engaged in caregiver recruitment efforts within the community. In addition to a robust social media campaign, FAM developed a public service announcement (PSA) to help spark caregiver interest. FAM trainings and FAM consult groups were also opened to any caregivers supporting system-involved youth affected by CSE, not only those connected with FAM. FAM partners established a Caregiver Recruitment Workgroup to help support and guide this process.

Notwithstanding significant changes and adaptations to the pilot, by July of 2022, just two caregivers had completed the RFA process–one primary and one secondary–and only one youth had been placed: a short-term arrangement until the youth turned 18 and then pursued transitional housing. However, in spite of the disappointing outcomes in terms of youth placements, many service providers within FAM reported that the pilot has been critical for expanding the conversation and shining a light on good practices for youth experiencing CSE. At this time, the FAM pilot is undergoing significant revisions based on the findings from the evaluation. Design and implementation of a new iteration of the FAM model (FAM 2.0) is scheduled to begin in early 2023.

KEY ACHIEVEMENTS

Youth Outreach and Engagement

- 16 youth identified and referred to FAM for services and support, 14 of which were during the evaluation period
- 12 youth engaged in permanency services, 10 of which were during the evaluation period.
- 1 youth placed in FAM caregiver home with supportive secondary caregiver for short-term placement
- 7 FAM and SF SOL youth supported with discretionary funds for clothing, food, cell phone, school supplies, and other needs
- Youth eligibility criteria developed, youth identification processes and interagency referral pathways established, youth enrollment process defined
- Youth identification and engagement activities undertaken, including placing FAM Permanency Worker at HYPE Center for direct engagement and outreach to referral partners like HSA
- Interagency referral protocol for youth revised and Service Coordination Team developed to improve case management
- Youth eligibility criteria expanded to serve non-minor dependents up to age 21 and expecting and/or parenting youth; discretionary fund eligibility expanded to providers serving CSE-affected youth across SF SOL

Caregiver Recruitment and Training

- 323 community caregiver inquiries received from JoinFAM.org
- 91 potential caregivers completed screening and approved to attend FAM orientation
- 27 potential caregivers attended FAM orientation
- 7 potential caregivers joined intake/RFA process
- 15 caregivers completed FAM training: 7 potential FAM caregivers and 8 non-FAM caregivers of youth at risk of CSE
- 2 potential caregivers completed RFA process: 1 primary and 1 secondary
- 4 caregivers supported with discretionary funds for furnishings, housing, food, fees for RFA, and other needs
- Caregiver outreach and engagement efforts completed, including word-of-mouth, presentations to local groups/organizations, public-facing website JoinFAM.org, paid Facebook advertising, extensive social media campaign, and PSA promoted online and at anti-trafficking events
- Caregiver orientation and specialized training curriculum developed; orientation process streamlined for more flexible engagement; training streamlined, updated with simplified language, and made available to non-FAM caregivers of at-risk youth; training well-received by attendees
- FAM consult groups developed and eligibility expanded to non-FAM caregivers of at-risk youth
- Caregiver Recruitment Workgroup developed within FAM collaborative; social media recruitment toolkit created

Collaboration, Coordination and Referral

- Promising model of foster care for CSE-affected youth developed, with continual commitment to adaptation and improvement of all elements of the pilot over time
- Collaborative of Organizations in San Francisco County established and developed to support the FAM pilot with a wealth of knowledge, resources, and deep commitment to improving outcomes for CSE youth
- Relationships, connection, and communication between FAM partners strengthened over time
- Advisory Boards including youth impacted by CSE and caregivers established and engaged
- Toolkits, guiding principles, protocols, presentations, a team handbook, specialized trainings, and other invaluable tools created to support placement of CSE and at-risk youth with in-home placements
- Systems put in place for data tracking and evaluation to continuously improve FAM and inform similar placement programs and models nationwide

FINDINGS

YOUTH IDENTIFICATION AND ENGAGEMENT

Strengths and Successes

FAM partners and external service providers have gained knowledge and tools to support and refer youth at risk of or experiencing CSE.

According to interviewees, training of FAM partner staff has helped to improve their knowledge and skills to better engage, support, and refer youth at risk of or experiencing CSE. Collaboration and knowledge-sharing among FAM partners with differing expertise in CSE has also helped to expand their knowledge and skills. Interviewees identified a variety of training and advocacy materials, accessible in a shared drive, as being particularly helpful. They also mentioned the value of awareness-raising efforts by FAM partners, such as meetings with HSA, trainings at HSA, a Youth User Experience meeting, and the development of a FAM brochure. These activities helped to augment awareness about FAM services, deepen understanding of the referral process, and encourage referrals to FAM services among providers not involved in FAM.

> *"They [the FAM collaborative] have expanded the conversation in a way that has been helpful and really shined a light on best practices for kids experiencing commercial sexual exploitation in a way that has been beneficial. . . . I think that the work and the effort to continue to try to find ways to improve what happens for kids in this situation is valuable."*

Expansion of FAM criteria increased the number of vulnerable youth eligible for FAM services.

Original eligibility criteria for FAM included minors under the age of 17.5 at the time of enrollment. However, during the course of the pilot, FAM partners learned that many of the youth identified by HSA as being survivors or at risk of CSE were 18 or older and therefore ineligible for FAM. Service providers also reported that engaging and building trust with youth takes time, and some turn 18 during that process. As such, FAM criteria were broadened to include youth up to age 21, as well as referrals for expecting and/or parenting youth. Permanency services were also expanded to serve youth who decide not to pursue placement in a FAM home.

> *"A lot of [these] young people . . . are the ones that are experiencing so much trauma, and then also dual diagnoses. They're mid-teens, which is when a lot of this needs to happen. A lot of the coordination and getting people connected, and all of this family-finding work needs to happen . . . when they're the least stable and the hardest to stay in contact with. Which means that it's very start stop with this process. Sometimes, they hit 18, and developmentally, they're in a better place to be able to cope. If they've made it that far, then it's really good to know that FAM is still on the table for them."*

Challenges

Despite significant efforts by the pilot partners, including expanded FAM eligibility criteria, the initiative ultimately placed only one youth in a home setting during the pilot timeframe. In general, FAM services were unable to meet the needs of youth in this community. This was in part due to tension between the original design and the priority needs of youth. For example, FAM focuses on permanency services and was not designed as an emergency placement model, but youth in this population often need a place to stay immediately.

> *"When youth are MIA, out of placement in the life, they don't have time to talk about reconnecting with extended family. They're focused on where they're gonna sleep that night or what they're eating."*

Additional challenges are detailed below.

Family-based placements were unavailable.
A key shortcoming of the pilot was the lack of family-based placements available during the project timeframe. This was largely due to the fact that FAM did not have caregivers ready for youth. Although the pilot was designed to include a list of approved community caregivers that youth could be connected with immediately, that did not occur due to caregiver recruitment and retention challenges. (See Caregiver Recruitment, Engagement, and Training section.)

Few service providers referred youth to FAM services.
Service providers outside of FAM often did not refer youth because they were unfamiliar with FAM services, the referral process, or the value-add of FAM. Some providers were skeptical that FAM would meet youths' needs, which frequently involved the need for immediate housing. Others were hesitant to refer to FAM without available placements. Many youth were already in family placements, and social workers did not want to disrupt existing placements

Credit: Freedom Forward

in order to refer youth. There was also confusion about the difference between the individual agencies that providers have been referring to for years and the new FAM pilot. Some providers were unaware of the expanded eligibility criteria, which could have deterred referrals. Finally, the large number of organizations involved in FAM and the communication and coordination challenges between providers also limited referrals. (See Collaboration, Coordination, and Referral section.)

Service providers struggled to engage youth in this community.
Service providers described the effort required to engage youth who are away from placement, using terms such as "hard," "difficult," and "really a challenge". Some providers did not anticipate the level of crisis that these youth experience and struggled to effectively support them with the resources available. A number of youth were not involved in any services or connected to any caring adults, and providers reported that it was difficult to reach these youth to even begin discussing the FAM pilot. Youth who are involved in services may not be in contact with providers for months at a time. Service providers emphasized that trust- and rapport-building are essential to youth engagement, but that these are

INSIGHTS FROM YOUTH REFERRALS

While only one youth was enrolled during the FAM pilot, a lot can be learned from the 14 youth referrals that were received during the evaluation period. Analysis of referral case notes led to the following findings, which may prove useful in the development of FAM 2.0.

Demographics: Of 14 youth referrals, 12 were girls/women, one was a boy/man, and one was a non-binary youth. Where known, ages ranged from 13 to 21. Youth referrals were followed for periods of less than one month up to nine months.

Housing stability: Over the weeks to months in which youth referrals were followed, just two had stable housing placements. Two were away from placement throughout the referral period, with one known to be living with her exploiter. The remaining youth had as many as two to four different placements during this time, including temporary placements with biological family, emergency short-term placements, STRTPs, and transitional housing. Eight of these had—often extensive—periods where they were away from placement, during which at least two were known to be living with their exploiters.

Permanency efforts and challenges: Permanency efforts were made on behalf of ten youth. For three, no potential caregivers were identified from among family and adult friends. For the remaining seven, though suitable caregivers were identified, just one led to a successful placement (with one additional case ongoing at the time the evaluation concluded.) Family and friends were often unwilling or unable to care for youth; common reasons for this included housing challenges, health issues, current or prior justice system involvement, and unemployment. At least three became unresponsive during the permanency process. Even when potentially suitable family or friends could be identified, youth often refused placement with them due, at least in part, to their histories together.

Family-based placement challenges: Even if suitable caregivers were identified from among family or the community, youth were often unavailable for placement. As previously mentioned, during the referral period, eight youth had periods in which they were out of placement and often out of touch with their case workers and social workers. Three spent time in juvenile detention and four experienced health challenges that delayed placements, including two pregnancies and one psychiatric hospitalization. A couple youth expressed frustration with frequent staff turnover among FAM collaborative agencies and the significant amount of time agency engagement in general required of them, which at least one felt was interfering with her schooling.

Reasons youth referrals closed: Of the 14 youth, only one was effectively placed in FAM housing (albeit short-term), with two cases ongoing at the end of the evaluation. Of the remaining youth, case workers determined that two were not at risk of CSE, two required higher levels of care than FAM could provide, two were ineligible for FAM because they were seeking placement with siblings, one was out of the coverage area, one was reunified with a parent, and three chose to pursue transitional housing opportunities rather than family-based placements.

understandably time-consuming. Others noted that moving to a home setting was too much of an adjustment for some youth, and that older youth over the age of 18 frequently preferred independence to living with a family.

"When the case is really challenging, it's almost like the client's not ready to engage yet. The client's not ready to receive services yet. Then it doesn't matter how much the providers wanna do something and how often they try to get together and talk through strategies. It's just not happening yet. I can see how it just takes a lot of time and patience to get results."

Additional challenges included:

- **The COVID-19 pandemic,** which resulted in project delays, pausing of services or transitioning to potentially less effective virtual services, and challenges to outreach and engagement of at-risk youth. Some elements of the original design of SF SOL could not be executed or were delayed due to the pandemic and other constraints, such as the development of a short-term residential therapeutic program (STRTP) and the launch of the HYPE Center, both of which were intended to serve as sites for engaging youth in FAM.
- **Staff turnover,** which undermined trust-building with youth and service providers and required repeated discussions about coordination processes as new staff joined the pilot.
- **Differing capacity and approaches among some service providers to effectively support youth who have experienced CSE,** which hampered youth engagement and service provision.

CAREGIVER RECRUITMENT, ENGAGEMENT, AND TRAINING

Strengths and Successes

Caregivers have gained knowledge of CSE and trauma-informed care for youth.

A total of 15 caregivers (seven potential FAM caregivers and eight non-FAM caregivers) attended three training sessions during the pilot, including nine women and one man of varying ethnicities: Black, Asian, Latinx, and white. Pre- and post-tests from ten participants revealed improved understanding of CSE and trauma-informed care among caregivers. Trainees showed marked improvements in understanding related to being able to identify CSE warning signs, knowing how to use healthy conflict resolution strategies, and making their home a safe environment for youth with trauma histories. They also demonstrated increased understanding that boys also experience CSE and that minors cannot legally choose to engage in commercial sex.

> *"It's really a beautiful thing because at the end of the day [after training], they [caregivers] don't have stigmas. They recognize that these are kids in a bad situation, not bad kids."*

A multi-pronged outreach strategy helped to recruit caregivers.

FAM partners deployed a variety of outreach efforts to identify caregivers including:

- A Caregiver Recruitment Workgroup, which met bi-weekly to discuss and develop strategies to improve recruitment efforts.
- A caregiver recruitment toolkit to help FAM partners in their recruitment via social media.
- The development of "FAMbassadors," internal and external FAM partners who help spread the word about the opportunity to participate as a FAM caregiver.
- Digital advertising campaign strategies, with social media advertisements being particularly effective at generating interest.
- A PSA video,[46] which was promoted online and at anti-trafficking events.
- The expansion of the caregiver training to non-FAM caregivers, which helped to build awareness and increase engagement with FAM among other organizations.

Multiple efforts helped to improve engagement and communication with potential caregivers.

FAM streamlined the caregiver recruitment workflow in several ways, which improved communication with potential caregivers. Changes were made to the caregiver signup website to reduce the number

46 Freedom Forward. "FAM (Family And Me) PSA." Accessed November14,2022.https://www.youtube.com/watch?v=150xNfMBsKY.

CAREGIVER REFLECTIONS

Five caregivers who engaged with FAM or FAM trainings participated in semi-structured interviews. They reflected on caregivers' experiences and offered recommendations to improve the FAM model:

Motivations: Caregivers reported being motivated by a desire to help children and youth in need, and noted the personal reward of seeing their efforts and support help to create a better future for children.

Essential attributes: Building trust, being non-judgmental, and having good listening skills were seen as the most important factors in developing a successful relationship with a foster youth.

Valuable resources: Family therapy and support/consult groups can be valuable sources of support because they provide a space to talk to and receive advice from fellow caregivers, to learn from others' experiences, and to better prepare caregivers for challenges that may arise.

Recommendations: Interviewees had a number of suggestions to improve FAM's caregiver training such as:

- Providing ongoing training, post-training mentoring support, and/or refresher courses.
- Including a module on how to support youth from different cultural contexts.
- Providing future training sessions in-person (rather than online), and including caregiver presenters to share firsthand experiences.
- Offering the training in Spanish.

of people signing up who did not meet requirements. Family Builder's Family Developer became engaged earlier in the recruitment process to improve communication and retention of interests. Online platforms for tracking individuals interested in the FAM caregiver training, caregiver monthly groups, and RFA orientation helped strengthen caregiver engagement and communication. In addition, the FAM orientation sign-up process was expanded to include both one-on-one and group formats for more flexible engagement, and language used in the FAM training was simplified to make it clearer and more accessible.

Challenges

There were numerous challenges in the recruitment, training, and retention of caregivers. Only one primary and one secondary caregiver completed the RFA process during the course of the pilot. Although a number of people expressed interest in becoming caregivers via the FAM website, many of these did not meet basic requirements to attend orientation, and few of those who did chose to attend. An even smaller number decided to move forward after the orientation session and participate in an intake interview. Although an exit survey was developed for prospective caregivers who withdrew from the process, just two completed the survey: one withdrew due to health challenges and one moved out of the county. More formal data on the causes of retention challenges are lacking. The COVID-19 pandemic was likely a hindrance to recruitment, as it was suspected that potential caregivers did not want to bring new people into their homes; the pandemic further undermined caregiver outreach and engagement. Other key barriers are listed below.

Housing requirements were a significant barrier to caregiver retention and RFA.

To meet licensing requirements, caregivers must have a spare bedroom for the youth, which is prohibitive for many families, particularly in the Bay Area with its housing affordability and availability crisis. Although FAM offered compensation at the Intensive Services Foster Care (ISFC) rate, which is significantly higher than the standard rate, and discretionary funding to

Credit: Freedom Forward

support caregivers' home set-up, ongoing financial support for rent was not included. Interested caregivers would have to give up their (often rent-controlled) homes and move into larger ones to participate, which many found impractical and unsustainable. When asked about the reasons for potential caregivers not following through, service providers emphasized housing as a primary issue.

> *"They can't afford to move, or they have a rent-controlled apartment they're reluctant to give up. People drop out when they find out the youth needs their own room, or they say they'll come back when they obtain appropriate housing to take care of licensing. . . . I don't know how feasible that is in the Bay Area rental market, and we can't provide any assistance, like [from] our discretionary fund . . . It's not supposed to be rental maintenance."*

The caregiver RFA process was prohibitively time-consuming.

The RFA process to become a caregiver involves extensive training, home inspections, and background checks, among many other requirements. In some cases, these took a year or more to complete, depending on caregiver responsiveness. The training requirements and paperwork were also particularly intensive, and some participants found the information requirements intrusive. Potential caregivers may not have been aware of the extensive demands at sign-up, and may have become overwhelmed by the RFA process.

> *"My best guess would be that it feels long and confusing and overwhelming to these potential caregivers. Some amount of that is inevitable because it is a long process. Maybe we could do a better job of holding them through it [and] making the benefits feel really worth it."*

Stigma and fears regarding FAM youth inhibited caregiver recruitment.

FAM partners reported that stigma towards youth impacted by CSE deterred caregivers. Potential caregivers reportedly worried that these youth were "troubled" and might have unmanageable behavioral issues. During outreach efforts, advertisement campaigns were unclear about the population served. Restrictions on social media advertisements prohibited terms such as "commercially sexually exploited" or "teens who have been trafficked". In addition, partners were hesitant to use these terms in an effort to prevent labeling or further stigmatizing youth. Once potential caregivers were made aware of youths' history of exploitation, many were no longer interested in participating. Service providers underscored the challenges to identifying people willing to commit to supporting youth affected by CSE – particularly older youth. One service provider shared, "People are afraid that the youth are just gonna be too difficult. That scares them away."

COLLABORATION, COORDINATION, AND REFERRAL

Strengths and Successes

Communication and coordination among FAM partners improved over time.

Despite challenges, many aspects of communication and coordination among FAM partners were

strengthened during the course of the pilot. In particular, the new FAM Director, who was brought on in September 2020, helped to promote interagency cohesion and behind-the-scenes coordination. Regular and effectively-run meetings, such as the FAM Steering Committee, the Service Coordination Team, and a Caregiver Recruitment Workgroup, helped partners to stay focused on collective goals, troubleshoot challenges, keep up to date on activities and referrals, and promote accountability across organizations. Collectively developed resources, such as toolkits, trainings, and the PSA, helped build pride in collaborative work. Communication and information sharing between service providers reportedly helped to improve referral processes.

> *"I feel like there's a need and a want to really get down and solve all our issues. As soon as the recommendations came from the second report, we spent all of January navigating that and figuring out what ways we can make this work."*

Collaboration between FAM implementing partners and government agencies was strengthened. Relationships and coordination among FAM implementing partners and city and county agencies, including HSA and DOSW, deepened over the course of the pilot. DOSW helped to facilitate better relationships between FAM service providers and government agencies, in particular HSA. During the second half of the pilot, FAM partners made significant efforts to engage HSA and educate leadership and staff about the FAM pilot. Service providers reported that the strengthened relationship between FAM and HSA leadership led to more appropriate referrals.

FAM partners demonstrated deep commitment to youth affected by CSE and to the mission of the pilot. FAM partners were dedicated to working together to ensure CSE-affected youth had their urgent needs met and were ultimately placed in safe, supportive, and loving homes. They maintained their commitment to youth throughout the COVID-19 pandemic and worked to creatively adapt the pilot in an attempt to reach more CSE-affected youth, for example, by expanding eligibility criteria and optimizing the use of discretionary funds to meet youth needs. Service providers recognized this commitment among the organizations involved in FAM. As one provider noted, "There's some real heartfelt dedication. [It] was a very strong group of providers."

Challenges

Despite some notable strengths and improvements in interagency collaboration, other aspects of coordination, collaboration, and referrals among FAM partners remained challenging throughout the pilot.

Relationship-building and trust among partner organizations was an ongoing challenge. While most service providers reported improved relationships over time, some continued to report feelings of mistrust, competition, and a general lack of respect among partner organizations throughout the pilot. Numerous factors contributed to this, such as tensions arising from differing levels of experience serving CSE-affected youth and differing approaches to service among partner organizations, particularly between those that prioritized seeking family and other supportive persons for permanency and those that prioritized recruiting community caregivers. Other exacerbating factors included unrealistic expectations of partners, feelings that others were not fulfilling their responsibilities, and a build-up of stress and demoralization resulting from ineffective coordination and communication.

> *"Well, I think there's a fair amount of tension 'cause there's a lot of finger pointing about whose fault it is. There's not a great amount of trust between partners—between some partners. There's disparities in how everybody works."*

Developing agreed roles, responsibilities and goals across multiple organizations was difficult.
Although FAM leadership made efforts to better define various agencies' roles and responsibilities, increase transparency, and promote collective buy-in to shared objectives, significant challenges remained. Effective collaboration with so many partner organizations was difficult. Not all partners were aligned with FAM's goals and approaches; some organizations had differing views on how to achieve the pilot's objectives. Diffuse roles and responsibilities weakened accountability. Some providers were confused about which agencies were responsible for which services, particularly case management, while others were unclear about their expected deliverables.

Staff turnover and overwhelming workloads undermined interagency cohesion and hindered implementation.
Many service providers reported grappling with high stress levels, overwhelming workloads, and burnout exacerbated by the COVID-19 pandemic. Tensions arose between dedicated FAM staff, who had more time to focus exclusively on FAM, and staff who split responsibilities with other programs within their organizations and struggled to meet competing demands. Work-related stressors contributed to high levels of staff turnover during the course of the pilot, which disrupted activities and eroded cooperation among FAM partners. Staff turnover also undercut trust-building, exacerbated stress levels among already overworked staff, and undermined consistent messaging about FAM.

"I feel like . . . the turnover's still going on. That certainly doesn't help with any type of collaboration. [It] is actually a challenge that the individual organizations keep having turnover—people leaving and new people coming—and the team having to get to know a person. That's still going on. I don't think it has improved yet."

Referral processes required further clarity, agreement, and strengthening.
Referrals were hindered by a lack of understanding among partners about the youth referral processes. Service providers reported that there were multiple referral pathways, too many coordinating organizations, and competing intake processes. A Youth User Experience meeting held in early 2022 and other efforts helped to clarify the youth referral pathway and was well-received among partners, but challenges remained.

Additional challenges included:

- **Difficulties in coordinating with government organizations,** such as lengthy bureaucratic processes, concerns about data confidentiality, and confusion among government organizations about what services FAM offers and how they differ from existing services, particularly in the absence of community placements.
- **Frustrations with data collection,** including what data to collect; with whom to share the data; time required to collect and submit data; confusion about differing data requirements between monitoring, external evaluation, and grant reporting; and at times, resistance to data sharing among partners.

FUTURE DIRECTIONS

THE FOLLOWING SECTION synthesizes service providers' reflections on the main learnings from the pilot and implications for the next iteration of the FAM model (FAM 2.0).

The Need for Emergency Placement Options

The critical need for emergency placement options for youth at risk of CSE emerged as a key finding during each cycle of data collection. Many of the youth who met FAM eligibility criteria and were referred to FAM were in unstable housing placements or away from placement altogether, and at least two were known to be living with their exploiters. FAM providers reported that this made it very difficult to connect with them and engage them in services. In addition, family-based care may not be the most appropriate next step for youth who are away from placement. Several service providers described the need for emergency, transitional placement options for youth in crisis to access services and stabilize before moving into a more structured home setting. As one provider shared,

> *"Going from living on the street, in the life, bouncing around with family, to being in a structured family-based home environment is a real big jump and not necessarily something a lot of youth are ready for."*

Providers described the importance of a harm reduction-focused, low-barrier placement option that offers flexibility for youth to come and go and promotes youth agency in decision-making. Such a program could allow for a more gradual transition into family-based care and increase the chance of success by allowing youth to spend time with potential caregivers before moving in with them.

Providers raised several questions about how emergency placement would operate in practice. For example, how will they be staffed: with service providers or professional caregivers? What is the ideal number of youth served in one space? How can they be designed to appeal to CSE-affected youth? How would the location be kept confidential, particularly from exploiters? Other challenges would include state licensing issues, ensuring safety of residents and staff, and potentially high operational costs. An effective emergency placement model for this community will require thinking outside of the box and testing creative new approaches.

Complementary Efforts: Permanency and Community Caregiver Approaches

This pilot utilized a combination of two approaches to recruit caregivers: 1.) identifying family members, relatives, or other supportive adults in youths' lives who could serve as a caregiver through permanency services (a "permanency approach"), and 2.) recruiting caregivers from the community for both placement and permanency (a "community caregiver approach"). The findings suggest that both

approaches have complementary value and should be implemented in parallel.

FAM partners used a permanency approach, which they felt was beneficial for a number of reasons. Recruiting community caregivers for older youth and youth impacted by CSE can be challenging. Potential caregivers who are already part of a young person's network may be the most promising. Likewise, identifying family or known caregivers may help suss out caregivers who are committed to a long-term, supportive relationship with youth after the pilot ends or they age out of the foster care system. As one provider highlighted,

> *"What are we really doing for these young people if we're not giving them some level of permanency to change their life? We can take 'em in for a while, and then the funding ends. The contract ends.... ISFC ends. They're back on the street. What good did we do? What is our real goal here?"*

At the same time, a permanency approach can also be fraught. The process is generally time-consuming and youth often have immediate needs for housing and support. Another provider shared,

> *"I'm glad that our [child welfare] system has made [permanency] a priority 'cause youth do deserve permanent relationships. They do deserve a connection to family and kin and all of the things that come with permanency. They also deserve a safe place to live now. I just think those can be two different things."*

In addition, youth who have experienced CSE may have damaged or severed relationships with family members or relatives, and it can take time to rebuild connections and trust. They may have experiences of abuse and exploitation within their family. Further, permanency may not be a priority for youth who are in crisis and are primarily concerned with more urgent needs, like food and shelter for the night.

Credit: Freedom Forward

As such, community caregiver options are also critical to enable youth to be placed in a family home rather than an institutional setting. Service providers emphasized the importance of dedicating more time and resources to caregiver recruitment activities from the outset and implementing a wide variety of recruitment strategies to raise awareness and educate community members about CSE and the opportunity to serve as a caregiver. They stressed that recruitment ads and materials must be transparent about the population that FAM serves in order to attract people who are truly committed to supporting this community of youth.

All potential caregivers—family members and community members—require significant support to meet RFA requirements and to effectively care for a young person with complex needs, particularly caregivers who also have histories of CSE, prior criminal justice system involvement, or negative experiences with government systems. This often includes ongoing financial assistance to meet housing requirements. Specialized training in trauma-informed care is also essential for caregivers supporting this community of youth.

Simplifying the FAM Model and Streamlining Service Delivery

A clear lesson from the pilot is the need to simplify the FAM model and streamline service delivery. This iteration of FAM involved three organizations delivering services to youth and a separate organization responsible for pilot design, oversight, and management. The rationale for involving multiple providers, rather than delivering comprehensive services in-house through one organization, was twofold: 1.) to draw on existing expertise and specialized services for youth impacted by CSE, rather than duplicate existing services, and 2.) to increase sustainability of FAM after the pilot funding ends by strengthening existing referral pathways and services. In practice, having so many partners hold different components of the pilot led to significant collaboration and communication challenges, confusion among service providers, external partners, and youth, and a weakening of investment in, and ownership of, the pilot over time.

The complexity of a model involving so many partners also made it challenging to maintain effective communication, ensure alignment on pilot goals and procedures, and implement FAM as one coordinated program. Partners explained that there were many levels of leadership within the FAM collaborative, with "too many cooks in the kitchen," and no clear mechanism for decision-making.

> *". . . Our [FAM] team was so siloed by organization when the whole point of FAM was to create a singular, unified, coordinated model. . . . Each organization wanted to do their own intake, and their staff did not see themselves as FAM staff."*

More than half of the FAM providers who participated in closing interviews recommended having fewer organizations involved and providing more or all of FAM services through one organization in FAM 2.0. Simplifying and streamlining service provision would also make it easier for youth to access services by reducing the number of organizations and providers that they need to interact with. Many partners also emphasized the need for the organizations implementing the FAM model to have expertise in working with youth impacted by CSE and the child welfare system.

Sustainability Challenges and Opportunities

Sustainability of the FAM pilot emerged as an important topic of discussion in later stages of the project. Some partners expressed concerns that the FAM model was impractical due to its high cost and complexity, while others felt there should have been more planning and discussion of sustainability from the start. Half of service providers in closing interviews emphasized that, in order to build in a plan for sustainability, it would have been helpful to have engaged HSA more meaningfully from the outset. Involving the county child welfare department in the design process could help secure their buy-in and commitment to effectively collaborating and making referrals. It could also assist service providers in developing realistic implementation goals in light of the current system and its constraints. Likewise, early collaboration could also help to reduce the duplication of existing services, training, and resources for youth and caregivers. Some FAM partners recommended that, ideally, the FAM model of care should be transitioned to HSA to manage or implement and that there should have been more conversation with the state about sustained funding for FAM.

Some FAM partners felt that viewing FAM as a model of care (rather than a standalone program), with components that could be brought to youth and caregivers in existing placements with other FFAs, would also be more sustainable than a comprehensive program involving numerous partners and highly specialized wraparound services for youth.

When looking forward at priority components of FAM that should continue into FAM 2.0, interviewees focused on the secondary caregiver component and discretionary funding. Most service providers reported that the secondary caregiver component was a very promising and important part of the model. They felt it helps to ensure that youth have at least two highly trained adults who they can go to for support, as well as giving primary caregivers much-needed respite and peer support afforded by a co-parenting model. To promote sustainability, however, FAM would need to work with the county or the state to incorporate this component into existing structures and regular funding streams. In addition, interviewees felt discretionary funding was a necessary component of the model in order to support and retain caregivers.

> *"There's so much money in the child welfare system that's not directly benefiting youth. How do we make this money immediate and responsive? Discretionary funds—fast and flexible—should be a critical part of [FAM] 2.0."*

Finally, some partners emphasized that the most important strategy to improve sustainability of the FAM model is to demonstrate that it works. FAM providers generally felt that the model has yet to be effectively piloted and evaluated due to the challenges in recruiting caregivers and lack of youth participants. However, they were hopeful about the opportunity to serve youth and families and evaluate the model in FAM 2.0.

RECOMMENDATIONS

The following recommendations, based on the findings of this evaluation, are intended to inform the next iteration of the FAM model (FAM 2.0) to be launched in 2023. The recommendations may also be valuable for donors, policymakers, and practitioners working to improve placement models and support services for youth impacted by CSE.

YOUTH IDENTIFICATION AND ENGAGEMENT

1. **Engage youth who have previously experienced CSE in assessing and redesigning the FAM model to ensure it meets the needs of CSE-affected youth.** Work with youth who have previously experienced CSE to better understand and serve this population. Actively collaborate with the FAM Youth Advisory Board in model design, implementation (particularly youth outreach and engagement), and monitoring in the next phase of FAM. Ensure that the FAM model is responsive to the needs of youth experiencing CSE, rather than seeking youth who fit the existing framework.
2. **Develop an emergency placement model, or partner with other service providers to offer emergency placement options, for CSE-affected youth.** Ensure emergency placement options have a harm reduction focus and offer youth flexibility and a safe space to stabilize and engage in services before they transition to a FAM home.
3. **Consider extending FAM components to youth who are already in placements.** Prioritize bringing the components of FAM that are unique or are not currently offered through traditional foster family agencies (FFAs) to existing placements, such as access to secondary caregivers, flexible discretionary funding, and specialized training for their caregivers.
4. **Expand direct outreach efforts to youth, particularly in-person.** Conduct direct outreach efforts at virtual and in-person locations where youth live or spend time, such as the HYPE Center. Brainstorm additional outreach strategies with the FAM Youth Advisory Board.
5. **Offer permanency and community housing options in tandem.** Provide youth with the option to engage in permanency services to strengthen relationships and explore potential caregivers within their family or existing networks, as well as community-based placements with caregivers who are not previously known to youth. Ensuring that both options are available will allow youth to pursue the pathway to placement that best fits their unique needs and desires and is responsive to the willingness and capacity of family members and other supportive adults.

6. **Develop creative solutions to engage CSE-affected youth who face increased barriers to engagement and family-based placement.** Consider emergency housing and other stable placement options for youth out of placement while pursuing home-based options. Develop ways to further support and remain engaged with youth who are expecting or parenting, have unique health challenges, or are involved in the juvenile justice system.

CAREGIVER RECRUITMENT, ENGAGEMENT, AND TRAINING

1. **Expand caregiver outreach and work to destigmatize CSE.** Further share digital advertisements and the caregiver PSA on social media and other media channels, and develop and share new outreach materials. Ensure these materials help to destigmatize youth who have experienced CSE, while accurately representing the diverse race/ethnicity, gender, and sexual orientation of this population. Continue to track signups from outreach campaigns to better determine their effectiveness, including why and with whom they were effective.
2. **Identify key reasons why potential caregivers withdraw during the recruitment and RFA processes and develop strategies to strengthen retention.** Reach out to potential caregivers who drop out of the recruitment and RFA processes to obtain more insights into their decision. Gather feedback from caregivers who have completed the RFA process about their experiences. Map out when and why caregivers are dropping out or stalling in the process. Develop targeted interventions to improve retention at significant drop-off points.
3. **Explore ways to streamline the RFA process and further support caregivers to complete requirements.** Identify any possible measures to minimize the length of time involved in the RFA process and make it more accessible. Begin the process as soon as potential caregivers express interest, offer flexible formats for completing training requirements, and provide consistent, ongoing support as they go through the steps. Consider creating a tool that caregivers can reference when questions arise, such as a timeline and FAQ detailing the RFA process.
4. **Develop strategies to address housing barriers to caregiver participation.** Work with the Caregiver Recruitment Workgroup and other key stakeholders to brainstorm ways to support potential caregivers struggling to meet housing requirements, such as using FAM discretionary funds to provide for security deposits, application fees, furniture, moving costs, or as temporary rental assistance. Explore advocating for long-term policy solutions, such as collaborating with the Mayor's Office of Housing and Community Development and the San Francisco Housing Authority to include foster caregivers as a priority population to attain affordable housing.
5. **Continue to expand FAM services to caregivers outside of FAM who are already serving CSE-affected youth.** While continuing to explore ways to better serve youth who are currently out of placement, consider collaborating with FFAs to extend FAM to caregivers and youth with existing placements. Consider bringing other promising components of FAM that are not currently available through traditional FFAs to existing placements, such as access to secondary caregivers, specialized training, and flexible discretionary funding, to ensure that caregivers are equipped with the

skills and resources they need to serve this population of youth.

6. **Consider advocating for more flexible requirements for secondary caregivers.** Easing requirements on housing or exploring ways to shorten the RFA process for secondary caregivers could allow adult family and friends who are not eligible or willing to serve as primary caregivers to take on the secondary role. By reducing barriers to serving as a secondary caregiver, adult friends and family members who are already playing a supportive role for youth could benefit from FAM's specialized training and resources.

COLLABORATION, COORDINATION, AND REFERRAL

1. **Simplify the FAM model, reduce the number of implementing organizations, and streamline service delivery.** Reduce the number of implementing partners involved in service delivery and provide as many services through one FFA as possible to reduce confusion, coordination challenges, and make it easier for youth and caregivers to access support. Consider simplifying the model to retain only those components that are unique to FAM and were identified by partners as particularly promising: secondary caregivers, highly specialized caregiver training addressing trauma and CSE, and flexible discretionary funds. Ensure that the organization(s) implementing the FAM model of care has expertise in working with youth impacted by CSE and the child welfare system.
2. **Further clarify service provider roles and promote consistent communication and trust-building among partners.** Establish practical collective goals and instate regular data sharing across providers to improve coordination and accountability before beginning implementation of FAM 2.0. Increase cohesion by identifying new ways to delineate what each organization and individual is responsible for, and ensuring that each service provider knows what their counterparts do and who to go to if they have specific questions or requests. Consider establishing additional targeted workgroups, akin to the Service Coordination Team and Caregiver Recruitment Workgroup, to improve interagency communication and functioning. Explore additional ways to build trust among partners, such as more frequent communication and one-on-one meetings as well as FAM retreats or workshops to come together, reflect on progress, and engage in collective goal-setting.
3. **Promote referrals by expanding outreach efforts with HSA and other referral agencies.** Enhance engagement with HSA and other referral agencies, such as through information sessions and trainings, to develop and strengthen relationships with social workers and other referring partners. Consider establishing additional pathways for referrals into FAM, such as through collaboration with the Juvenile Probation Department. Accurately communicate to referring agencies what FAM components are available to set expectations and avoid frustration when pieces are not yet in place. Consider expanding the scope of the pilot beyond San Francisco to other Bay Area counties to increase the number of youth eligible for FAM.
4. **Strengthen referral processes to improve service provision for youth.** Streamline referral processes to minimize time requirements of youth, to ensure youth engage with as few service providers as possible, and to ensure that any direct service contacts are responsive, consistent, and work

to build meaningful rapport with the youth. Improve internal communication on youth referral processes to make certain that no youth are lost in the referral process and that they are provided with appropriate services in a timely manner.

5. **Ensure women of color, youth, survivors of CSE, direct service providers, and other key stakeholders have meaningful roles in high-level decision-making within FAM.** Ensure Black women in particular are involved in FAM leadership and on the SF SOL Steering Committee to reflect the demographics of San Francisco Bay Area youth impacted by CSE who are involved in the child welfare system. Involve more youth and survivors of CSE as subject matter experts in decision-making. Ensure that direct service providers are involved in shaping and improving the FAM model of care, including in design, implementation, and monitoring. Improve transparency and communication between management and those in direct service roles.
6. **Prioritize efforts to reduce burnout and staff turnover.** Where feasible, create more full-time staff positions for service providers within FAM. Review expectations of existing staff and staff workloads and ensure that they are appropriate and feasible. Ensure project budgets allow partners to offer cost-of-living and merit increases to staff salaries. Explore ways to reduce, consolidate, outsource, or automate time-consuming administrative tasks. Provide specialized training, technical support, and mentoring, particularly for service providers who have not worked with this youth population. Brainstorm with staff to find additional ways to address burnout and turnover, and to promote staff well-being.
7. **Develop a plan for sustainability from the start.** Engage in concrete discussions with CDSS and HSA about how to extend FAM services and support after the next pilot period ends and develop a plan for sustainability that addresses issues such as potential long-term funding streams, strategic advocacy, uptake by the county, and replication to other locations, if the model is successful. Develop a strong relationship with HSA from the outset and meaningfully engage them in the conceptualization and design of the next iteration of FAM to improve long-term buy-in, increase referrals to the program, and reduce duplication of existing training and services.
8. **Ensure rigorous external evaluation of FAM 2.0.** Conduct research to assess the feasibility of the next iteration of the FAM model, as well as the influence of intervention activities on youth and caregiver outcomes. Engage youth with lived experience in CSE and foster care, caregivers, service providers, and other key stakeholders in the evaluation design process. Ensure that the evaluation supports ongoing iteration and improvement of the FAM model and centers the voices of youth.

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