ARKANSAS
HUMAN TRAFFICKING COUNCIL

Child Sex Trafficking (CST) Coordinated Rapid Response Protocol

This protocol is not designed to restrict or change current investigative policies, procedures, or practices within a particular law enforcement agency, but rather to enhance current investigative response.

OUR GOALS

To identify all forms of human trafficking.

To provide all victims access to services.

To investigate and prosecute HT cases at the local, state, and federal levels.

To address individualized service needs through a comprehensive array of service providers.

OUR CORE VALUES

Diligence

- Meeting expectations.
- Continued agency commitment.

Perseverance

- Resolve conflict promptly.
- Continue to support victim – no matter status of case.
- Keep working the case even if it is overwhelming.

Accountability

- Define rules of engagement.
- Clear communication.

Integrity

- Confidentiality.
- Avoid backdoor conversations.

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I. Purpose

This protocol serves as one tool used by a collaborative, multidisciplinary team (MDT) to improve the experiences of victims/survivors of sexual exploitation and/or trafficking in Arkansas. The protocol is designed to make critical changes to individual, agency, and systems efforts in the response to sexual exploitation and trafficking. In Arkansas, this protocol is designed for use by individuals and the agencies working directly with minors who have been exploited or trafficked.

This protocol focuses on the critical elements of the initial, rapid response in an effort to improve outcomes for victims/survivors. Each agency adopting this protocol agrees to use this information to strengthen their practices, policies, and procedures. Each participating agency agrees to invest the appropriate time and resources to ensure change occurs to comply with this protocol.

AHTC Council adoption of this document serves as a commitment to that work on behalf of all agencies.

II. Definitions/Terminology

A. Child Sex Trafficking Victim
   1. Victims of child sex trafficking (CST) are defined as a person less than eighteen (18) years of age who has been subject to sexual exploitation because the person:
   2. Is a victim of trafficking of persons under A.C.A. § 5-18-103;
   3. Is a victim of child sex trafficking under 18 U.S.C. § 1591, as it existed on January 1, 2017; or
   4. Engages in an act of prostitution under A.C.A. § 5-70-102 or sexual solicitation under A.C.A. § 5-70-103.

B. High Risk Victims (HRV)
   1. Missing (i.e., runaway) children under 18 years of age that have been recovered multiple times regardless of whether the parent, guardian or custodian filed a report with the appropriate agency. Multiple will be defined as recovered missing children who have been missing on more than (3) occasions in a 12-month period.
   2. Children who are 12 years of age or younger and are missing (i.e., runaway).
   3. Children under 18 years of age who have been reported as and are currently in missing (I.e., runaway) status for a prolonged period of time. Prolonged period of time will be defined as children who have been or were missing for over (15) consecutive days.
   4. Foster child that is categorized as missing from out-of-home placement. A child or youth in DCFS custody is categorized as missing if the child or youth, runs away, is abducted by a known/unknown person, or is otherwise absent from care with no

known location.

5. Children under 18 years of age with repeated reports of sexual abuse and exploitation. Repeat victims of sexual abuse or exploitation will be defined as (2) or more events in a 12- month period.
6. Children under 18 years, based solely on a screening tool, is it is reasonably suspected that there is a high likelihood CST or sexual exploitation.
7. Child victim of sex trafficking.

C. Commercial Sexual Exploitation of Children ("CSEC") Advocate or Agency

1. CSEC is a broad term that encompasses all forms of child sexual exploitation and abuse. This may include many of the other terms, including child sex trafficking (CST).
2. CSEC Advocate refers to an employee or volunteer advocate of an agency recognized as providing specialized services to victims of child sexual exploitation and abuse (i.e., CST).
3. CSEC Agency is the non-government organization (NGO) that employees or supervises volunteers who provide specialized services to victims of child sexual exploitation (i.e., CST).

D. Case Discovery/Origination Types

1. Recovered Victim
   a) Any child under 18 years of age who is recovered by law enforcement officers, ASP CACD, or ADHS DCFS under circumstances which appear the child is a victim of child sex trafficking.
   b) A recovered missing child who is 12 years of age or younger when they are recovered by law enforcement, ASP CACD, and ADHS DCFS.
   c) Any recovered High-Risk Victims.
   d) Victims who are identified at, or present at, an area hospital emergency room.
   e) Any child recovered by law enforcement officers, ASP CACD, ADHS DCFS, partnering agencies operating under this protocol, who based on the totality of the circumstances at the time of the recovery, feel the child should be classified as an HRV.
2. Child Abuse Hotline Referrals
   a) Referrals which allege possible CST
   b) Referrals on a possible HRV
   c) Referrals which allege possible child labor trafficking.
3. Placement Disclosures/Referrals- These are victims who have already been recovered and/or disclose while in the system.
   a) Referrals from partnering agencies operating under this

protocol, placements, juvenile detention facilities, ADHS Division of Youth Services, or shelters where the victim discloses actual or possible CST.

b) Disclosure of sex abuse/exploitation by an HRV

4. Conventional System Reports

a) Case reported through traditional crime reporting to a law enforcement agency.

5. Assessment Referrals

a) A referral where there has been no victim disclosure, but based solely on a screening tool, it is believed there is a high likelihood of CST or sexual exploitation.

E. Response Continuum

1. The response to reported, or discovered cases of HRV, or victims of CST is defined as follows:

a) Identification

b) Notification Procedures to LE/Child Abuse Hotline/AHTC Coordinator

c) Rapid Response Team

d) MDT Response/Agency-Specific Response

e) After-care and Long-term Supportive Care Response

F. Rapid Response Team (RRT)

1. A RRT should be utilized when a HRV or victim of CST has been recovered, regardless of whether a disclosure has been made, or when there is a reasonable belief that a child is in an exploitative situation.

2. A Rapid Response Team should consist of, but is not limited to, representatives from the following:

a) Law Enforcement

b) ASP CACD

c) ADHS DCFS

d) Children's Advocacy Center

e) CSEC Advocate

f) Prosecutor

g) Medical

h) AHTC Coordinator

3. The Rapid Response will be divided into three phases providing a hierarchical delivery of services:

a) Crisis Intervention (Initial Response within the first six hours)

b) Crisis Management (6 hours to 24 hours)

c) Coordinated Investigation & Care Management (24 hours to resolution)

4. Rapid Response Team Roles and Responsibilities

a) When notified, team members will respond in a timely manner.
   (1) Timely manner is defined as a two (2) hour response time in urban areas and as a four (4) hour response time in rural areas. Response times should never exceed six (6) hours.
b) Participate in the multidisciplinary investigative process,
c) Routinely share information among team members and provide information about case status as needed and as allowed by law,
d) Refer appropriate cases to the MDT or RRT for purposes of continued investigation, victim/family advocacy, victim support, victim placement, and /or mental health services in a time and coordinated manner,
e) Attend relevant cross discipline trainings and trainings specific to handling investigations involving victims of CST or HRV.
f) Attend and actively participate in the MDT and/or AHTC collaboration staffing, meetings and special case reviews.
g) Participate in AHTC activities including professional education, community educational efforts, and team building programs.
h) Provide feedback and suggestions regarding procedures and operations of the RRT/MDT process.

III. Case Discoveries/Assignment/Response

A. CST/HRV cases could present in a multitude of ways requiring different levels of response dependent on how the case was discovered, reported. Cases are often multi-jurisdictional in nature, starting and ending in the different jurisdictions. To de-conflict, prevent dual follow up investigations, or confusion, the following will be a guide in determining initial investigative responsibility in descending order.
   1. Recovery location/city,
   2. Location of the offense, or
   3. Location of victim's residence.

IV. Initial Investigative Response

A. Rapid Response for Recovered HRV or victim of CST
   1. When a HRV or victim of CST is recovered, law enforcement (LE) will generally receive the initial notification.
      a) If an HRV or victim of CST is recovered by other means (i.e.,

ASP CACD, ADHS DCFS, or other partnering agencies operating under this protocol), LEA will be immediately notified. (**see Section III**).

2. Upon notification of a case which would require utilizing a RRT, law enforcement will immediately notify ASP CACD. The law enforcement agency and ASP CACD will respond and ensure an investigative interview is initiated based on the policies and procedures of the responding agencies. The goal of this initial investigative interview to obtain the minimal facts necessary to determine the following:
   a) Child's safety, health, protection
   b) Determine if a criminal offense occurred.
3. Upon determination that the case is a CST/HRV, law enforcement will notify the Arkansas Human Trafficking Council (AHTC) Coordinator who will coordinate the CSEC advocate response, if needed, in a timely manner, and other
4. The ADHS DCFS caseworker will respond, upon request, and is responsible for conducting any necessary safety assessments. The ADHS DCFS caseworker will coordinate appropriate placement, if removal or custody is necessary, and protective services for the victim.
5. Initial placement may occur after a medical evaluation, if applicable. If initial placement occurs after a medical or psychological evaluation, a CSEC Advocate will remain with the victim until the placement is completed, in most cases.
6. Upon completion of the initial investigative interview and initial placement, if necessary, law enforcement, ASP CACD, and ADHS DCFS will conduct their respective investigations using a coordinated multi-disciplinary (MDT) approach and refer the victim to the nearest CAC for appropriate services.

B. Initial Investigative Response for Conventional System Reporting

1. Reports made with a law enforcement agency having original jurisdiction will be handled according to that agency's current investigative practices and procedures.
   a) If the law enforcement agency having original jurisdiction cannot handle an investigation involving CST, that law enforcement agency will refer the investigation to the appropriate law enforcement agency according to that agency's current investigative practices and procedures.
   b) If original jurisdiction cannot be determined, see Section III for guidance until an appropriate jurisdiction can be ascertained.
2. The law enforcement agency assigned to the investigation will

immediately notify the ASP CACD Area Manager or area ASP CACD on-call Investigator for an immediate coordination and potential response. The law enforcement agency shall notify the Child Abuse Hotline, 1-800-482-5964, in accordance with state mandated reporting laws.

3. The law enforcement agency assigned to the investigation will notify the AHTC Coordinator for CSEC advocate assignment and agency coordination.
4. AHTC Coordinator will coordinate with LE and ASP CACD to determine whether activation of a RRT is indicated based on the hotline referral information. If RRT activation is indicated, the RRT should follow protocols outlined above.

C. Initial Investigative Response for Assessment Referrals

1. Possible cases identified from an assessment referral where there is no disclosure should be handled as follows:
   a) Information should be sent to the AHTC Coordinator to assist with coordinating of advocacy and comprehensive screening services at CAC and/or CSEC advocacy agency.
   b) If CST or Sexual Exploitation is identified, then the AHTC Coordinator should be notified immediately and the AHTC Coordinate will ensure proper notification is made to the appropriate law enforcement and ASP CACD for an investigative response.
2. If no current victimization is identified, any psychological/social issues will be identified, and appropriate referrals made for victim services.
3. Any assigned investigative agencies will conduct an initial or ongoing investigation based on their current policies and procedures utilizing a coordinated MDT approach.
4. If at any time a need for the RRT approach is indicated, the investigative agency will immediately notify the AHTC Coordinator to assist with coordination of that RRT pursuant to this protocol.

D. Investigative Response for Child Abuse Hotline Referrals

1. Child Abuse Hotline will notify the child welfare agency responsible for handling the child maltreatment investigation pursuant to interagency agreements and state law.
2. Child Abuse Hotline will immediately notify the AHTC Coordinator of referrals accepted by the hotline for investigation as identified in Section II.
3. Child Abuse Hotline will notify the AHTC Coordinator of all sexual abuse or sexual exploitation referrals screened out by the hotline as identified in Section II.
4. ASP CACD will immediately notify law enforcement having original

jurisdiction or based on the guidelines outlined in Case Discovery/Assignment in Section III.

5. AHTC Coordinator will coordinate with LE and ASP CACD to determine whether activation of a RRT is indicated based on the hotline referral information. If RRT activation is indicated, the RRT should follow guidelines in this protocol for initial investigation and crisis response.

E. Investigative Response for Placement Disclosures/Referrals

1. Cases involving disclosures of CST, or sexual abuse/exploitation by a HRV, by a child in a placement, as defined in Section II, should be handled as follows:
   a) Disclosures of CST, or sexual abuse/exploitation by HRV, should be reported to the AHTC Coordinator who then should ensure the proper notification is made to the appropriate law enforcement and ASP CACD for a coordinated initial investigation.
   b) The AHTC Coordinator should notify local law enforcement agency having original jurisdiction. The local law enforcement agency will follow protocols in Appendix 5.
2. The placement provider should subsequently notify the Arkansas Child Abuse Hotline in accordance with the state mandating reporting laws.
3. The assigned law enforcement agency will follow protocols as outlined in Appendix 5.
4. The AHTC Coordinator will coordinate with a CSEC agency for CSEC Advocate assignment.

V. AHTC Coordinator Role

A. Provide coordination for all participating agencies and service providers to ensure a strong, cohesive and collaborative approach to all CST/HRV from identification through the investigation process until case has been discharged of the multi-disciplinary team coordinated services. AHTC Coordinator will also assist and ensure resources are identified and met, and critical relationships are cultivated and maintained amongst the Multi-Disciplinary AHTC Rapid Response Team.

B. AHTC Coordinator Responsibilities (**In First 24–72-hour period):**

1. Actively receives notifications 24/7 from law enforcement, the Child Abuse Hotline, ASP CACD, ADHS DCFS, or other referral sources by way of phone calls, text messages, or email, and given all necessary information possible of disclosed or suspected CST/HRV.
2. Initiate request for collection of available information in the appropriate database systems for victim and offender information

and prior history. AHTC Coordinator will notify appropriate agencies and ensure proper information sharing among agencies as permitted by law.

3. Potential sources for this information may include law enforcement criminal reporting or case management systems, Arkansas Crime Information Center (ACIC), National Crime Information Center (NCIC), ADHS's comprehensive child welfare information system (CCWIS), and CAC/MDT databases.
4. Contacts and coordinates with CSEC advocacy agencies
    a) If a HRV or victim of CST is an active client or previously received services from a CSEC advocacy agency, the AHTC Coordinator will contact that agency, if known, to assess whether that agency should assume lead advocate responsibilities based on geographic location and proximity to the victim's residence or placement.
    b) If a HRV or victim of CST has not received prior services from a CSEC advocacy agency, the AHTC Coordinator will contact a CSEC advocacy agency to assume lead advocate responsibilities based on geographic location, proximity to the victim's residence or placement, and victim needs.
    c) Multiple advocacy agencies may provide or may have provided services for a HRV or victim of CST. The AHTC Coordinator will help coordinate services or information sharing between advocacy agencies as needed.
5. Confirm arrival of CSEC Advocate to victim's location or alternate site as desired.
6. Facilitate Rapid Response Team staffing (through phone calls/emails/face to face meeting) and capture all agency decisions and action plans.
7. Assists and coordinates with RRT for any necessary medical evaluations for HRV and victims of CST;
8. Actively maintains updated information of shelters and other placement providers able and available to accept a HRV or victim of CST for placement purposes;
9. If appropriate, assist law enforcement, ASP CACD, ADHS DCFS, or Juvenile Corrections with contacting shelter agencies or other placement providers for placement and adheres to policies for placement requests.
10. Maintain contact with the assigned CSEC advocacy agency/Advocate or other members of the RRT responding directly to victim for applicable updates to coordinate timely decisions required by each RRT agency/member during the crisis intervention and crisis management response.

11. Coordinate between ASP CACD, ADHS DCFS, and law enforcement to ensure that victims are not interviewed multiple times.

C. AHTC Coordinator Responsibilities (**In subsequent periods of time):**

1. Actively maintains contact with advocate to follow the status of CST/HRV victims until case has been discharged from MDT;
2. Actively shares information with Rapid Response Team of status of CST/HRV victims;
3. Actively coordinate collection of data and ensure information is entered within database software and reporting of statistical information when needed;
4. Collect data of placements and outcomes to our response;
5. Assist in facilitation of collaboration and coordination between the agencies and service providers.
6. Attend the multidisciplinary investigative process, and other relevant cross discipline trainings;
7. Attend and actively participate in RRT/MDT case reviews, staffing, or meetings, and takes lead role in ensuring accountability for participation by all agencies.
8. Coordinates and facilitates all necessary follow-up on each agency's action plans.
9. Participate in AHTC activities including professional education, community educational efforts, cultivation of relationships amongst the RRT and MDT, and team building programs.
10. Provide conflict resolution and mediation on all team complaints and policy issues as needed with respect to each agency's internal process.
11. Assist in facilitation of collaboration and coordination between the agencies and service providers.

VI. CSEC Advocate Role

D. Primarily responsible for the trauma-informed case management, emergency response, victim stabilization and advocacy services for the HRV and victims of CST throughout the process of crisis response, crisis intervention, crisis management, and long-term care management.

1. Responsible for personal contact and rapport with the victim from initial contact in accordance with organization policies, protocols or training.
2. Serves to manage coordination of services from the victim's side, ensuring that the victim is well heard and well served by other service and investigative partners.

E. Participating Child Sex Trafficking (CST) and High-Risk Victim (HRV) serving CSEC agencies (see Appendix 3).

1. Into the Light

2. The Genesis Project
3. Hope Found NEA

F. Participating Child Sex Trafficking (CST) and High-Risk Victim (HRV) serving agencies commit to:

1. Crisis Intervention (first 6 hours):
   a) Respond to AHTC Coordinator's notification within (1) hour.
   b) Arrive to victim's location, designated by AHTC Coordinator, in a timely manner, and begin providing in person support, establishing rapport to develop relationship and establish emotional support. A CSEC Agency's policies or protocols may specify locations in which an advocate cannot response (e.g., home or hotel).
   c) Focus on immediate needs of the victim.
   d) Affirm and validate physical needs and emotional state; staying focused on the victim's needs without being unduly distracted by other activities happening simultaneously.
   e) Work willingly with other entities as needed to support the victim's care and to interpret actions and circumstances for the child's understanding.
   f) Maintain confidentiality of criminal or child maltreatment investigative information or other RRT/MDT partner plan unless expressly permitted to do so by the RRT/MDT agency/member or by law.
   g) Share all information the CSEC Advocate obtains from the victim to the investigative agencies. It should be a priority for the RRT or MDT to protect the integrity of the victim/advocate relationship.
2. Crisis Management (6-24 hours):
   a) Stay present with victim until placement and stabilization (when practical).
   b) Ensure a designated advocate or approved parent/guardian is present during subsequent hours.
   c) Actively maintain contact and continue to build a trusting relationship with the victim.
   d) Empower victim to make safe and healthy decisions.
   e) Update AHTC Coordinator as appropriate.
   f) Develop a safety plan with victim to help optimize victim/survivor's safety: plans in case of dangerous situations arise, identifying safe friends and safe places, in coordination with the RRT and/or MDT.
   g) Advocate for CST/HRV specialized, trauma-informed, victim-centered services/residential placement as decisions are being made by RRT/MDT.

h) Attempt to schedule a follow-up meeting with the victim within 72 hours.

3. Care Management (24 hours to Resolution):

a) Develop a care plan in collaboration with the client that effectively addresses their needs and goals they would like the advocates assistance with that includes.

b) Providing necessary level of relational intervention and intensive case management in collaboration with other agencies and legal guardian.

c) Meeting face-to-face and through other modalities with the victim to build and maintain healthy, supportive relationships.

d) Maintaining contact with the victim based on any established care plan, CSEC advocate agency protocols or potential needs of the partnering investigative agencies.

e) Respond to urgent or emergent requests 24 hours a day, seven days per week or ensure coverage is provided by other CSEC agency advocates.

f) May schedule, coordinate, transport or accompany victim to appointments/court or meet within the community following all established CSEC advocate agency protocols for such activity to enhance safety and mitigate risk.

g) Provide support for healthy choices, including avoiding or curtailing runaway episodes.

h) Routinely share information among RRT and MDT members and provide information to victim about case status as needed and as allowed by law. Sharing information with the RRT and MDT includes notification to law enforcement of suspected or known runaway episodes.

i) May, on behalf of the victim, support expression of their needs and wishes.

j) Respond to family needs as indicated by RRT/MDT action plans and within advocate agency scope.

k) Document pertinent information resulting from advocate relationship with victim and services provided.

l) Provides victim services in accordance with the Victim Service Agreement.

m) Maintains advocate relationship with victim throughout their engagement in the response continuum until he or she is no longer eligible for services.

VII. Arkansas Children's Advocacy Centers Protocol to CST and HRV Cases

A. The CAC identifies, screens, and provides no-cost services to a children

or juveniles who are at risk of, or have experienced child sex trafficking.

B. Effective and improved interventions for HRV or victims of CST
   4. Enhanced safety planning when child's case is not prosecuted, or when non-offending caregiver persistently minimizes or demonstrates persistent lack of belief in allegation.
   5. Child is flagged as potential HRV in database.
   6. Enhanced caregiver understanding of risk for future victimization/acting out behaviors.
   7. Might include runaway prevention/intervention services.

G. Identification and response through screening and assessment tools, and AHTC coordination efforts to ensure potential HRVs are recognized and flagged in an effort to increase long term services and to minimize crimes committed against children in the future.
   1. Protocol for assessment tools identifying high risk victims that are completed by partner agencies or external agencies will continue to be developed as statewide assessment tool is pushed out.

H. Care coordination in collaboration with the AHTC Coordinator and CSEC Agencies.

I. CAC wrap-around services can include the following and are offered according to standardized practices and procedures:
   1. Child-focused setting that is comfortable, private, physically and psychologically safe for diverse populations of children and nonoffending family members and other caregivers, and space for a multidisciplinary response to investigations child sexual abuse, exploitation and trafficking.
   2. Upon referral to the CAC by partner investigative agencies, any primary service can serve as the initial point of entry for CAC services:
      a) Primary victim services available through a CAC include
         (1) Victim and family advocacy services,
         (2) Specialized mental health services,
         (3) Specialized medical examinations, including medical forensic examinations, and
         (4) Forensic Interviews.
      b) Other services available should include:
         (1) Victim outreach and identification
         (2) Screening and risk factor identification
         (3) Service planning and delivery
         (4) Case management/case coordination
         (5) Risk assessment and safety planning
         (6) Victim advocacy
         (7) Mental health services
         (8) Medical services

J. Crisis Intervention:

1. Rapid response consultation with MDT partners or victim, family, or other parties.

2. Forensic Interview

a) Every CAC has trained forensic interviewers who conduct evidence-based, victim-centered, trauma-informed interviews with child victims. The purpose of the CAC forensic interview is to obtain information from a child about abuse allegations, including trafficking, that will support accurate and fair decision-making by the MDT within the criminal justice, child protection, and service delivery systems.

b) Forensic interview services are available upon request from partnering investigative agencies (law enforcement, ASP CACD, ADHS DCFS, prosecuting attorney's office, or court of competent jurisdiction).

c) Protocols for interviewing HRV and victims of CST to be identified or developed. Any protocol used to interview HRV or victims of CST should be nationally recognized.

d) Partnering investigative agencies may conduct forensic interviews at a local CAC. Full use of equipment and services is available. Investigative partners conducting interviews at a CAC will adhere to developed and adopted protocols for interviewing a HRV and victim of CST.

e) Pre- and post-interview meetings conducted with Family Advocates, Forensic Interviewer, Mental Health team (when appropriate), Specialized Medical Providers, and RRT/MDT to formulate plan to:

(1) Understand family dynamics,

(2) Assess for additional medical or mental health concerns to be addressed,

(3) Work with child or family navigating the criminal justice and child welfare investigations

(4) Assist with immediate resources as necessary.

(5) Coordinate response with CSEC Advocate and AHTC Coordinator.

K. Crisis Management Immediate and Case Management to ensure:

1. Information and referral.

2. Assist the victim or family in meeting needs (financial, transportation, concrete needs).

3. Victim rights information shared with family.

4. Ongoing case navigation.

5. Trauma screenings are completed in a timely fashion to

understand general trauma symptoms, suicidality, etc.

6. Provide, or provide access to, mental health services at CAC or outside/external provider
7. Family is engaged and provided wrap-around services to optimize their protective factors and attachment with child victim.
8. Immediate and long-term trauma informed evidence based mental health services.
    a) Mental health services are designed to reduce trauma symptoms, provide psychoeducation to youth about trafficking related concerns, decrease problematic, dangerous or self-destructive behaviors, increase safety awareness and planning; bolster the skills and behaviors of primary caregiver, increase attachment between primary caregiver and victim, increase victim's ability to successfully navigate justice system.

L. Enhancing family response to improve short- and long-term outcomes.

1. CAC will work in conjunction with any partner agency to assist with improving the skills of family members so that they can more effectively engage with their child. Family members can improve their ability to keep their child safe, to have a functional, healthy, nurturing relationship; and to assist their child's pursuit of justice by better understanding the criminal justice system.

M. In conjunction with RRT/MDT, the CAC will continue to provide advocacy and coordination at the leadership levels within community agencies to improve the community response and eliminate barriers to effective treatment and outcomes.

VIII. The Role of the Arkansas Child Welfare System Response

A. The role of the Arkansas Department of Human Services' (ADHS) Division of children and Family Services (DCFS) – Investigation Unit and the Arkansas State Police's (ASP) Crimes Against Children Division (CACD) is to investigate reports of child maltreatment and provide services to children who have been abused or neglected by a person responsible for a child's care, custody or welfare.

B. In the response to sexual exploitation and trafficking, ADHS DCFS and ASP CACD work with children and families to promote safety, permanency and well-being for alleged child victims. This requires close collaboration with law enforcement, prosecuting attorneys, CACs, and the AHTC network to reduce trauma to victims and provide adequate support for children and their families or caregivers. If it is safe, and in the child's best interest, the goal of the child welfare system is to keep children in their home and community.

C. Sexual exploitation and trafficking of a minor are mandated reports,

regardless of who the reported offender is. Once reported to the Arkansas Child Abuse Hotline, all child sex exploitation and trafficking should be screened in for a child maltreatment investigation by the ASP CACD and referred for services through a CAC, CSEC Agency and/or DCFS. The intent is to ensure that between the organizations that a victim has access to any necessary services and not to duplicate services offered between these service providers.

D. The Arkansas State Police, Crimes Against Children Division, and Arkansas Department of Human Services Division of Children and Families commits to:

1. Participate as part of the Rapid Response Team in instances of CST or HRV.
2. Routinely and timely share information among team members and provide information about case status as needed and as allowed by law.
3. Refer appropriate cases to the AHTC Care Coordinator for purposes of continued investigation, victim/family advocacy, victim support, victim placement and/or mental health services in a timely and coordinated manner.
4. Provide feedback and suggestions regarding procedures and operations of the AHTC process.
5. Assist Rapid Response Team in determining alternatives for child placement even when lacking the authority to investigate.

E. The Role of the Arkansas State Police Crimes Against Children Division.

1. ASP CACD Responsibilities (**Initial Investigation – First Six Hours**)

a) When a Report of CST or HRV is received through the Arkansas Child Abuse Hotline:

(1) The assigned ASP CACD Investigator will:

(a) Fully identify the child

(b) Search and review all prior history.

(c) Determine if the child is currently in the care and custody of ADHS or another state.

(i) If so, the ASP CACD Investigator will notify their immediate supervisor and ADHS DCFS.

(2) Notify the following members of the rapid response team:

(a) Appropriate law enforcement agency,

(b) Child Advocacy Center, and

(c) AHTC Coordinator.

(3) Timely response as part of RRT within the MDT to conduct a coordinated and joint investigation to

determine the existence of child maltreatment in accordance with agency policies, procedures and state law.

(4) Refer the victim for a consultation with a specialized medical provider for a specialized medical evaluation or medical forensic examination in accordance with medical protocols in Section IX.

(5) Assess whether any safety threats exist and coordinate with ADHS DCFS for health and safety assessment according to agency policies, procedures, and state law.

(6) Determine if any acute behavioral or psychological interventions are necessary and coordinate with appropriate agencies to ensure the victim is safe from harm.

(7) Coordinate with the AHTC Coordinator for proper referrals to the CAC or CSEC agency.

b) When a Child is Recovered by a Law Enforcement Agency:

(1) Law enforcement should immediately notify the ASP CACD Area Manager or on-call investigation of any recovered HRV or victim of CST and their location.

(2) The ASP CACD investigator will respond to the location of the child as part of the RRT within the MDT to begin the initial assessment and initiation of the coordinated and joint investigation.

(a) The ASP CACD Investigator, in consultation with the ASP CACD Area Manager, will act as evaluator to determine if a child has suffered from any type of sexual abuse or exploitation, abuse or neglect that would warrant an investigation by their agency in accordance with agency policies, procedures and state law.

(b) ASP CACD should make a report to the Arkansas Child Abuse Hotline regardless of whether an investigation is warranted for documentation purposes.

(3) The ASP CACD investigator will serve as a liaison between law enforcement, ASP CACD, and ADHS DCFS.

(4) The assigned ASP CACD Investigator will:

(a) Fully identify the child

(b) Search and review all prior history.

(c) Determine if the child is currently in the care and custody of the ADHS or another state.

(i) If so, the ASP CACD will notify their immediate supervisor and ADHS DCFS.

(5) Determine whether any safety threats exist and notify ADHS DCFS for health and safety assessment according to agency policies, procedures, and state law.

(6) Notify the AHTC Coordinator of the recovery and efforts.

(7) Coordinate with law enforcement to refer the child victim to the nearest CAC, if available, for interview. The ASP CACD Investigator will observe and participate in any interview conducted at a CAC or that law enforcement conducts.

(8) Determine whether any safety threats exist and notify ADHS DCFS for health and safety assessment according to agency policies, procedures, and state law.

(9) Consult with other RRT/MDT members and assess other immediate needs of the victim ensuring that the HRV or victim of CST's immediate medical or acute mental/behavioral health needs are addressed.

F. The Role of the Arkansas Department of Health, Division of Children and Family Services.

1. The focus of ADHS DCFS is the safety and protection of children and to act in the children's best interest. The decisions made concerning the protection of the child shall be based upon the professional judgement of the ADHS DCFS staff in conformance with current ADHS DCFS policy, statutory law and placement factors.

2. DCFS commits to respond timely to requests by law enforcement or ASP CACD for a health and safety assessment.

3. If it is determined:

a) The child is already in the ward of the State of Arkansas, or the allegations fall within the jurisdiction of the ADHS DCFS or ASP CACD and custody will be assumed of the child by the state.

(1) The child will be transported to a CAC or safe location to be monitored until appropriate placement can be secured, and the child transported safely to their

placement.

(a) If transported to a CAC, CAC services will be provided to the victim.

(2) ASP CACD Investigator or ADHS DCFS staff may assist in the supervision of children that are thought to be at high flight risk until appropriate placement is secured.

4. The ADHS DCFS staff will consult with other RRT/MDT members to assess immediate needs of victims or such as medical or behavioral health needs, and DCFS begin placement search for child or juvenile.
5. If the ADHS DCFS or ASP CACD has sufficient jurisdiction to investigate and a removal of the child is necessary and allowable under agency policy and/or law, the ADHS DCFS will notify the AHTC Coordinator to identify and execute appropriate placement for the child while adhering to the policies and procedures of the ADHS DCFS.
   a) Developmentally appropriate safety planning with the youth and family should begin immediately. This begins with timely face-to-face contact, upon request, to assess child safety.
   b) Collaboration with all team members is required to determine whether placement is necessary. If applicable, ADHS DCFS will find an appropriate placement based on the individual needs of the youth, considering the impact of trafficking or exploitation.
6. If the ADHS DCFS or ASP CACD has sufficient jurisdiction to investigate and DCFS deems a protection plan is sufficient to protect a child from further harm, the ADHS DCFS will execute a such plan in accordance with agency-specific policies and state law. ADHS DCFS will notify the AHTC Coordinator and ASP CACD of any safety plan and interventions established.
   a) Developmentally appropriate safety planning with the youth and family should begin immediately. This begins with timely face-to-face contact, upon request, to assess child safety.
   b) Collaboration with all team members is required to determine whether compliance with the safety or protection plan.
7. ADHS DCFS should provide the necessary services to help intervene and prevent child sex trafficking. Any service cases should be coordinated between ADHS DCFS and any other victim service providers serving that child or juvenile to avoid duplication

of efforts.

a) ADHS should offer supportive services to any victim of CST or HRV that do not involve a child in its custody.

b) ADHS should open a protective services case on all ASP CACD investigations with a TRUE finding.

8. ADHS DCFS will notify any appointed attorney ad litem or CASA of a child that the child has been recovered, or identified/reported as a CST or HRV.

IX. Referrals for Medical Evaluation and Medical Forensic Examination

A. The purpose of a medical evaluation in suspected child sexual exploitation and abuse cases is to help ensure the health and safety of the child, diagnose, document, and address medical conditions, differentiate medical findings indicative of abuse from those that are not a result of abuse, provide reassurance and education to the child and non-offending caregivers, and assess the child for any additional concerns (i.e., emotional, behavioral, etc.).

B. The medical forensic (or medical legal) examination for sexual assault goes beyond addressing and treating the victim's acute medical needs.

1. The medical forensic exam is also used to properly collect, document, preserve, and maintain the chain of custody for evidence collected during the assessment and treatment of a victim presenting post sexual assault.

2. The victim's narrative of events, the physical findings from the exam, along with the collected evidence, should be correlated to provide information that can be utilized as evidence if prosecution is pursued.

C. All victims of CST victims should be referred for a medical evaluation, medical forensic examination, and toxicology regardless of whether there was an acute sexual assault. All HRV should be assessed for possible medical evaluation, medical forensic examination, and toxicology.

1. To eliminate multiple exams, team members should make every effort to screen for previous medical evaluations or medical forensic examinations at other locations prior to making a referral.

D. Medical forensic examinations shall be conducted by a specialized medical provider (pediatric emergency medical physician, child abuse pediatrician, pediatric nurse practitioner, or sexual assault nurse examiner) that is properly licensed and trained.

1. Child sexual abuse medical evaluations or medical forensic examinations evaluate for physical findings of healed and acute injuries, sexually transmitted infections and genital variants not associated with trauma or sexual abuse.

2. Proper identification of healed injuries is crucial in the evaluation

of children due to delayed disclosures.

3. The provider must be able to differentiate between normal variants of the genitalia, findings commonly caused by conditions other than trauma/sexual abuse, and findings caused by trauma/sexual abuse.
4. While most community healthcare providers do not have specialized training and experience in evaluating children who have been sexually abused, they have training on when to report to the child abuse hotline at a minimum.

E. Informed Consent

1. Informed Consent is required for the medical evaluation or medical forensic examination of a HRV or victim of CST.
2. Specialized medical providers should assess the victim's ability and legal capacity to provide informed consent giving special consideration for victims that are minors, have cognitive disabilities, under the influence of alcohol/substance/drug, or incapacitated.
3. Institutions should have policies that include procedures to determine whether minor victims are their own guardians; if there is a guardian, to determine the extent of the guardianship; to obtain consent from a guardian if needed; and what to do if the guardian is not available or is suspected of abuse or neglect.
4. Consent from a legal guardian or custodian:
   a) In general, emergent medical care can be done without legal guardian consent if the medical provider deems that delay in care could have negative consequences for the minor.
   b) It is best practice to try to get consent from the legal guardian before doing an unclothed physical exam, even if consent is by phone.
   c) If specialized medical provider proceeds without consent from the legal guardian, the decision or its necessity should be thoroughly documented.
5. When it comes to medical care regarding sexual health, unless otherwise permitted by law or where an exception exists.
   a) Arkansas law provides that certain minors are permitted to consent to contraceptive services, STI prevention, testing and treatment, HIV prevention, testing and treatment, prenatal care, and any service regarding sexual health and wellbeing (except abortions).
   b) Exceptions to parental consent requirements also exist
      (1) When the parent or guardian is the suspected offender, or
      (2) Where the parent or guardian is unavailable and the

minor child capable of understanding and giving informed consent.

c) To provide informed consent, a minor child should be able to weigh the risks and benefits of different treatment and evidence collection options.

6. If a victim is in a drug-facilitated altered mental state, specialized medical providers should continue to use informed consent practices.

a) If the victim is incapable of consenting to treatment, obtaining consent to perform an exam should be deferred until the victim able to give consent.

7. Absent life threatening and emergency medical conditions, a minor that Arkansas law specifies is permitted to provide informed consent should be afforded the opportunity to provide informed consent, rather than a parent or legal guardian, absent other legal processes (I.e., search warrant).

F. A medical evaluation, medical forensic examination, or portions thereof, will not be performed on a HRV or victim of CST that does not assent to that exam or those portions thereof.

1. The specialized medical provider providing the medical evaluation or medical forensic examination will need to be able to explain to the victim the purpose for evidence collection, photography, documentation, and many other aspects of the medical examination process which could be used by the justice system, and the impact of declining all or portions of a medical forensic evaluation.

G. Medical evaluations and medical forensic examinations

1. Medical stabilization of a HRV or victim of CST always takes priority over medical forensic examination.

2. The purpose of a medical evaluation in suspected child sexual exploitation and abuse cases is to help ensure the health and safety of the child, diagnose, document, and address medical conditions, differentiate medical findings indicative of abuse from those that are not a result of abuse, provide reassurance and education to the child and non-offending caregivers, and assess the child for any additional concerns (i.e., emotional, behavioral, etc.).

3. Medical evaluations and medical forensic examinations, including evidence collection, will be guided by the scope of informed consent, medical forensic history provided, specialized training, best practices, and institution policies.

4. Three categories of medical evaluations or medical forensic examinations:

a) **Emergent** - Indicators for an emergent medical evaluation
   (1) Current vaginal or rectal pain or bleeding
   (2) Altered Mental State, report of current illicit drug use or signs of withdrawal,
   (3) Active suicidal ideations if unable to get victim an immediate evaluation for acute mental health placement)

b) **Acute** – Indicators for an acute sexual assault exam (<96 hours)
   (1) Contact or penile-vaginal penetration within last 96 hours in post-pubertal females or within 72 hours in male victims or pre-pubertal females that could have resulted in exchange of foreign DNA (perpetrator should be 10 years of age or older).
   (2) Anal, oral, or vaginal penetration in the last 96 hours (potential for acute injury or STD)
   (3) Penile-vaginal penetration of post-pubertal victim in last 96 hours (indication to offer pregnancy prophylaxis or STI post-exposure prophylaxis.)
   (4) Presence of physical symptoms such as genital/anal pain, discharge, sores, bleeding, itching, painful urination that can occur with injury or STI
   (5) Amnesia for a possible sexual assault event (I.e., drug facilitated sexual assault) that would have occurred in the last 96 hours.

c) **Non-acute** - Indicators for a non-acute sexual assault exam (>96 hours)
   (1) At the request of the victim, or legal guardian, when the timeframe exceeds 96 hours and there has been a disclosure by a victim of child of sexual abuse, exploitation or trafficking.
      (a) May be indicated to identify acute or healed injuries (pain, bleeding, etc.), infections or pregnancy resulting from sexual contact or penetration, or to answer questions and offer reassurance about a victim's health and body.
      (b) Healed injuries and sexually transmitted infections can be identified many months after the last contact (without the victim being aware there is a problem).

5. The medical forensic examination and evidence collection should be done in tandem as a seamless process to increase efficiency and decrease omissions and victim anxiety.

6. If it is determined that a female minor HRV or victim of CST has not reached the onset of menses, they should be examined by healthcare providers specifically trained in pediatric sexual abuse by being referred to CAC and/or transferred to Arkansas Children's Hospital.
7. Specialized medical providers should inform an HRV or victim of CST of his or her right to have a CSEC or CAC advocate, or non-offending legal guardian, present at the time of the medical evaluation or medical forensic examination.

H. Child Advocacy Centers and Local Hospitals
1. Whenever possible, medical evaluations for suspected child sexual abuse, including HRV or victims of CST, should be accomplished in a manner that keeps victims in their communities.
2. If there is a local CAC available to perform the necessary medical evaluations and medical forensic examinations, the RRT/MDT investigative partnering agencies should refer HRV or victims of CST to the nearest CAC.
3. If a HRV or victim of CST presents to a local hospital prior to any reports to law enforcement or the child abuse hotline, the HRV or victim of CST should be referred a local CAC, if available, for exams rather than transfer to ACH – absent emergency medical conditions.
    a) If there is a communication protocol between the local hospital and CAC, the local hospital staff must make sure the CAC has specialized medical providers reasonably available to assume responsibility for the patient and necessary services in acute situations.
    b) If the local hospital does not have a protocol with a local CAC, Arkansas Children's Operation Center can assist with coordination with local CACs to determine availability of SANEs in acute situations.
    c) The local hospital should hold the victim at the local hospital until an investigative agency (I.e., law enforcement, ASP CACD or ADHS DCFS) arrives for proper referral procedures to the local CAC.
    d) Victims or their caregivers should be instructed that the victim should not bathe or change clothes before arriving at the CAC.

I. Arkansas Children's Hospitals and Outside Hospitals
1. Most sexual abuse exams are not medical emergencies, though for select cases, an evaluation at an emergency department may be necessary.
    a) Arkansas Children's Hospital (ACH) is always open and

available for assessment of HRV or victims of CST with emergency medical conditions. Available 24 hours a day, seven days a week, the Arkansas Children's Operations Center provides a seamless transfer process for patients who originally present to an local hospital's emergency department that is unable to provide necessary medical care for minor HRV or victim of CST.

b) Arkansas Children's Operation Center can be reached by any local outside hospital at 888-764-5437 for transfer purposes.

2. The local, outside hospital should notify local law enforcement agency and make a report to the Child Abuse Hotline to activate the response for child safety by the ASP CACD and/or ADHS DCFS.

a) Absent life-threatening conditions, the local outside hospital should hold the HRV or victim of CST for contact with the local RRT/MDT.

b) Victims or their caregivers being transferred should be instructed that the victims should not bathe or change clothes between leaving the referring local hospital and arriving at ACH.

c) ACH cannot provide transportation for any individuals riding in the ambulance from the referring local hospital to ACH back to the local their community. This should be communicating to those individuals prior to transport.

3. The RRT/MDT should continue to refer the HRV or victim of CST to a CAC and CSEC Agency for additional victim services available in the victim's local community.

J. UAMS TeleSANE Program

1. The University of Arkansas for Medical Sciences (UAMS) -Institute for Digital Health & Innovation (IDHI): TeleSANE Program is available to adolescent HRV or victims of CST. The TeleSANE program is a statewide program that has met specific criteria that allows for a consulting sexual assault nurse examiners to be on call 24/7/365 to consult with local emergency department medical providers on medical evaluations and medical forensic examinations in acute (non-emergent) situations. The UAMS TeleSANE Call Center can be reached at (501) 686-8500. (See Appendix for Participating Hospitals.)

2. The availability of this program should never supersede the use of a CAC for a child victim when a CAC is available and accessible to the victim. Adult evaluations of sexual assault include the use of a speculum exam which may be an additional and unnecessarily

traumatic introduction to speculum exams for adolescent victims. It is not recommended practice for pediatric and adolescent sexual assault exams to include the use of speculum outside of specific medical indications. If it is determined that a female minor has not reached the onset of menses or the benefit of a local exam is not outweighed by the consideration of harm to an adolescent victim experiencing an adult forensic exam, they should be examined by specialized medical providers specifically trained in pediatric sexual abuse by being referred to CAC and/or transferred to Arkansas Children's Hospital depending on the level of acuity.

3. TeleSANE program consultations may include: (1) assistance with consenting the patient for the exam; (2) offering community based advocacy presence during the exam; (3) guiding the Spoke Hospital clinician with obtaining a medical history and history of the assault; (4)head to toe physical examination; clinical forensic photography and documentation; (5) offering guidance with the collection of forensic evidence and maintaining the chain of custody and on state and local reporting requirements; (6) assisting with CDC recommendations of prophylactic medications post sexual assault; and (7) providing local, state, tribal and national resources for follow up care.
4. The female victim must be post-menses and consensually sexually active to qualify for medical evaluation or medical forensic examination through a local emergency department or clinic operating under an agreement with the TeleSANE program.
    a) Post menses is categorically defined as a female (1) between the ages of 16 – 18 years of age, (2) that has started her menstrual cycle, and (3) has had at least one (1) consensual encounter prior to the reported sexual abuse, exploitation, or trafficking.
5. Depending on level of acuity, trauma or emergent conditions, transfer to ACH may be medically necessary to provide necessary care.
6. The RRT/MDT should continue to refer the HRV or victim of CST to a CAC and CSEC Agency for additional victim services available in the victim's local community.

K. Laboratory Testing and Toxicology

1. Laboratory testing and recommendations may vary based on victim age and type of contact. Specimens are processed by the medical provider or an outside laboratory. Results are documented and included in the victim's medical records at the institution or clinic collecting the specimens for testing.
2. Toxicology samples should be collected if there is a concern for a

drug-facilitated sexual assault.

a) Blood specimens should be collected within 24 hours of a known or suspected drug-facilitated sexual assault.

b) Urine specimens should be collected within 120 hours of a known or suspected drug-facilitated sexual assault.

c) Toxicology samples are items of evidence that require processing at the ASCL.

L. Post Exam Procedures

1. If the HRV or victim of CST does not show-up for a scheduled medical examination or medical forensic examination, the specialized medical provider should notify the appropriate RRT/MDT member that referred the child for the examination. The RRT/MDT will make every effort to follow-up with the family and ensure the child does receive an exam.

2. The CAC, local hospital, or ACH will provide results of any exam conducted under this protocol to ASP CACD, ADHS DCFS, law enforcement or other investigating agencies as appropriate and per institution police and HIPPA compliance.

3. Evidence Collection, Storage, Transfer, and ASCL Submission

a) Sexual Assault Evidence Collection Kits are provided through ASCL.

b) When indicated, specialized medical providers will collect, package, and store evidence (i.e. sexual assault evidence collection kits, clothing, toxicology samples) according to the best practices for Arkansas Sexual Assault Evidence Collection and a facility's policies and procedures.

c) Specialized medical providers or healthcare facilities must maintain control of evidence during the exam, while evidence is being dried, and until it is in the kit container and sealed. The medical facility is responsible for the proper and secure short-term storage of the sexual assault evidence collection kit and evidence until it is picked up by the law enforcement agency.

(1) Law enforcement must pick up toxicology samples and items of evidence for submission to the ASCL.

(2) Law enforcement must pick up sexual assault evidence collection kits within three (3) business days once notified by the specialized medical or healthcare provider.

d) The sexual assault evidence kit must be submitted to the ASCL by law enforcement as soon as possible, but no later than fifteen (15) days after receiving the sexual assault evidence collection kit.

M. Documentation
   1. All medical records are documented per hospital or healthcare facility standards. This includes, but is not limited to medical history, test performed and results, physical examination findings, and photographic documentation.

N. Release of medical evaluation or medical forensic examination records
   1. Medical records, including personal health information, shall be confidential and shall not be released unless otherwise permitted by state and federal laws.
   2. There is a reasonable expectation of privacy in the name of a child victim and medical records of a child. When applicable, circuit courts should issue a protective order to ensure that those items of evidence for which there is a reasonable expectation of privacy and that otherwise should be sealed are not distributed to persons or institutions that have no legitimate interest in the evidence.

X. Juvenile Corrections and Probation

A. Victims/survivors of child sexual exploitation and trafficking often interact with the juvenile justice system. Many of the risk factors for involvement in both sexual exploitation and the juvenile justice system are quite similar.

B. Sexually exploited or trafficked youth may be forced into or otherwise involved in committing delinquent acts, whether related to their exploitation or not.

C. Often, the exploitation is not immediately known, and the youth may already be involved in the criminal justice system at the time the disclosure is made. Additionally, youth in corrections programs such as detention facilities and residential treatment programs are often potential targets for recruitment.

D. Recommendations
   1. Screening
      a) Screen all youth for a history of sexual exploitation or trafficking.
   2. Assessment
      a) Provide detained youth with a psychological evaluation and chemical assessment.
   3. Notification
      a) Notify the AHTC Coordinator of any youth involved in the juvenile correction programs that have
         (1) Disclosed of child sex trafficking; or
         (2) Are identified as a HRV through appropriate screening or assessment tools.
   4. Collaboration

a) Work with any investigative agencies.
b) Allow members of the RRT or MDT access to any juveniles as part of the collaborative efforts to prevent or respond to child sex trafficking or sexual exploitation.

XI. Prosecution

A. The role of the prosecuting attorney, Attorney General or United States Attorney's office is to seek justice by filing, prosecuting, and/or pursuing appropriate state or federal criminal charges or juvenile petitions involving cases of child sexual exploitation or sex trafficking. All charging, prosecuting and case decisions shall be based on up the professional judgement of these agencies.

B. The prosecuting attorney, Attorney General or United States Attorney's office commits to:

1. Participate, as needed, as part of the RRT, or be available to the RRT/MDT in a consultation capacity.
2. Assist law enforcement in resolve jurisdictional concerns (i.e. state or federal charging decisions),
3. Lead the prosecution of cases involving child sex trafficking. This includes reviewing evidence, preparing legal documents, filing charges, and representing the state in court. play multiple roles in the response to child sexual exploitation and trafficking.
4. Collaborate with law enforcement agencies to gather evidence, interview witnesses, and conduct investigations. This partnership is essential for building a strong case against the traffickers.
5. Advocate for the best interests of the child in court, presenting evidence, examining witnesses, and making legal arguments to secure convictions against the defendants.
6. Work closely with victim advocates to ensure the child's safety and well-being. This includes securing protective orders, ensuring safe housing, and coordinating with social services.

XII. Confidentiality and Mandated Reporting

A. Sexually exploited and trafficked children have rights to privacy and confidentiality in some cases.

B. RRT/MDT members and victim service providers must inform a HRV or victim of CST of these rights and a provider's legal/professional/ethical information sharing limits while offering services.

1. All victim services providers should use the established release of information forms to ensure appropriate protections of victim/survivor information.
2. Information about the HRV or victim of CST will only be shared with written consent or as required by law or professional ethical codes.

C. Mandated reporting laws and cross-reporting requirements exist to protect children from abuse or neglect.

1. All CST or sexual exploitation involving a minor is a mandated report in Arkansas.
2. Professionals and providers who are mandated reporters will report all incidences of suspected CST to the Arkansas Child Abuse Hotline. In order to keep the process youth-centered, the provider or professional should speak with the victim about their requirement to report.

XIII. Appendix 1: Acronym Guide

ADHS – Arkansas Department of Human Services

AHTC – Arkansas Human Trafficking Council

ACH – Arkansas Children's Hospital

ASP – Arkansas State Police

CACD – Crimes Against Children Division (within ASP)

CAC – Child Advocacy Center

CACar – Children's Advocacy Centers of Arkansas

CLEST – Commission on Law Enforcement Standards and Training

CSAM – Child Sexual Abuse Material

CSEC – Child Sexual Exploitation of Children

CST – Child Sex Trafficking

CP – Continued Presence

DCFS – Division of Children and Family Services (within ADHS)

HRV – High Risk Victim

HT – Human Trafficking

LE – Law Enforcement

LEA – Law Enforcement Agency

LEO – Law Enforcement Officer

MDT – Multidisciplinary Teams (within CACar)

NGO – Non-profit Government Organizations

OVC – Office for Victims of Crimes

RRT – Rapid Response Teams

XV. Appendix 2: Glossary

ASSESSMENT REFERRALS – A referral where there has been no victim disclosure, but based solely on a screening tool, it is believed there is a high likelihood of CST or sexual exploitation.

CARETAKER – A parent, guardian, custodian, foster parent, or any person 14 years of age or older who is entrusted with a child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, childcare facility, public or private school, or any person legally responsible for a child's welfare.

CHILD or JUVENILE– A person who is from birth to the age of 18.

CHILD ABUSE HOTLINE – The Child Abuse Hotline is maintained by the State Police Crimes Against Families Division, for the purpose of receiving and recording notification made pursuant to the "Child Maltreatment Reporting Act". The Child Abuse Hotline is staffed 24 hours per day and has statewide accessibility through a toll-free telephone number.

CHILD ABUSE HOTLINE REFERRAL – Reports to the child abuse hotline that includes allegations of possible child sex trafficking, referrals involving a possible HRV, or alleged possible child labor trafficking.

CHILD ADVOCACY CENTER or CHILD SAFETY – A nonprofit child-friendly facility that provides a location for forensic interviews and forensic medical examinations and ensures access for specialized mental health services during a child maltreatment investigation. CACs "receive, review, and track reporting from the Department of Human Services relating to the alleged abuse or neglect of a child in order to ensure a consistent and comprehensive approach to providing services to a child and the family of a child who is the victim of alleged abuse or neglect. CACs, as community-based and trauma-informed organizations, coordinate a multidisciplinary response to child abuse or neglect, and offer evidence- based intervention and support directly to children and families at no cost.

CHILD MALTREATMENT – Physical abuse, sexual abuse, emotional abuse, neglect, sexual exploitation or abandonment of a child.

CHILD MALTREATMENT INVESTIGATION – A fact finding assessment that occurs when an allegation of child maltreatment is received. Completion is reached when a determination is made concerning the allegations.

CHILD SEX TRAFFICKING – Refers to the recruitment, harboring, transportation,

provision, obtaining, patronizing, or soliciting of a child or juvenile for the purposes of a commercial sex act. Proof of force, fraud or coercion is not required when the victim is a minor, nor is it a requirement that a 3rd party benefit from or facilitate the exchange.

CHILD SEX TRAFFICKING VICTIM – Victims of child sex trafficking are defined as a person less than eighteen (18) years of age who has been subject to sexual exploitation because the person:

1. Is a victim of trafficking of persons under A.C.A. § 5-18-103;
2. Is a victim of child sex trafficking under 18 U.S.C. § 1591, as it existed on January 1, 2017; or
3. Engages in an act of prostitution under A.C.A. § 5-70-102 or sexual solicitation under A.C.A. § 5-70-103.

A child does not have to have an identified trafficker to be a victim of child sex trafficking.

COMMERCIAL SEX ACT - Any sex act where something of value – such as money, food, drugs or a place to stay – is given to or received by any person for sexual activity.

CONVENTIONAL SYSTEM REPORTS – Case reported through traditional crime reporting to a law enforcement agency.

COMMERICAL SEXUAL EXPLOITATION OF CHILDREN (CSEC) – A broad term that encompasses all forms of child sexual exploitation and abuse. This may include many of the other terms, including child sex trafficking (CST).

CSEC ADVOCATE – An employee or volunteer advocate of an agency recognized as providing specialized services to victims of child sexual exploitation and abuse (i.e., CST).

CSEC AGENCY is the non-government organization that employees or supervises volunteers who provide specialized services to victims of child sexual exploitation (i.e., CST).

CUSTODIAN – A person (not a parent or legal guardian) who stands in loco parentis to the child OR an agency or institution (i.e., ADHS DCFS) given custody of a child through a court order.

DEVIATE SEXUAL ACTIVITY – Any act of sexual gratification involving:

1. The penetration, however slight, of the anus or mouth of one person by the penis of another person; or
2. The penetration, however slight, of the labia majora or anus of one person by

anybody member or foreign instrument manipulated by another person.

DISSEMINATE – To allow to view, expose, furnish, present, sell, or otherwise distribute, including on an electronic device or virtual platform, and is not limited to an act that takes place in the physical presence of a child.

FAMILIAL CHILD SEX TRAFFICKING – Child sex trafficking involving the exploitation of a child or juvenile by individuals responsible for their care, safety and trust.

GROOMING – To knowingly disseminate to a child thirteen (13) years of age or younger with or without consideration a visual or print medium depicting sexually explicit content with the purpose to entice, induce, or groom the child to engage in the following with a person: sexual intercourse; sexually explicit conduct; or deviate sexual activity.

GUARDIAN – Any person, agency or institution so appointed by a court.

HIGH RISK VICTIMS (HRV) – A child or juvenile that falls in one of the below categories:

1. Missing (i.e., runaway) children under 18 years of age that have been recovered multiple times regardless of whether the parent, guardian or custodian filed a report with the appropriate agency. Multiple will be defined as recovered missing children who have been missing on more than (3) occasions in a 12-month period.
2. Children who are 12 years of age or younger and are missing (i.e., runaway).
3. Children under 18 years of age who have been reported as and are currently in missing (I.e., runaway) status for a prolonged period of time. Prolonged period of time will be defined as children who have been or were missing for over (15) consecutive days.
4. Foster child that is categorized as missing from out-of-home placement. A child or youth in DCFS custody is categorized as missing if the child or youth, runs away, is abducted by a known/unknown person, or is otherwise absent from care with no known location.
5. Children under 18 years of age with repeated reports of sexual abuse and exploitation. Repeat victims of sexual abuse or exploitation will be defined as (2) or more events in a 12- month period.
6. Children under 18 years, based solely on a screening tool, is it is reasonably suspected that there is a high likelihood CST or sexual exploitation.
7. Child victim of sex trafficking.

LAW ENFORCEMENT AGENCY – Any police force or organization whose primary responsibility as established by law or ordinance is the enforcement of laws of this state and is staffed 24 hours a day.

MANDATED REPORTER – Individuals identified in the "Child Maltreatment Reporting Act" who must immediately notify the Child Abuse Hotline or law enforcement if they have reasonable cause to suspect that a child has been subjected to or died from child maltreatment, or who observe the child being subjected to conditions or circumstances which would reasonably result in child maltreatment.

MEDICAL PROVIDER – Any emergency Department of a hospital licensed under § 20-9-214.

OUTPATIENT MENTAL HEALTH EMERGENCY – Defined by the Community Mental Health Center's actions and protocol, including, but not limited to, facilitation of admission to a hospital or other appropriate 24hour treatment facility.

PLACEMENT DISCLOSURES/REFERRAL – Referrals that involve victims who have already been recovered and/or disclose sexual abuse, sexual exploitation by a child or HRV while in the system. The referral may come from partnering agencies or organizations operating under this protocol, placements, juvenile detention facilities, ADHS Division of Youth Services, or shelters where the victim discloses actual or possible CST.

PROTECTION PLAN – A written plan developed by DCFS in conjunction with the family and support network to protect the juvenile from harm and which allows the juvenile to remain safely in the home.

RAPID RESPONSE TEAM (RRT) – A group of individuals from various organizations that should be utilized when a HRV or victim of CST has been recovered, regardless of whether a disclosure has been made, or when there is a reasonable belief that a child is in an exploitative situation. A Rapid Response Team should consist of, but is not limited to, representatives from the following:

1. Law Enforcement
2. ASP CACD
3. ADHS DCFS
4. Children's Advocacy Center
5. CSEC Agency
6. Medical
7. Prosecutor
8. AHTC Coordinator

RECOVERED VICTIM CASE – A case involving the recovering of a child by in the following instances:

1. Any child under 18 years of age who is recovered by law enforcement officers, ASP CACD, or ADHS DCFS under circumstances which appear the child is a victim of child sex trafficking.
2. A recovered missing child who is 12 years of age or younger when they are recovered by law enforcement, ASP CACD, and ADHS DCFS.
3. Any recovered High-Risk Victims.
4. Victims who are identified at, or present at, an area hospital emergency room.
5. Any child recovered by law enforcement officers, ASP CACD, ADHS DCFS, partnering agencies or organizations operating under this protocol, who based on the totality of the circumstances at the time of the recovery, feel the child should be classified as an HRV.

RESPONSE CONTINUUM – Defines the level of response to reported, or discovered cases of HRV, or victims of CST is defined as follows:

1. Identification
2. Notification Procedures to LE/Child Abuse Hotline/AHTC Coordinator
3. Rapid Response Team
4. MDT Response/Agency-Specific Response
5. After-care and Long-term Supportive Care Response

SEXUAL ABUSE – Any of the following acts committed:

By a person 14 years of age or older to a person younger than 18 years of age:

1. Sexual intercourse, deviate sexual activity or sexual contact by forcible compulsion
2. Attempted sexual intercourse, deviate sexual activity or sexual contact by forcible compulsion
3. Indecent exposure or
4. Forcing the watching of pornography or live sexual activity

By a person 18 years of age or older to a person not his or her spouse who is younger than 15 years of age:

1. Sexual intercourse, deviate sexual activity or sexual contact
2. Attempted sexual intercourse, deviate sexual activity or sexual contact
3. Solicitation of sexual intercourse, deviate sexual activity, or sexual contact;

By a person twenty (20) years of age or older to a person not his or her spouse who is younger than sixteen (16) years of age:

1. Sexual intercourse, deviate sexual activity, or sexual contact;
2. Attempted sexual intercourse, deviate sexual activity, or sexual contact; or
3. Solicitation of sexual intercourse, deviate sexual activity, or sexual contact;

By a caretaker to a person younger than 18 years of age:

1. Sexual intercourse, deviate sexual activity or sexual contact
2. Attempted sexual intercourse, deviate sexual activity or sexual contact
3. Forcing or encouraging the watching of pornography
4. Forcing, permitting or encouraging the watching of live sexual activity
5. Forcing listening to a phone sex line
6. Committing an act of voyeurism

By a person younger than 14 years of age to a person younger than 18 years of age:

1. Sexual intercourse, deviate sexual activity or sexual contact by forcible compulsion
2. Attempted sexual intercourse, deviate sexual activity or sexual contact by forcible compulsion

SEXUAL CONTACT – Any act of sexual gratification involving the touching, directly or through clothing, of the sex organs, buttocks, or anus of a person or the breast of a female; the encouraging of a child to touch the offender in a sexual manner; or the offender requesting to touch a child in a sexual manner. Normal affectionate hugging is not construed as sexual contact.

SEXUAL EXPLOITATION – Allowing, permitting, or encouraging participation or depiction of the juvenile in prostitution, obscene photographing, filming, or obscenely depicting a juvenile for any use or purpose.

SPECIALIZED MEDICAL PROVIDER – A medical provider (doctor, nurse practitioner, or registered nurse) with the proper training commensurate with state licensing boards and regulations, and specialized training in performing medical forensic examinations on children.

PLACEMENT DISCLOSURES/REFERRAL – Referrals that involve victims who have already been recovered and/or disclose sexual abuse, sexual exploitation by a child or HRV while in the system. The referral may come partnering agencies operating under this protocol, placements, juvenile detention facilities, ADHS Division of Youth Services, or shelters where the victim discloses actual or possible CST.

XVI. Appendix 3: Participating Child Sex Trafficking (CST) and High-Risk Victim (HRV) serving CSEC agencies

Into the Light

A. Into the Light is a nonprofit organization based in Arkansas that focuses on combating human trafficking, particularly sex trafficking, and providing support to its victims. The organization works to raise awareness, offer education, and provide direct services to survivors of trafficking. They aim to help victims find healing and empowerment by offering resources such as counseling, emergency shelter, and long-term recovery programs. Additionally, Into the Light engages in community outreach and collaborates with local and state agencies to address and prevent human trafficking across Arkansas.

B. Into the Light Resources
   1. Prevention: They educate high-risk children and communities on how traffickers lure victims, aiming to prevent trafficking through awareness.
   2. Intervention: The organization provides crisis intervention and collaborates with social services and law enforcement to ensure safety and justice for trafficking survivors.
   3. Advocacy: They offer trauma-informed support, mentorship, case management, and advocacy in legal and law enforcement settings to help survivors rebuild their lives.

Genesis Project

A. The Genesis Project in Arkansas is a survivor-led, faith-based nonprofit organization dedicated to empowering individuals overcoming exploitation and sex trafficking. Founded by Kathy Bryan in 2022, the organization focuses on providing support, training, and collaboration to assist survivors and other organizations involved in anti-trafficking efforts. While faith-based, it is inclusive of all individuals regardless of religious background. The Genesis Project is committed to creating a statewide coalition to strengthen efforts against human trafficking.

B. Genesis Project Resources
   1. The Genesis Project provides resources for survivors of human trafficking, including trauma-informed and evidence-based care, victim advocacy, and holistic support. Their services encompass housing, therapeutic care, education, medical needs, and case management. They also offer training for law enforcement, advocates, medical personnel, and organizations to enhance their knowledge in combating trafficking. The organization aims to empower survivors by advocating for them and helping them rebuild their future.

Hope Found NEA

A. Hope Found NEA is a nonprofit organization founded in 2019 in response to human trafficking cases in Northeast Arkansas. It aims to end human trafficking through awareness, education, and coordinating services for victims and survivors. The organization provides presentations to educate the community and offers direct support to trafficking victims. They collaborate with law enforcement and have been involved in operations to recover victims and arrest traffickers.

B. Hope Found NEA resources

1. Hope Found NEA provides resources focused on prevention and restoration for survivors of human trafficking. They offer educational presentations to raise awareness, direct support for victims, and work on developing a restoration campus for survivors. The organization collaborates with law enforcement and other partnering agencies operating under this protocol to coordinate services and enhance the fight against trafficking. They also run a helpline for individuals in need of assistance.

XVII. Appendix 4: Quick Reference to Related Statutes

Criminal Laws

Trafficking of Persons A.C.A. § 5-18-103

Child Sex Trafficking 18 U.S.C. § 1591

Prostitution A.C.A. § 5-70-102

Sexual Solicitation A.C.A. § 5-70-103

Child Maltreatment Laws

Definitions A.C.A. § 12-18-103

Confidentiality A.C.A. § 12-18-104

Cooperative Agreements A.C.A. § 12-18-106

Liability A.C.A. § 12-18-107

XVIII. Appendix 5: AHTC Resources and Contacts

AHTC Coordinator

Sergeant Matt Foster (501) 516-5896

ADHS DCFS Navigator

Wendy Russell (870) 810-7376

Service Providers

Into the Light – Call or Text (877) 743-7348

The Genesis Project – (501) 236-9052

Hope Found NEA – NEA Human Trafficking Hotline (870) 336-7256

Child Advocacy Centers – See Appendix 7

XIX. Appendix 6: AHTC LE Policies, Procedures, and Protocols

XX. Appendix 7: CAC Location Maps and On-Call Contact Information

The Children's Advocacy Centers of Arkansas is the membership organization of the network of Arkansas' child advocacy centers operating 24/7/365 to provide no-cost services to child victims, and provides operational oversight for the county-based multidisciplinary teams across the state.

Children's Advocacy Centers of Arkansas
124 W. Capitol Ave, Ste 1630
Little Rock, AR 72201
(501) 615-8633
Website

Home and Additional CAC Locations	Address	Telephone	Website
CAC of Independence County	510 E. Boswell Street, Batesville, AR 72501	(870)569-8099	link
CAC of South Arkansas (AR)	1838 Morning Star Road, El Dorado, AR 71730	(870)862-2272	link

CAC of South AR - Ashley County	300 E. Adams, Hamburg, AR 71646	(870)862-2272	
CAC of South AR - Drew County	510 W Gaines, Monticello, AR 71655	(870)224-4435	
CAC of Southeast Arkansas	211 W. 3rd Avenue, Suite 130, Pine Bluff, AR 71601	(870)850-7105	link
Central Arkansas CAC	609 Locust Street, Conway, AR 72034	(501)328-3347	link
Central Arkansas CAC - Van Buren County	1396 Hwy. 65 S Ste.29, Clinton , AR 72031	(501)328-3347	
Child Safety Center of White County	414 Rodgers Drive, Searcy, AR 72143	(501)268-4748	link
Children and Family Advocacy Center (CFAC) of Benton County	414 Rodgers Dr, Little Flock, AR 72756	(501)268-4748	link
CFAC of Western Benton County	5155 Shankles Rd., Gentry, AR 72734	(479)621-0385	
Children's Protection Center (CPC)	1210 Wolfe Street, Little Rock, AR 72202	(501)364-5490	link
CPC - North Pulaski	1919 Northeastern Ave, Jacksonville, AR 72076	(501)453-1299	
Children's Safety Center of Washington County	3242 South Gene George Blvd., Springdale, AR 72764	(479)872-6183	link
Cooper-Anthony Mercy CAC (CAMCAC)	216 McAuley Court, Hot Springs, AR 71913	(501)575-3258	link
CAMCAC - Saline County	205 East South St. STE 3-5, Benton, AR 72015	(501)575-3258	
Grandma's House CAC	501 West Stephenson Ave, Harrison, AR 72601	(870)391-2224	link
Grandma's House CAC - Baxter County	914 South Main St., Mt. Home, AR 72653	(870)391-2224	
Grandma's House CAC - Carroll County	206 South Main Street, Berryville, AR 72601	(870)391-2224	
Grandma's House CAC - Madison County	200 E, Main, Huntsville, AR 72740	(870)391-2224	
Hamilton Center for Child Advocacy	2713 S. 74th Street, Suite 203, Fort Smith, AR 72903	(479)783-1002	link
Mending Hearts CSC of Eastern Arkansas	703 Calvin Avery Drive, West Memphis, AR 72301	(870)551-4351	link
Mending Hearts CSC of Eastern Arkansas - St Francis County	925 N. Washington, Forrest City, AR 72325	(870)551-4351	
Northeast Arkansas CAC	2729 E Nettleton, Jonesboro, AR 72401	(870)275-7902	link
Ouachita Child Safety Center	1308 U. S. Highway 71,, Mena, AR 71953	(501) 623-5591	link

Percy and Donna Malone CSC (PDMCSC)	442 Mount Zion Road, Arkadelphia, AR 71923	(870)403-6879	link
PDMCSC - Hot Spring County	1002 Schneider Dr Suite 101, Malvern, AR 72104	(870)403-6879	
PDMCSC - Nevada County	221 W Main Street, Prescott, AR 71857	(870)403-6879	
River Valley CAC	2206 Red Hill Lane, Russellville, AR 72802	(479)498-4747	link
River Valley CAC - Johnson County	300 E Main St., Clarksville, AR 72830	(479)440-8016	
Texarkana CAC	1203 Main Street, Texarkana, TX 75501	(903)792-2215	link
Wade Knox CAC	1835 West Front Street, Lonoke, AR 72086	(501)676-2552	link
Wade Knox CAC - Monroe County	401 Fourth St., Brinkley, AR 72021	(501)676-2552	

XXI. Appendix 8: Arkansas Children's Operation Center

Making children better today and healthier tomorrow often starts with a patient transfer or the need for consultation. The Arkansas Children's Operations Center offers the highest level of service as a one-call transfer system, providing a single-entry point for consultations or to transfer patients to the Arkansas Children's system.

Available 24 hours a day, seven days a week, the Arkansas Children's Operations Center provides a seamless transfer process for patients, families and providers with a centralized entry point to all Arkansas Children's facilities.

Contact the Arkansas Children's Operations Center to initiate a transfer today at 888-764-5437 (KIDS).

Information Required

- Referring physician, referring facility and contact number
- Patient information
    - Name, date of birth, sex
    - Chief complaint/reason for transfer
    - Concerns and differential diagnosis
    - Vital signs (heart rate, respiratory rate, blood pressure, pulse oximetry, temperature, and weight)
    - Any interventions, medications, or treatments completed
- Any imaging or labs completed; we will ask for imaging to be share through a digital online repository and labs/notes to be faxed at the time of acceptance; this allows our treatment team to being reviewing the care of the patient prior to arrival

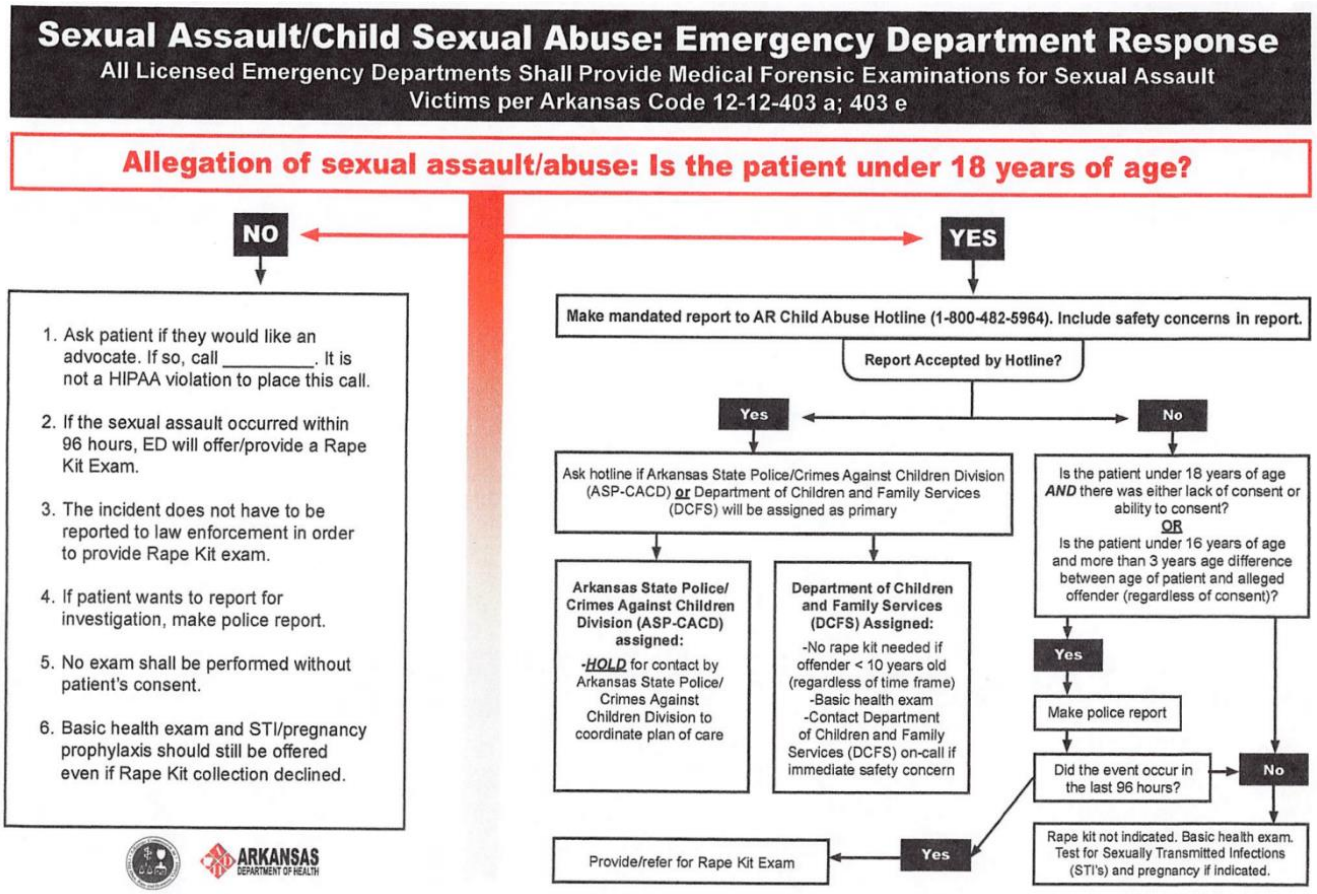
Dr. Sara Sanders, MD
Operations Center Medical Director
501-364-4392
scsanders@uams.edu

Kirsten Johnston
Patient Care Services Director- Operations Center
johnstonka@archildrens.org

XXIII. Appendix 9: Sexual Assault/Child Sexual Abuse – Emergency Department Response Chart

All license emergency departments must provide medical forensic examinations for sexual assault victims in accordance with Arkansas law. Not all emergency departments have specialized medical providers trained to perform medical forensic examinations on child victims.

UAMS TeleSANE program may provide those emergency departments listed in Appendix 10 with consultation and assistance in conducting certain medical forensic examinations as outlined in this protocol in Section IX.



XXIV. Appendix 10: List of Hospitals participating in UAMS TeleSANE program

UAMS Institute of Digital Health & Innovation
Sexual Assault Assessment Program
TeleSANE
4301 W. Markham St., Slot #519
Little Rock, AR 72205
501-686-8500

City	Hospital Name
Ashdown	Little River Medical Center
Batesville	White River Medical Center
Benton	Saline Memorial Hospital
Bentonville	Northwest Medical Center
Benton	Saline Memorial Hospital
Blytheville	Great River Medical Center
Cabot	Cabot Emergency Hospital
Cherokee Village	White River Medical Center
Clarksville	Johnson Regional Medical Center
DeQueen	Sevier County Medical Center
Eureka Springs	Eureka Springs Hospital
Fordyce	Dallas County Medical Center
Fort Smith	Crisis Intervention Center of Fort Smith
Harrison	North Arkansas Regional Medical Center
Heber Springs	Baptist Health Medical Center – Heber Springs
Hot Springs	CHI St. Vincent and National Park Medical Center
Jacksonville	Unity Health Medical Center
Jonesboro	Family Crisis Center of Northeast Arkansas
Jonesboro	St. Bernards Medical Center
Little Rock	U.A.M.S.
Little Rock	Baptist Health Medical Center
Malvern	Baptist Health Medical Center – Hot Spring County
Mena	Mena Regional Health System
Monticello	Baptist Health Drew County
Mountain View	Stone County Medical Center
Mountain Home	Baxter Regional Medical Center
Osceola	SMC Regional Medical Center
Russellville	Saint Mary's Regional Medical Center
Sherwood	CHI St. Vincent North
Springdale	Northwest Center for Sexual Assault
Warren	Bradley County Medical Center
Walnut Ridge	Lawrence Memorial Hospital

Appendix 10: AHTC Case Flow Chart – Minor Child

-The criminal and civil investigation should be coordinated with LE and ASP CACD.
-CACD should coordinate with LE to schedule the first contact with the victim, witnesses, and offender.
-CACD shall coordinate with LE before making a true finding.
-ADHS will assess safety upon request from CACD. DCFS will determine next steps based on safety assessment.
-CACs shall provide or refer child for mental health services, and forensic medical exams, and provide family/ victim support and court prep for the victim.
-CACs will coordinate forensic medical exams and anything of evidence value with LE.