An Evaluation of the Safe Harbor Initiative in Minnesota – Phase 4

REPORT TO COMMISSIONER

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An Evaluation of the Safe Harbor Initiative in Minnesota – Phase 4 Report to Commissioner

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Contents

An Evaluation of the Safe Harbor Initiative in Minnesota – Phase 4 1

Executive Summary and Introduction 4

Grantee Reporting about Youth Receiving Safe Harbor Services and Service Types 6

Client demographics illustrate Safe Harbor's reach to youth from various demographic backgrounds 6

Safe Harbor improvement and sustained implementation: Housing and supportive services trends and descriptive information 8

Youth and Community Evaluation of Safe Harbor Services 16

Key findings from youth surveys and interviews 17

Community respondent interviews with Safe Harbor network 21

Assessment, Collection, and Distribution of Funds under Minnesota Statute section 609.3241 22

Phase 4 Evaluation Recommendations and Conclusion 23

Recommendations 23

Conclusion 25

Executive Summary and Introduction

In the decade since Safe Harbor became Minnesota law, the state has built an extensive network in response to the sexual exploitation of youth, and more recently human trafficking, both sex and labor. The network spans from state and local government to Tribal Nations and community-based nonprofit programs. Founded on a public health approach within the Minnesota Department of Health (MDH) in recognition of the significant health and social impacts created by exploitation and trafficking on populations, Safe Harbor also partners extensively with entities in public safety, human services, and human rights, including the Minnesota Department of Human Services (DHS), the Minnesota Department of Public Safety (DPS) and the Minnesota Coalition Against Sexual Assault (MNCASA) to offer a comprehensive multidisciplinary response.

State law requires the Safe Harbor Director, based in MDH, to submit a biennial evaluation of the program to the commissioner of health under Minnesota Statute Section 145.4718. The purpose of the evaluation is to ensure Safe Harbor is reaching its intended participants, increasing identification of sexually exploited youth, coordinating across disciplines including law enforcement and child welfare, providing access to services, including housing, ensuring the quality of services, and utilizing penalty funds to support services.

The Safe Harbor law passed in 2011 and after a three-year planning period called No Wrong Door, the Safe Harbor system was fully enacted in 2014. In the years since, Safe Harbor has submitted three evaluation reports to the legislature, beginning in 2015. Each evaluation was conducted by Wilder Research at the Amherst H. Wilder Foundation (Wilder) under a competitive contract with MDH. The evaluation process is an opportunity to hear and learn from trafficked and exploited youth as well as participants from a variety of disciplines who respond to the needs of these youth on a daily basis.

For the current Phase 4 report, MDH contracted with Wilder again while MDH's Safe Harbor Program produced accompanying evaluation materials. As a result, this Phase 4 Safe Harbor evaluation draws from complementary background reports that are combined to represent a variety of perspectives from both outside and within the Safe Harbor network. These resources not only evaluate Safe Harbor's activities, but also address these activities in the context of significant current events including the global COVID-19 pandemic and the civil rights movement in Minnesota, as well as around the nation and world, in the wake of George Floyd's murder. The supplemental evaluation materials, containing expanded findings, data, and appendix are available on the MDH website at [Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf)](https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf) (hereinafter Supplemental Materials). Note that table and figure numbering in this report differs from the Supplemental Materials.

All findings focus on the Safe Harbor network and activities between April 1, 2019, and June 30, 2021. The Wilder data collection and analysis took place between January 1, 2021, and June 30, 2021. The MDH data collection and analysis took place between September 1, 2020, and August 1, 2021.

Between January 2021 and June 2021, Wilder interviewed grantees, multidisciplinary partners, and youth clients, and also surveyed youth clients to evaluate Safe Harbor. Wilder submitted its report

including several findings and recommendations to MDH. Wilder found evidence for outcomes related to multidisciplinary partnership and access to services, including culturally specific services; the factors contributing to Safe Harbor's impact; gaps and challenges; opportunities for improvement; and the pandemic's impact on service provision. MDH analyzed the provision of the statewide Safe Harbor Regional Navigator component and the reach of the Safe Harbor Network to identify and serve youth, as well as availability, accessibility, and equity of Safe Harbor supportive services and shelter and housing, in addition to training for providers. MDH then drafted this Phase 4 evaluation report including combined findings, recommendations, and conclusions. Summary recommendations are listed here, but included with further detail in the report:

Recommended actions:

- Increase stakeholder ability to identify youth.
- Expand protections and services regardless of age and remain flexible in identifying service needs.
- Increase and improve access to services, especially for youth from marginalized cultures and greater Minnesota.
- Support more diverse and consistent staffing.
- Increase amount and cultural appropriateness of technical assistance, education, and training provided.
- Increase prevention efforts (by decreasing demand and identifying risk factors).
- Support improvement of more continuous, comprehensive, and robust outcome and process evaluation as well as inferential research.
- De-silo the response to sex and labor trafficking.
- Increase youth voice and opportunities within Safe Harbor.
- Heal organizational trauma to better help organizations, staff, and clients.
- Improve equity by conducting a cultural needs assessment with several cultural groups as well as strategically directing allocations of funds and resources to culturally specific groups.
- Strengthen relationships within the public health approach.
- Further promote government agency collaboration.

Grantee Reporting about Youth Receiving Safe Harbor Services and Service Types

Client demographics illustrate Safe Harbor's reach to youth from various demographic backgrounds

Average age of clients. Youth clients provided grantees with their self-defined demographic information during intake. The average age at the time of enrollment for new clients was 16.7 years. The average age for total services was higher, 17.1 years, suggesting that clients who reenroll in services may be slightly older (Table 1). Some demographic data is missing, which may undercount certain groups.

Table 1. Average age per unique enrollments and total services

Average age	Mean *(M)*	Standard deviation *(SD)*
Unique enrollments (*n*=1168)	16.73	3.703
Total services (*n*=2391)	17.13	3.436

Note: The sample size in parentheses represents the analytic subsample, given missing data. The standard deviation indicates an age range, plus or minus that number of years to the mean.

Grouping clients by race and ethnicity. Table 2 shows a similar percentage between unique enrollments and total services by each group. Safe Harbor served 263 Black/African American clients; 163 American Indian clients; 437 White clients; 165 multiracial or biracial clients; and 95 youth placed in an aggregate Person of Color (POC) category, which included clients who identified as Pan-Asian, Pan Latinx, and Middle Eastern. POC referred to a client category created by the Safe Harbor Program Evaluator.

The creation of the POC category was to deidentify clients while including their information; not all clients may self-identify as a person of color. Clients were placed in the multiracial group when they indicated more than one racial background and can include White. Those clients were not double counted in the POC category. Similar to the creation of the POC category, the transgender and non-binary and queer and questioning categories contained individuals who self-identified along a broad spectrum of gender identities and sexual orientations.

Table 2. Clients' race demographic information

Race demographic	Unique enrollments (*n*=1123)	Total services (*n*=2633)
Black	263 (23.4%)	629 (23.9%)
American Indian	163 (14.5%)	394 (15.0%)

Race demographic	Unique enrollments (*n*=1123)	Total services (*n*=2633)
POC	95 (8.5%)	262 (8.7%)
White	437 (38.9%)	1075 (35.7%)
Multiracial	165 (14.7%)	273 (9.1%)

Note. The sample size in parentheses represents the analytic subsample, given missing data.

The [Human Trafficking in Minnesota (https://www.leg.mn.gov/docs/2019/Mandated/191234.pdf)](https://www.leg.mn.gov/docs/2019/Mandated/191234.pdf) report, indicated that of the sex trafficking survivors identified and served by law enforcement and social services providers, the percentages by racial demographic ranged from 30 to 33% Black, six to 23% American-Indian, two to 13% of Hispanic and Asian descent, 30 to 40% White, and one to eight percent multiracial. During this biennium, the race demographic among Safe Harbor clients were 23% Black, 14% American Indian, 8.5% POC, 38.9% White, and 14% multiracial (Table 2). Preliminary evidence suggests that Safe Harbor may be less effectively reaching the Black youth population and more effectively reaching multiracial youth in need of services.

Grouping clients by gender identity. Table 3 shows the vast majority of clients identified as female (89%, 1,071). Yet, Safe Harbor served 86 male youth clients and 47 transgender and non-binary youth. Though the numbers are low, findings showed the Safe Harbor initiative exhibited some success in reaching transgender and male survivors. Four percent and seven percent of the Safe Harbor services population were transgender and male survivors, respectively, whereas the population was two and three in the Human Trafficking in Minnesota report.

Table 3. Clients' gender identity information

Gender identity	Unique enrollments (*n*=1204)	Total services (*n*=3000)
Female	1071 (88.9%)	2687 (89.4 %)
Male	86 (7.1%)	203 (6.8%)
Transgender and non-binary	47 (3.9%)	110 (3.7%)

Note. The non-binary category includes gender expansive and gender non-conforming individuals who may not identify as transgender or non-binary.

Grouping clients by sexual orientation. Table 4 shows the majority of youth clients who accessed Safe Harbor services identified as heterosexual (71%) and bisexual (21%). There is limited capacity to make inferences about the efficacy of Safe Harbor's reach to LGBTQIA2S+ populations because of a lack of data in the relevant literature and inconsistent reporting of sexual orientation information in grantee data.

Table 4. Clients' sexual orientation information

Sexual orientation	Unique enrollments (*n*=857)	Total services (*n*=2247)
Queer and questioning	28 (3.2%)	101 (4.4%)
Bisexual and pansexual	179 (20.8%)	443 (19.7%)
Gay or lesbian	39 (4.5%)	99 (4.4%)
Heterosexual	611 (71.2%)	1604 (71.3%)

Note. The queer and questioning category include queer, asexual, and questioning individuals. The creation of the category was to aggregate and deidentify clients; not all clients may identify as "Queer."

Grouping clients by demographic information provides evidence of Safe Harbor's reach to specific demographic populations. When service access and the types of services provided are separated by client demographics and region types any differences that emerge can point to areas to improve culture or resources. Knowing who accesses which services and where can help MDH better implement Safe Harbor. Importantly, MDH did not collect information about disability so there is no information on the initiative's impact for clients with disabilities.

Safe Harbor improvement and sustained implementation: Housing and supportive services trends and descriptive information

Key findings. Grantee reporting on client enrollments and services provided and referred demonstrates the statewide network of housing and supportive services development and implementation over the biennium, quarterly. Region-specific data highlighted Safe Harbor's network and programmatic reach to serve youth in all regions across the state. Despite the pandemic, during the evaluation period Safe Harbor increased:

- Client supportive services by 30%.
- Housing and bed options by 83%.

However, there are differences in quarterly access to services and in the types of services clients received based on race demographic. Findings revealed the need to address access barriers for specific populations, especially during times of crisis, and equity within the Safe Harbor initiative. Grantee reporting supported that a region-specific and culturally responsive approach empowers communities to tailor antitrafficking responses to local and cultural needs.

Housing and supportive services increased client enrollments and frequently reenrolled clients into Safe Harbor. In the Phase 4 evaluation, the Safe Harbor Program parsed out and identified unique clients, unique enrollments, and unique or total services. The ability to distinguish between the categories allowed MDH to analyze the total number of youth served (unique clients and unique enrollments) and client reenrollment patterns (total services), quarterly. Overall,

Safe Harbor saw unique enrollments rise during the pandemic's beginning and peak in the summer of 2020. Total services remained relatively stable throughout the biennium (Figure 1).

Unique clients served (N=1270) and unique enrollments (N=1207). Due to missing data, unique clients and unique enrollments are not the same samples. Some clients did not provide or were not asked demographic enrollment information. Most of the statistical analyses use the unique enrollments sample (Figure 1).

Figure 1. Enrolled clients served through housing and supportive services: Quarterly trends

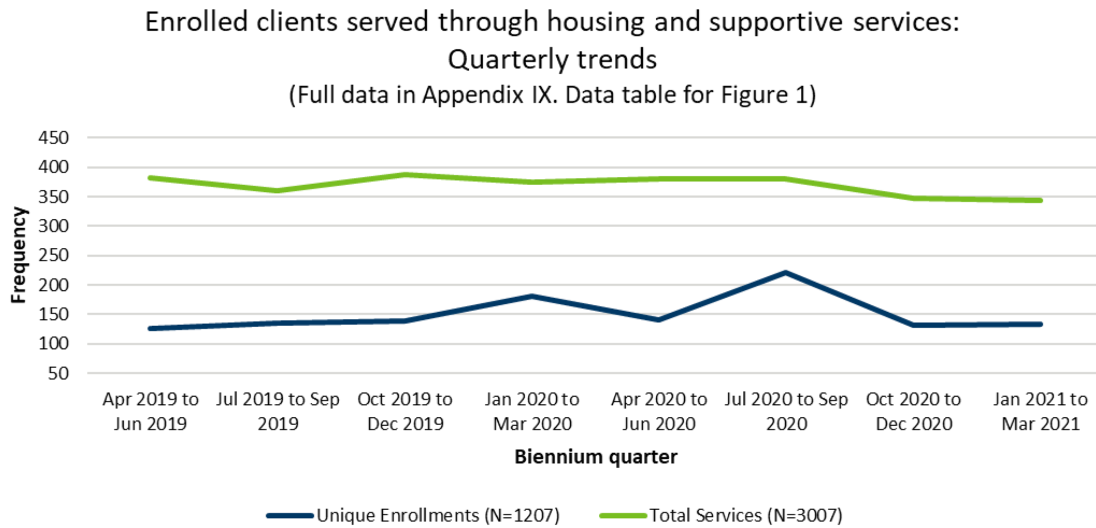

Figure 1 shows the quarterly trends of client enrollments and reenrollments or the total services to those clients received during the biennium.

Ineligible clients (N=160). Not depicted in Figure 1 is the number of clients who were ineligible for Safe Harbor services. This total is likely an underestimate due to a small window for reporting given brief interactions with ineligible clients. Of the total number of ineligible clients, being over the age limit was the primary reason for ineligibility (90%).

Total services (N=3007). Total services represent clients whose record ID numbers were repeated while service information, such as the service quarter and type of services provided and referred, differed. The data suggested reentry into different Safe Harbor supportive services agencies or programs during the biennium, and clients receiving multiple different services during those visits.

Repeat and multiple services. Repeat services further explains clients reenrolling in services in a possible range of one to eight quarters between April 2019 and March 2021. Repeat services showed that over 50% of Safe Harbor clients reentered Safe Harbor programming, with a median of reentering for services in two different quarters (Table 5). The category of multiple services draws from the total services sample and revealed that over 85% of Safe Harbor clients received multiple services at a time, with a median of four services per visit. There was a possible range of 1 to 18 services (see Appendix VI

of Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf); however, the most services a single client received at a time was 15 (Table 5).

Table 5. Repeat and multiple housing and supportive services among clients

Services frequency	Number (%)	Median (Range)
Repeat Services (*N*=1270)	673 (52.9%)	2 (1-8)
Multiple Services (*N*=3007)	2606 (86.7%)	4 (2-15)

Grant usage for direct services. Most clients received services funded through the MDH supportive services grants; 68% for unique enrollments, and 85% for total services (Table 6). Note, the Regional Navigator role is undercounted in direct services with clients because that is not their primary function; however, they tend to be the first point of contact for clients. Funding from the Office for Victims of Crime (OVC) in the United States Department of Justice federal expansion grant accounted for a small portion of direct services (10) to labor trafficking clients (7). Safe Harbor OVC expansion grant activities focus on outreach, identification, state collaboration with Tribal Nations, and case investigation.

Table 6. Client housing and supportive services by grant type

Grant type	Unique Enrollments (*N*=1207)	Total Services (*N*=3007)
MDH Regional Navigator	40 (3.3%)	141 (4.7%)
MDH Supportive Services	821 (68.0%)	2543 (84.6%)
DHS/OEO Housing	339 (28.1%)	312 (10.4%)

Note: Totals do not equal 100 percent due to some missing data and a small number of services provided by a federal grant.

Region descriptive information highlights Safe Harbor's statewide network impact. In 2020, Safe Harbor divided Minnesota into nine regions and updated its Safe Harbor Services Map (https://www.health.state.mn.us/communities/safeharbor/documents/safeharbormap.pdf) to show the most current Safe Harbor system statewide. In the prior biennial evaluations, there were eight regions. Appendix X of Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf) describes the counties within each region.

Regional Navigator regions. Table 7 shows the unique enrollments and total services for each of the nine regions. Region-specific resources and collaborations provided evidence of Safe Harbor's statewide implementation and structural impact.

Table 7. Client housing and supportive services by state regions

State region	Unique enrollments (*N*=1207)	Total services (*N*=3007)
Northwest	25 (2.0%)	102 (3.3%)
Northeast	156 (12.3%)	510 (16.9%)

State region	Unique enrollments (*N*=1207)	Total services (*N*=3007)
West Central	80 (6.3%)	203 (6.8%)
East Central	86 (6.8%)	137 (4.7%)
East metro*	175 (13.8%)	442 (13.8%)
West metro*	294 (23.1%)	632 (21.9%)
Southwest	120 (9.4%)	204 (6.8%)
South Central	5 (0.4%)	10 (0.3%)
Southeast	329 (25.9%)	767 (25.5%)

*Note: The region breakdowns are specified by the Regional Navigator position and organize data by the counties each Regional Navigator oversees (see Appendix X of Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf)). The * indicates the two regions that make up the "Metro" region. South Central is likely undercounted because it is a new rural region and had a shortened data collection period. Southeast is likely overrepresented due to the region's efficiency in reporting. Reporting technical issues may have caused missing data.*

Region type. East and West Metro regions make up the "Metro" region type, which consists of nine counties. "Greater Minnesota" includes the remaining seven regions, which together served 801 unique enrollments who received a total of 1,932 services during the biennium (see Table 4 and Appendix X of Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf). According to Human Trafficking in Minnesota: A Report to the Minnesota Legislature (https://www.leg.mn.gov/docs/2019/Mandated/191234.pdf) (2019), law enforcement and service providers identified the majority of sex (60%) and labor trafficking (69%) victims in the Twin Cities metro. Conversely, Safe Harbor services in Greater Minnesota accounted for a greater proportion of unique enrollments and total services (Table 8); demonstrating that Safe Harbor is providing necessary resources that may not otherwise exist, according to the Phase 3 Safe Harbor Evaluation Report by Wilder.

Table 8. Client housing and supportive services by region type

Region type	Unique enrollments (*N*=1207)	Total services (*N*=3007)
Greater Minnesota	801 (63.1%)	1932 (64.3%)
Metro	469 (36.9%)	1075 (35.7%)

Note: Minnesota Metro is defined as the nine-county region specified in Appendix X of Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf). Greater Minnesota represents all other counties in Minnesota. Client numbers may be misrepresented due to inconsistencies in grantee data reporting.

Housing information characterizes Safe Harbor's development and responsiveness to rising housing needs, statewide. Though Safe Harbor housing grantees provide several supportive services, they specialize in various shelter and housing programs. As of June 30, 2021, 13 grantees operated 18 housing programs throughout the state and there were a total of 117 housing or

bed options operating in Safe Harbor during Phase 4 (Table 9). Appendix XI of the Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf) details available Safe Harbor housing and supportive services agencies.

Table 9. Housing services agencies, program, bed type, and number of beds

Housing Agency	Region Type	Housing Program	Type of Bed	Number of Beds
180 Degrees	Metro	Emergency Shelter	Shelter Beds	8
Evergreen Youth and Family Services	Greater MN	Scattered Site Housing	Housing Program Slots	7
Heartland Girls' Ranch	Greater MN	Congregate Transitional Housing	Housing Beds	10
North Homes Children and Family Services	Greater MN	Congregate Transitional Housing	Housing Beds	6
LSS Rochester	Greater MN	Scattered Site Housing	Housing Program Slots[a]	5
Ain Dah Yung	Metro	Site-based Independent Housing	Housing Units	15
Life House	Greater MN	Site-based Independent Housing	Housing Units	8
Life House	Greater MN	Congregate Transitional Housing	Housing Beds	5
Life House	Greater MN	Emergency Shelter	Shelter Beds	2
The Family Partnership	Metro	Scattered Site Housing	Housing Program Slots[a]	6
The Link	Metro	Site-based Independent Housing	Housing Units	5
The Link	Metro	Emergency Shelter	Shelter Beds[b]	8
Lutheran Social Services, Brainerd	Greater MN	Scattered Site Housing	Housing Program Slots	6
Lutheran Social Services, St. Cloud	Greater MN	Scattered Site Housing	Housing Program Slots[a]	3
Terebinth Refuge	Greater MN	Emergency Shelter	Shelter Beds	6
Terebinth Refuge	Greater MN	Congregate Transitional Housing	Housing Beds	3
Breaking Free	Metro	Emergency Shelter	Shelter Beds[a]	4
YMCA	Greater MN	Scattered Site Housing	Housing Program Slots[a]	10

Note: [a] denotes beds that were newly added in January 2020. [b] denotes that a portion of the beds were newly added in January 2020. Housing slots are scattered-site housing programs with participants living in their own apartments.

The 18 housing programs fall into four shelter and housing options:

- Congregate transition (*N*=5).
- Emergency shelter (*N*=5).
- Scattered-site housing (*N*=6).
- Independent housing (*N*=2).

These four categories of programs provide four housing and shelter types; shelter beds, housing beds, housing slots, and housing units.

- Shelter beds are in congregate facilities that function as an emergency shelter model.
- Housing beds are in congregate facilities that function as a housing program that is longer than a shelter.
- Housing slots are scattered-site housing located in the community. They do not require an agency to have physical beds on site. Instead, they have a number of "slots" in their program, and participants find housing once they have secured a program "slot."
- Housing units are site-based independent housing options located in the community.

Supportive services data demonstrated Safe Harbor's comprehensive service programming. In grantee report forms for services delivered, supportive services grantees enter the units of time devoted to providing a service to the client or referrals made on the clients' behalf. These units of time were transformed into instances of services provided and referred. Appendix VI of the Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf) includes the definitions about several types of services clients accessed through Safe Harbor programming. Some agencies are limited in the services they can offer. If the agency cannot provide the services, a grantee will refer the client to get the support needed.

Total instances of services provided and referred. Instances of service draws from the total services sample and expands on the multiple services clients received (Table 5). Analyses revealed that emotional support and case management accounted for 81% and 79% of total services (Figure 2). Grantee reporting revealed the most and least frequently provided and referred Safe Harbor services to clients. Mental health services were the most referred support, 22% of clients received a referral, although, 25% of clients received direct mental health services from Safe Harbor grantees (see Appendix IX of Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf), and Figures 2 and 3).

Total instances of services provided by region type. Services by region showed a similar pattern statewide; grantees provided emotional support for 84% clients in Greater Minnesota and 76% in the Metro, and case management for 76% of clients in Greater Minnesota and 83% in the Metro. Criminal justice advocacy was frequently accessed in Greater Minnesota and housing advocacy in the Metro (Figure 3).

Ranking method. The ranking analyses presented in the following tables represent the total number of times clients accessed a service relative to total number of times they accessed other services, in a quarter or region (Table 10). The rank of least frequently provided and referred services represents the lowest number of client counts (Table 11), which can be seen in Figures 2 and 3.

Figure 2. Total instances of services provided and referred (*N*=3007)

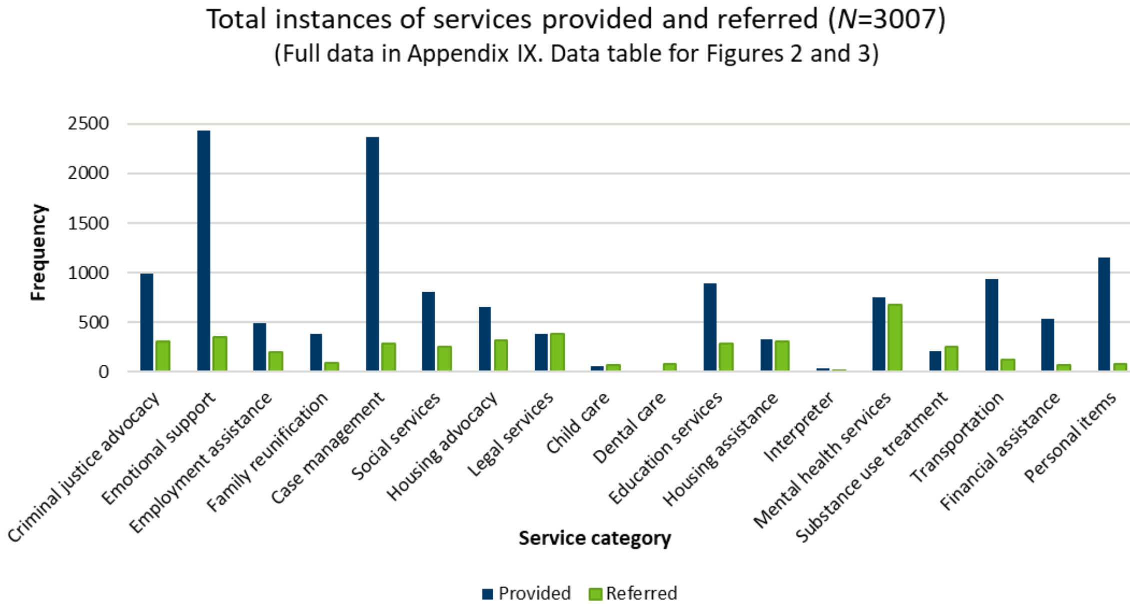

Figure 2 shows Safe Harbor supportive services that grantees provided and referred and the number of clients that accessed each service.

Figure 3. Total instances of services by region type (*N*=3007)

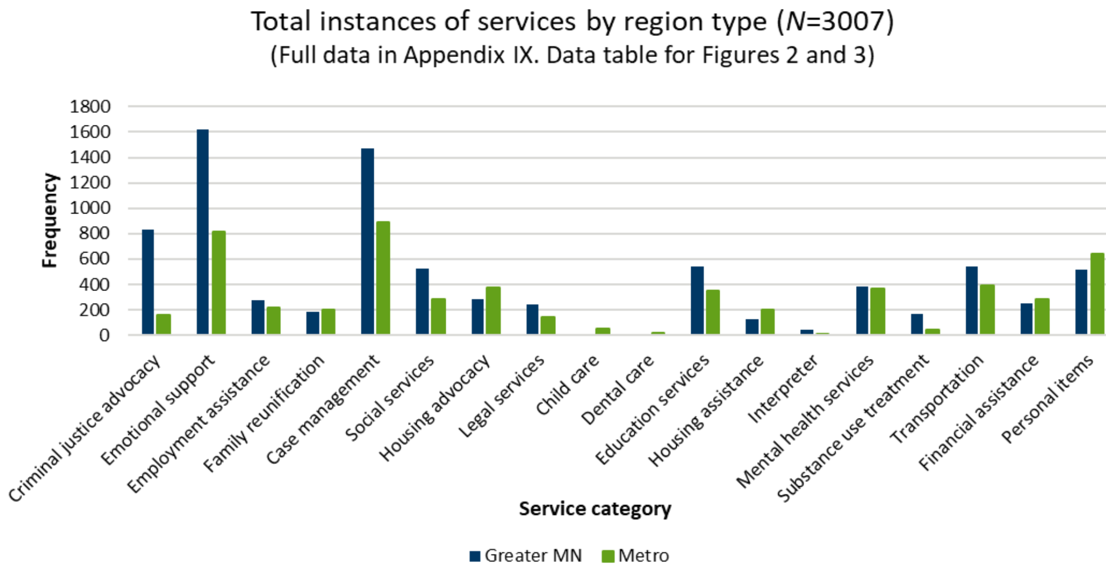

Figure 3 shows Safe Harbor supportive services that grantees provided in the Metro and Greater Minnesota and the number of clients that accessed each service.

Most frequently provided services trends. During the biennium, emotional support and case management remained the top frequently provided services; however, the most accessed services changed in different quarters (see Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf) at pg. 71). Transportation fell in need during the pandemic but remains an important resource for youth clients. Education services rose in the ranking of top provided services during the pandemic. The finding that the top five accessed services changed in different quarters may indicate that certain services are pertinent at different times or seasons (e.g., education services may follow school deadlines and schedules). Similarly, the top provided services differed by region type (see Figure 3) and race demographic (Table 10). Analyses revealed that while criminal justice advocacy and education services were among the top accessed services by White, Multiracial, and POC clients, criminal justice advocacy ranked 9th and 10th and education services ranked 6th and 12th among Black and American Indian clients, respectively.

Table 10. Top five frequently provided services by race demographic (*N*=3007)

Rank	Black	American Indian	POC	White	Multiracial
1	Case management (521)	Case management (299)	Emotional support (243)	Emotional support (913)	Emotional support (230)
2	Emotional support (517)	Emotional support (253)	Case management (214)	Case management (822)	Case management (225)
3	Personal items (317)	Personal items (154)	Personal items (124)	Criminal justice advocacy (498)	Personal items (126)
4	Transportation (253)	Transportation (119)	Education services (102)	Education services (367)	Criminal justice advocacy (114)
5	Housing advocacy (219)	Financial assistance (111)	Transportation (81)	Personal items (316)	Education services (108)

Note: Table 10 shows the top five frequently provided services by race demographic; the number 1 signifies the top service that clients accessed during that quarter. The number in the parentheses represents the number of services provided during the biennium to clients from a specific racial background.

Infrequently provided and referred services. The five least provided services were dental care, an interpreter, childcare, substance use treatment, and housing assistance (Table 11). Background evaluation by Wilder reported that "respondents noted a lack of services for trafficked youth who are pregnant, parenting, or both; and for those who have complex, intensive, challenging [or substance use treatment] needs" (see Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf) at page 37. The lack of childcare, interpreter, or substance use treatment services may affect Safe Harbor's accessibility and impede especially vulnerable clients' ability to utilize other Safe Harbor services in their area. Region specific findings showed that, in the Metro, grantees were least likely to provide

interpreter services. In Greater Minnesota, supportive service grantees were least likely to provide dental care (Table 12).

Table 11. The five least frequently provided services per total services (*N*=3007)

Rank	Least Provided Services	*n*	Least Referred Services	*n*
1	Dental Care	21	Interpreter	10
2	Interpreter	41	Financial Assistance	66
3	Child Care	59	Child Care	70
4	Substance use treatment	208	Personal Items	78
5	Housing Assistance	325	Dental Care	82

Note: Table 11 shows the top five least frequently provided and referred services; the number 1 signifies the lowest number of clients accessing that service or a referral to that service.

Table 12. The five least frequently provided services by region type (*N*=3007)

Rank	Greater Minnesota	Metro
1	Dental care	Interpreter
2	Childcare	Dental care
3	Interpreter	Substance use treatment
4	Housing assistance	Childcare
5	Substance use treatment	Legal services

Note: Table 12 shows the top five least frequently provided services by region; the number 1 signifies the lowest number of clients accessing that service.

Youth and Community Evaluation of Safe Harbor Services

Wilder Research (Wilder) evaluation activities from Phase 4 of Safe Harbor (February – June 2021) included surveying and conducting interviews with Safe Harbor clients, in addition to conducting interviews with Safe Harbor community partners. Data collection methods and respondents were selected based on the evaluation questions, in addition to budget and timeline considerations. The data collection activities for Phase 4 are described in more detail below.

- **Surveying Safe Harbor clients.** There were 46 respondents to the youth survey including participants from 13 grantee sites. More than half had been receiving services for more than one year (65%). Respondents' ages ranged from 14 or younger (3%), 15-17 (25%), 18-24 (67%) and 25 or older (6%). The majority identified as female (57%) while 4% identified as male and 39% chose not to respond. Youth were offered a $10 gift card as an incentive for completing the survey.
- **Interviews with Safe Harbor clients.** Wilder interviewed 19 youth participants in Safe Harbor grantee programs from March through May 2021. Interviewees were invited to participate by staff

across ten grantee organizations. Interviewees' ages ranged from 14 or younger (5%), 15-17 (32%), 18-24 (42%), and 25 or older (16%). Most (95%) identify as female. Youth were offered a $20 gift card as an incentive for completing the interviews. These interviews were conducted between March and June 2021.

- **Interviews with Safe Harbor community partners.** Wilder interviewed 56 community respondents about what is working and what needs improvement within the Safe Harbor network. These respondents represented a variety of sectors, with the highest proportion representing the law enforcement/legal sector (45%), followed by advocacy/Regional Navigator (36%; see Table 17).

Key findings from youth surveys and interviews

Nearly all youth survey respondents felt they learned about what resources are available in their area and how to use those resources (98% each; see Table 13). They also learned how to express their feelings in healthy ways and how to cope when they are upset or angry (97% each; see Table 14). For more information on youth's satisfaction with Safe Harbor and their sense of preparedness, support, and hopefulness see Appendix II of the Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf)

Table 13. "Since you started receiving services at [program], how much did you learn about each of the following?"

Questions/Scale	A lot	Some	A little	None
How to know if you are in a dangerous situation (*N*=42)	67%	17%	10%	7%
How to identify an unhealthy/abusive relationship (*N*=42)	67%	24%	2%	7%
How to "comfort yourself/cope" when you are upset or angry (*N*=42)[a]	50%	26%	21%	2%
How to reach your education goals (*N*=42)	57%	26%	12%	5%
How to express your feelings in healthy ways (*N*=42)	**52%**	**31%**	**14%**	2%
What resources are available in your area (*N*=43)	**67%**	**26%**	**5%**	2%
How to use resources in your area (*N*=42)	**62%**	**29%**	**7%**	2%
What sexual exploitation is (*N*=42)	69%	17%	7%	7%
How to use social media and the internet safely (*N*=42)	62%	17%	7%	14%
How to get professional medical care (*N*=43)	54%	35%	7%	5%
How to find safe and affordable housing (*N*=43)	51%	21%	19%	9%
How to reach your career goals (*N*=42)	52%	24%	14%	10%

Note. Percentages provided are of those youth/young adults who responded to the question (N=42-43). Row totals may vary from 100% due to rounding. [a] Question wording varied between survey versions.

Reasons youth access Safe Harbor. Interviewers asked youth what made them decide to begin the grantees' program. The most frequent answer was that interviewees were referred through another organization or agency, including other Safe Harbor grantees, or through child protection, foster care, or juvenile courts (37% of interviewees). The next most frequent answer was that a family member of the interviewee suggested they attend the program (21%). The last theme that emerged is that youth found the program on their own and reached out because they thought the grantee could help them meet a need they had, including help with a court case and a safe place to stay (16%).

Services youth need. Interviewers also asked youth to identify the biggest needs that they had when they started Safe Harbor programming. Interviewees could list as many answers as they wanted. In order from most to least frequently reported, interviewees said they needed:

- Positive social connections (37%)
- Employment assistance (21%)
- Safe housing (37%)
- Food (21%)
- Mental health supports (26%)
- A sense of safety or security (16%)
- Education assistance (21%)

Services youth access. Interviewers asked youth to describe the types of services and supports that they received through Safe Harbor programming. Youth could name as many services and supports as they could think of. In order from most to least common, the following themes emerged:

- Case management (42%)
- Emotional support (32%)
- Mental health supports, including referrals (42%)
- Independent living skills (26%)
- Education supports (37%)
- Legal help, including referrals (21%)
- Housing, including referrals or assistance finding independent housing (37%)
- Peer support groups (16%)
- Basic supplies including food, clothing, baby care products, and hygiene products (32%)
- Referrals to other supports not listed above, including to pro-social activities (16%)
- Employment supports (32%)
- Substance use supports (16%)

How services impacted youth. Interviewers asked youth to describe which, if any, of the services they received were particularly helpful and why. Interviewees could raise as many ideas as they liked. In order from most to least common, youth named the following supports as particularly helpful:

- Emotional support (42%)
- Mental health supports, including referrals (26%)
- Case management supports (21%)
- Employment help (16%)

Service gaps. Youth who took the survey administered by Wilder were asked if they needed services beyond what they had received from the Safe Harbor grantee who provided those services (Table 14). A large majority (88%) indicated that they did not need any additional types of services. For those who

did need additional services, the most common were mental health services (49%), transportation (38%), finding housing (35%) and finding or keeping a job (35%).

When asked how the program could make their services easier for people to use, youth provided a number of suggestions in open-ended responses, such as increasing and improving advertising and outreach to make services easier for people to use. This included generally raising awareness and more specifically, advertising through national and local media. When asked how the services can be improved, youth again suggested more outreach. They also suggested expanding the age limit, supporting individual autonomy, having smaller group sessions, offering classes on independent living and respecting cultural differences.

Table 14. "What else do you still want help with? (Check all that apply)"

Service area	Percent (*N*=37)
Mental health services for you	49%
Transportation	38%
Finding housing	35%
Finding or keeping a job	35%
Legal support	27%
Childcare	22%
Starting or returning to school	19%
Avoiding people who have hurt me in the past	19%
Mental health services for you and somebody else	14%
Health care	11%
Chemical health/treatment	3%

Note. This question was only included in the 2021 survey. Column total equals more than 100% because respondent could check more than one option, including 8% who selected "other" and 16% "none of the above." "Other" responses included: driver's license, starting a business, and assistance preparing for their child to return home

Interviewers asked youth what, if any, services they were hoping to get through the Safe Harbor grantee but did not receive for whatever reason. Most youth identified a service they wanted but did not receive (53%). Youth identified the following as services they still need:

- Employment assistance (42%)
- Housing (32%)
- Mental health supports (26%)
- Independent living skills (21%)

COVID-19 impacts. Almost half of survey respondents interviewed by Wilder said that COVID-19 made services harder to access (44%; see Table 15). Many survey respondents felt that COVID-19

negatively impacted their mental health (71%), their physical health (65%), and their ability to meet their basic needs (72%; see Table 15).

Nearly all survey respondents felt confident in their program's safety plans to protect clients from COVID-19 (98%) while slightly fewer felt they provided enough services and support to meet the additional needs due to COVID-19 (84%; see Table 15). More than half of youth survey respondents said that services they needed, even remote services, were not available because of COVID-19 (13 of 19; see Table 16).

Table 15. "How much do you agree or disagree with the following statements?"

Questions/Scale	Strongly agree	Agree	Disagree	Strongly disagree
COVID-19 negatively impacted my mental health (*N*=45)	29%	42%	29%	0%
COVID-19 negatively impacted my physical health (*N*=45)	27%	38%	36%	0%
COVID-19 negatively impacted my ability to meet basic needs for myself (i.e., food or water; clothing or hygiene necessities; connection to support networks)(*N*=45)	13%	49%	36%	2%
[Program] provided enough services and support to meet additional needs I had because of COVID-19 (*N*=45)	51%	33%	13%	2%
I felt confident in [program]'s safety plans to protect clients from COVID-19 (*N*=45)	56%	42%	2%	0%

Note. These questions were only included in the 2021 survey (version 3). Percentages provided are of those youth/young adults who responded to the question (N=45). Row totals may vary from 100% due to rounding.

Table 16. "Please let us know how frequently the following occurred"

Questions/Scale	Always	Sometimes	Rarely	Never
In-person services were canceled or postponed because of COVID-19 (*N*=19)	6/19	9/19	3/19	1/19
Services I needed, even remote services, were not available because of COVID-19 (*N*=19)	2/19	13/19	3/19	1/19
I did not have a device, internet, and/or data plan necessary to connect for remote services (for example, no smart device, or no Wi-Fi.)(*N*=18)	0/18	7/18	4/18	7/18
Remote or telehealth services didn't feel as helpful as in-person services (*N*=18)	3/18	11/18	3/18	1/18

Note. These questions were only included in the 2021 survey, and only asked of youth who responded "yes" to "Did COVID-19 make Safe Harbor services harder to access." Due to the relatively small number of respondents (N=18-19), counts are provided, rather than percentages.

Community respondent interviews with Safe Harbor network

Table 17 draws from interviews with several community partners engaged in the Safe Harbor initiative. A more in-depth analysis of the themes and how Wilder generated the qualitative findings can be found in the [Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf)](https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf).

Table 17. Multidisciplinary partnerships: Community respondent themes and exemplars

Themes	*N of theme endorsement*	Participant quotes
Relationships between grantees and law enforcement	20+	"We co-build it together. I see [LE] all for the humans they are. I see them as partners. The first time I met with them, they were primarily White males in uniforms and guns. They're part of creating the solution. And part of the solution requires that of owning how you have failed by perpetuating the problem. An acknowledgment, then an action." *-Advocacy sector*
Changes since 2019	20+	"We have improved lines of communication and points of contact between law enforcement agencies and [the] county prosecutor's office and navigators and service providers. It's not just that we know each other's faces. We have more of an idea of what particular agency to reach out to if we have questions or concerns." *-Prosecution*
Challenges	20+	"Identifying is huge. Public safety plays such a huge role in that, and we're among the first to deal with survivors. The barrier is still to get the signs, recognizing the signs of trafficking. Just learning what the signs are, it's not something that's instructed in law enforcement skills training. What are the at-risk youth indicators?" *-Law enforcement*
Impact of COVID-19	20+	"COVID has exacerbated trafficking and probably increased it and [pushed it] more underground, less visible…With people being isolated in their homes, loss of jobs and economic opportunities, kids not being in school, I think those factors create an environment for online exploitation and in-person exploitation." *-Government sector*
Culturally specific findings	20+	"I absolutely know that there are people that are out there doing the work with culturally diverse populations that aren't culturally competent, that don't understand how different things come into play when they're interacting with youth from different backgrounds. More training needs to be done. I think there needs to be more focus on onboarding and addressing cultural competency and our own personal biases as providers and individuals." *-Regional Navigator*
Protocol development sites	16	"And an 80-page protocol is not going to work when all they need to do is identify, [do the] mandated report, and get them connected to resources. That's all I want the protocol to be. Getting the protocol from a paper and getting it into practice." *-Juvenile justice*
Labor trafficking	5-9	"With labor trafficking, I think that also has improved in terms of identification. We are…thinking about the connection between labor and sex trafficking, and I think we are probably identifying both more because oftentimes they happen at the same time."*-State government*

Themes	*N of theme endorsement*	Participant quotes
Child Protective Services (CPS)	6	"There is a great need for not necessarily a shelter but… a housing program that does have access to psychiatry… and some of those longer-term mental health supports that are going to be helpful to follow someone over time " - *CPS Sector*
Next steps for Safe Harbor	20+	"Decriminalizing adult exploited persons [should be Safe Harbor's next steps], but that would be a monumental challenge… To convince the legislature of such a change. Victim advocacy groups, and perhaps Public Health, would need the support of Public Safety." *-Law enforcement*

Note. N represents the number of respondents that endorsed qualitative theme. Wilder interviewed 56 community respondents about what is working and what needs improvement within the Safe Harbor network. These respondents represented a variety of sectors, with the highest proportion representing the law enforcement/legal sector (45%), followed by advocacy/Regional Navigator (36%).

Assessment, Collection, and Distribution of Funds under Minnesota Statute section 609.3241

Minnesota Statutes section 609.3241, as amended during the 2021 Minnesota Legislative session, sets forth penalty assessment by the courts. These assessments are distributed to MDH for distribution to services supporting sexually exploited youth. In addition, these funds are distributed to DPS to support the law enforcement and prosecution response to sexual exploitation of youth.

During the spring of 2020, the Safe Harbor program conducted a competitive request for proposals process to award three-year grants for Safe Harbor Regional Navigators and Supportive Services. Safe Harbor set aside an additional $100,000 for grantees through funds distributed under Minn. Stat. § 609.3241 (as well as Minn. Stat. § 609.5315, disposition of forfeited property).

During the summer of 2020, the Safe Harbor program executed a one-year inter-agency agreement with the Minnesota Attorney General's Office for $40,000 to support the development of its statewide expungement program. Access to expungement was identified as a key need for sex trafficking victims in the 2018 Safe Harbor for All: Results from a Strategic Planning Process in Minnesota (https://uroc.umn.edu/sites/uroc.umn.edu/files/2019-11/SH4ALL-Findings-and-recommendations-1.13.19.pdf) submitted to MDH by The Robert J. Jones Urban Research and Outreach Engagement Center at the University of Minnesota, The Advocates for Human Rights, and Rainbow Research, as directed by the Minnesota Legislature, and reported to the Legislature in January 2019 by MDH through the Safe Harbor for All: Statewide Trafficking Victim/Survivor Statewide StrategicPlan(https://www.health.state.mn.us/communities/safeharbor/documents/mdhSH4ALLreport.pdf).

Finally, during the spring of 2021, the Safe Harbor program allocated funds totaling $125,000 from the penalty and forfeiture distributions to five existing Safe Harbor grantee programs to further enhance services to youth victims of sex trafficking and exploitation (The Advocates for Human Rights, Esperanza United (formerly known as Casa de Esperanza), Central Minnesota Sexual Assault Center, International Institute of Minnesota, and Southwest Crisis Center).

Phase 4 Evaluation Recommendations and Conclusion

Recommendations

The Phase 4 Evaluation addressed several topics, including building evaluation capacity, housing and supportive services to Safe Harbor clients statewide, new enrollments, multidisciplinary partnerships, youth clients' and community partners' evaluation of Safe Harbor, and the impacts of COVID-19 on youth seeking services. Further details and findings are available in the Supplemental Materials (https://www.health.state.mn.us/communities/safeharbor/documents/2021shevalsupp.pdf). This section contains recommendations drawing from information in this report, as well as information found in the background report.

Expand services and remain flexible

Recommendation. The need for Safe Harbor services grows and changes as the initiative expands. Grantees should remain flexible in the way services are delivered to meet clients' various needs. Findings showed that specific deficits in services may impede the efficacy of Safe Harbor because support is less accessible to specific populations, especially during crisis and for high needs clients. Some evidence suggested that one positive impact of the COVID-19 pandemic was that virtual services provided increased access to help for youth who traditionally have had difficulty attending in-person services. Evidence also suggested that virtual services are only helpful if clients have access to technology and private space to talk.

De-silo the issues of labor and sex trafficking

Recommendation. Safe Harbor should continue to invest in community engagement of subject matter experts and survivors, and explore the connective tissue between labor trafficking, sex trafficking, and various systems of oppression. The "de-siloization" of the human trafficking response is recommended, with the long-term goal of building a comprehensive strategy that addresses both labor and sex trafficking. Competing objectives and limits on funding can create a lopsided approach that is over-focused on sex trafficking to the detriment of both sex and labor trafficking survivors.

Expand youth voice and opportunities for inclusion

Recommendation. The Safe Harbor network must strategize new modes of outreach and connection with youth. Safe Harbor utilizes future evaluation to assess Safe Harbor youth outcomes and make the assessment participatory with youth survivors. Grantees expressed interest in forming youth advisory boards, youth-specific programming, and hosting conversations to engage youth with Safe Harbor. MDH and Safe Harbor grantees are strategizing several pieces of a larger investment to include youth in Safe Harbor trafficking prevention and compensate their expertise and experience with money, transferrable job skills, and a platform to affect change. Wilder's youth respondents reported they felt cared for when staff valued them and respected their voices. Youth expressed a need for economic opportunities, mental health support, and the skills and resources to change their life circumstances. Difficulties recruiting youth to evaluate Safe Harbor programming suggests a need to reconnect with youth who lost touch with services during the COVID-19 pandemic.

Promote healing organizational trauma and helping clients heal

Recommendation. Safe Harbor should continue to promote organizational healing and incentivize grantees to infuse practical applications of self-care in their agencies and support programs to develop self-care routines and skills with clients. The organizational well-being work within Safe Harbor established the intention of MDH to set a culture that supports healing the organizational traumas that occurred as a direct or indirect result of the COVID-19 pandemic, the murder of George Floyd, and pipeline construction (see Appendix XV). Inequity hinders trafficking prevention efforts and is directly felt within the Safe Harbor initiative. Safe Harbor remains focused on how to respond to crises and related inequity while establishing norms for organizational healing.

Conduct cultural needs assessments with several cultural groups

Recommendation. Safe Harbor should continue to conduct culturally engaged research with various cultural groups to understand their pathway into trafficking, the nuanced needs and culturally specific services they require, and their experiences interfacing with government systems or falling through the cracks. Between Phase 3 to Phase 4, Wilder changed the Safe Harbor evaluation protocols to investigate the cultural responsiveness of Safe Harbor. Participants contacted by Wilder expressed distrust between minority cultural groups and government systems of safety. Findings from the external evaluation suggested that Safe Harbor community respondents see a need for more culturally specific services. However, Wilder was not able to research the specific needs of each cultural group represented in the evaluation. Future research and participatory evaluation centering on cultural groups and leaders are required.

Build evaluation capacity and conduct inferential research

Recommendation. MDH should consider updating grantee report forms, reporting procedures, and data collection tools to improve and standardize the retention of grantee activities in between reporting cycles. Consistent evaluation promotes informed program implementation and development

by identifying gaps in network and services. The grantee reporting database, forms, and procedures are critical to the efficacy of Safe Harbor. MDH must reduce missing data and continue improving client-participant recruitment, data collection skills among grantees, and data management quality.

Advance and invest in initiatives and systems to increase equity

Recommendation. MDH should continue to strategically direct the allocation of funds and resources to specific cultural groups. This includes building systems to improve equity, inclusion, and representativeness within Safe Harbor and multidisciplinary partnerships. In addition, Safe Harbor should strategize more opportunities for engagement for youth, advocates, survivor-leaders, immigrants and refugees, and individuals from LGBTQI2S+, male-survivor, and racial minority communities. This effort includes identifying and removing barriers that prevent engagement with and by specific communities and promoting equitable compensation. The cultural needs assessments would provide insights into mitigating trafficking among particularly susceptible youth populations, such as those in foster care or juvenile justice facilities, immigrants, migrants, refugees, American Indian, LGBTQIA2S+ and male youth, youth of color, and youth who have disabilities.

Strengthen relationships within a public health approach

Recommendation. Safe Harbor should promote the continued development of multidisciplinary protocol teams and nurture multidisciplinary relationships. In addition, Safe Harbor should strategize to improve the presence of the mental health, health care, legal, medical, and substance use treatment sectors. Preliminary quantitative analysis showed youth accessing Safe Harbor services all over the state of Minnesota, suggesting the transient nature of clients. Therefore, Safe Harbor would benefit from growing relationships among all grantees to strengthen communication and collaboration in the statewide network response.

Conclusion

A comprehensive look at the Phase 4 evaluation demonstrates the unique impact of the multidisciplinary, statewide approach. Each partner, collaborator, grantee, provider, and survivor contribute to a robust anti-trafficking response filled with varying perspectives and objectives. At the same time, the Phase 4 evaluation has shown how vital cross-sector governmental and community collaboration is to prevent human trafficking and exploitation. The biggest lesson learned from observing MDH navigate nuances within a multidisciplinary response is that Safe Harbor must continue to orient each discipline to attain their individual sectors' objectives within an overall public health approach and the No Wrong Door model.