What Happens Now?
Using Best Practice Models to Support Children with Problematic Sexual Behaviors

PSB Diversion Program

JUST Response

March 21, 2019

Agenda

- What We Saw
- What We Learned
- What We Created
- Program Implementation

What We Saw

Data, Response, and Group Activity

SEX OFFENDER

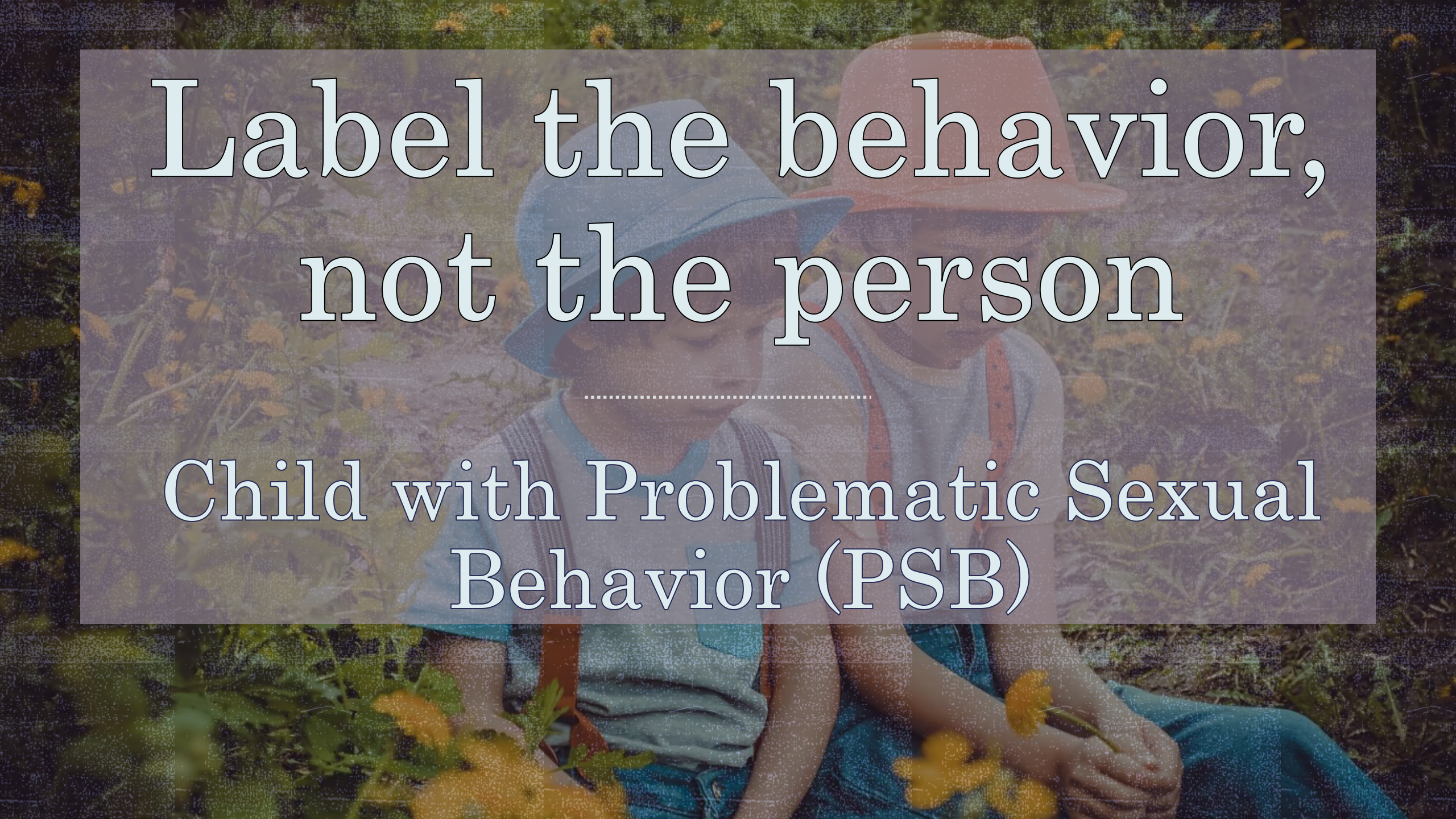
PREDATOR

RAPIST

CHILD ABUSER

MONSTER

SUSPECT



Label the behavior, not the person

Child with Problematic Sexual Behavior (PSB)

National and Local Prevalence

- Difficult to determine
- How youth are identified
- Inconsistent agency and governmental policies

- 25-30% of all forensic interviews regarding childhood sexual abuse the person identified as harming another is under the age of 18.
- Greater than 1/3 of sexual offenses committed by other youth and ¼ of child survivors are related to the youth with sexual behavior (Finklehor et al., 2009)
- Youth are quite distinct from adults who sexually offend in terms of etiology, context, impact, risk, needs, responsivity, and outcomes of behavior

Missoula Prevalence of Children with Problematic Sexual Behavior

CPS:

Youth Court:

First Step:

Historical Responses

Adam Walsh Act

- Sex offender registry and notification
- In some states, including Montana, no age limit

System involvement

- Law enforcement
- Child welfare
- Youth court

Removal from home and school

Stigma and silence

Poor mental health

Response to Problematic Sexual Behavior

Hysteria

Predator on the loose

Panic

Fear

Labeling of caregivers

Dismissiveness

“Kids will be kids”

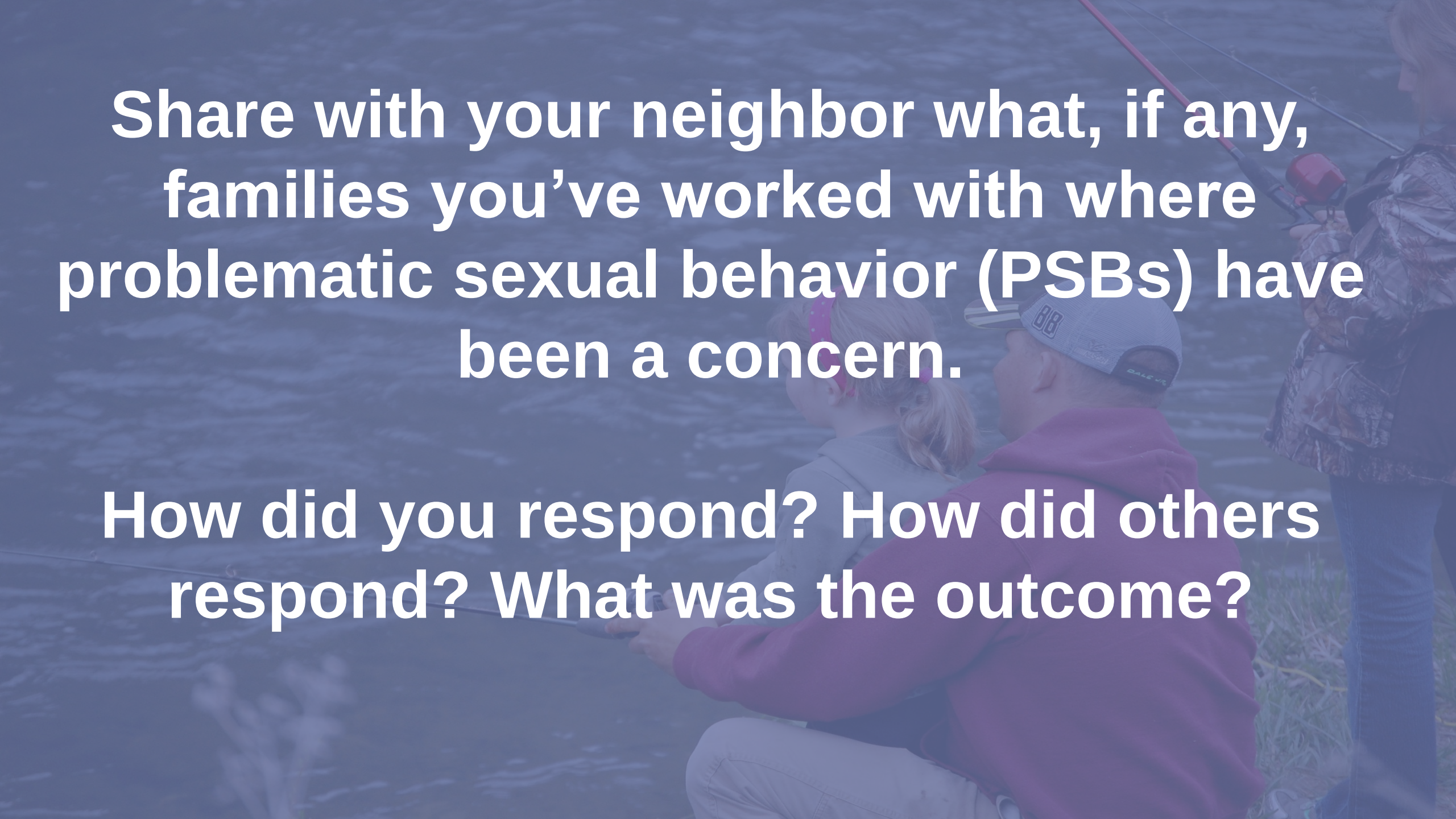
“Boys will be boys”

Confusion

Nobody wants to prosecute

No negligent caregiver

No CFS response



Share with your neighbor what, if any, families you've worked with where problematic sexual behavior (PSBs) have been a concern.

How did you respond? How did others respond? What was the outcome?

What We Learned

Research

Children with PSB are defined as children ages 12 and younger who initiate behaviors involving sexual body parts (i.e., genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others. (ATSA Task Force, 2008)

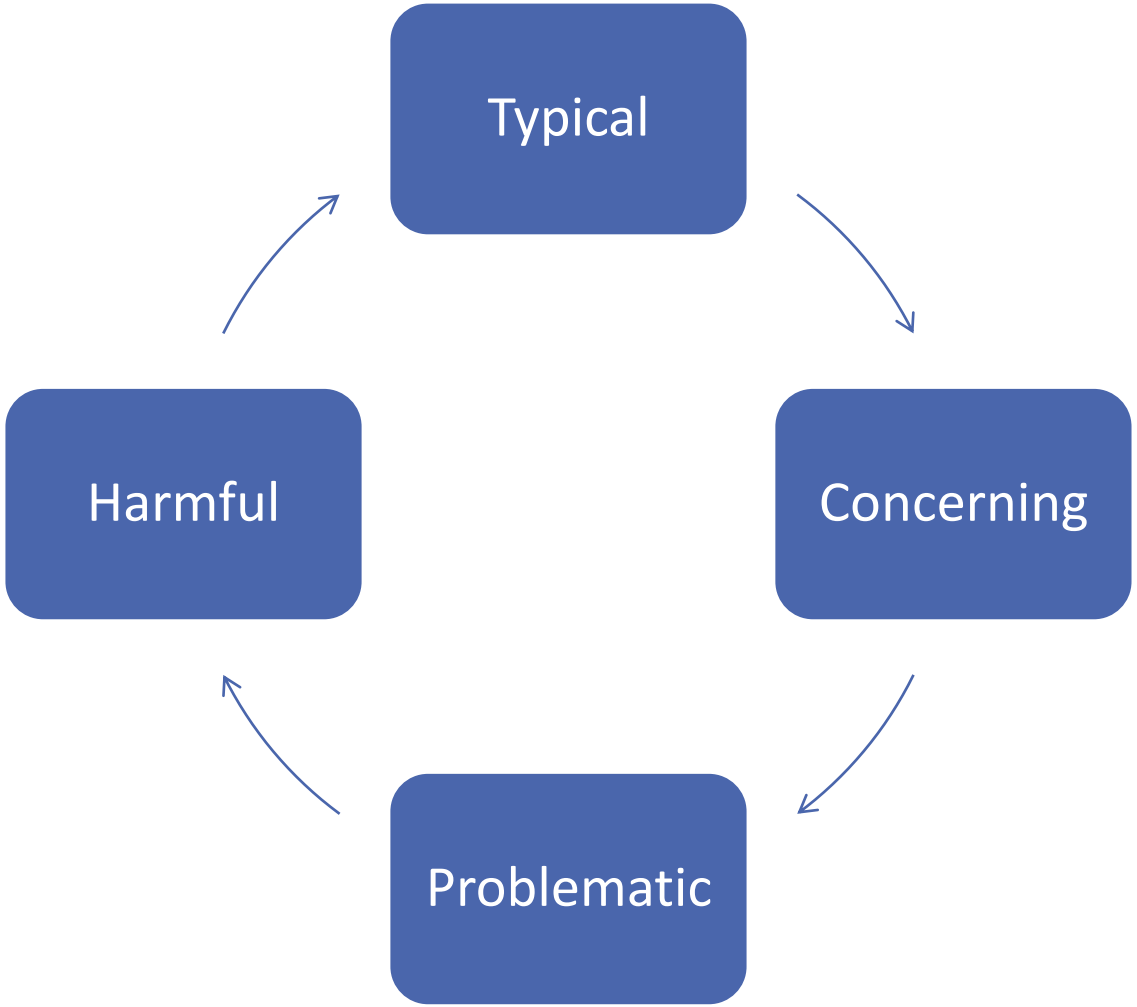
Typical Childhood Sex Play or Atypical Sexual Behaviors?

Typical Sexual Behaviors

- Involve body parts considered "private" or "sexual"
- Normal part of growing up
- Influenced by cultural and social factors

Problematic Sexual Behavior

- Involve body parts considered "private" or "sexual"
- Developmentally inappropriate
- Could be illegal
- Wide range of motives and origins



How do these behaviors develop?

- Early theories emphasized sexual abuse as the prominent cause of problematic sexual behaviors
  - Children who have been sexually abuse do engage in a higher frequency of behaviors than children who have not.

- Since 2000, it has been documented that there is a much higher percentage of children with no sexual abuse
- Current theories emphasize family, social, developmental, and economic factors

Interventions

Existing Programming

Children

- Trauma-Focused therapy
- Group therapy (unrelated to trauma)

Teens

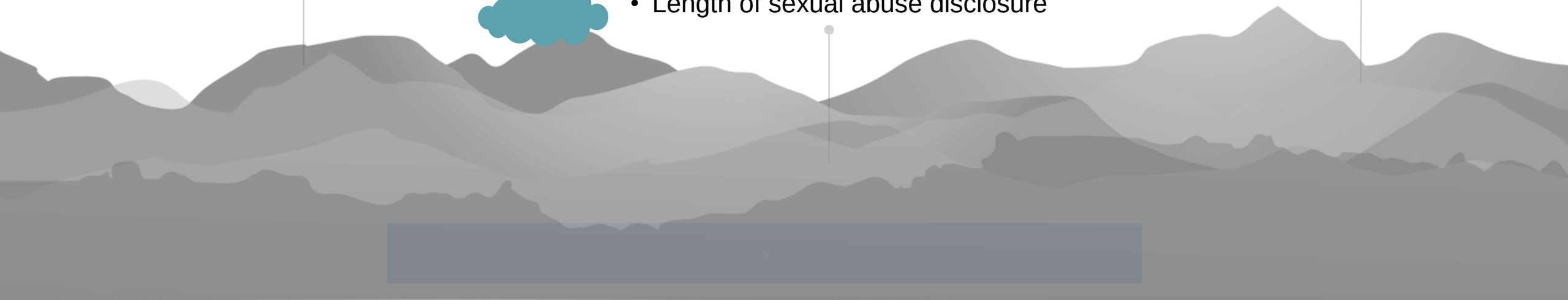
- Multisystemic Therapy
- Adolescent Diversion Project
- Special Needs Diversionary Program

Current Challenges

- Nonexistent prevention curricula
- Funding
- Children with PSB are often removed from homes and placed in residential treatment
- Sexual behavior recividism for children is low, even without services, however, there is still harm, accountability, family support, and high economic cost of children with PSB
- Length of sexual abuse disclosure

Innovative Programs

- Missoula, Montana



What We Created

For Missoula by Missoula

Can we respond better?

Connection

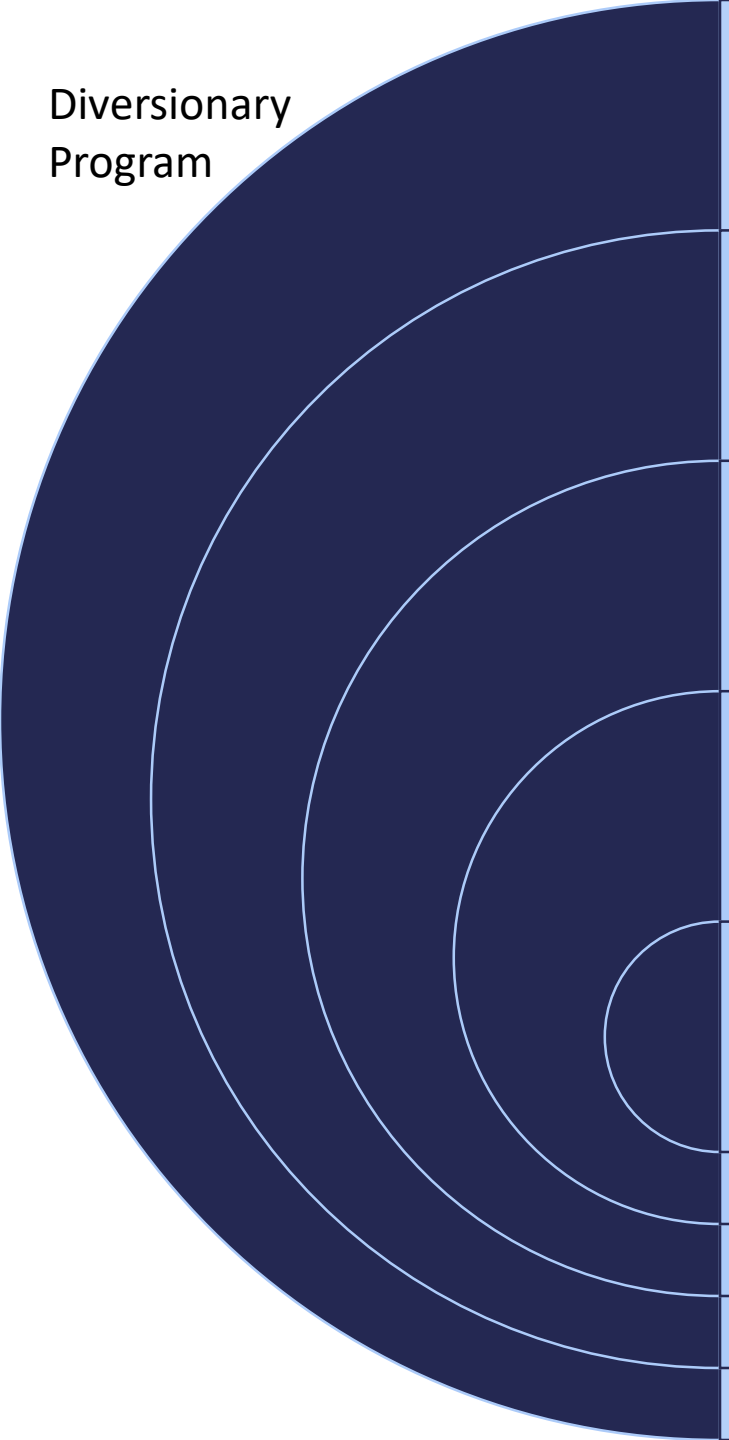
Community

Relationship skills

Communication skills

Foster ability to self-regulate

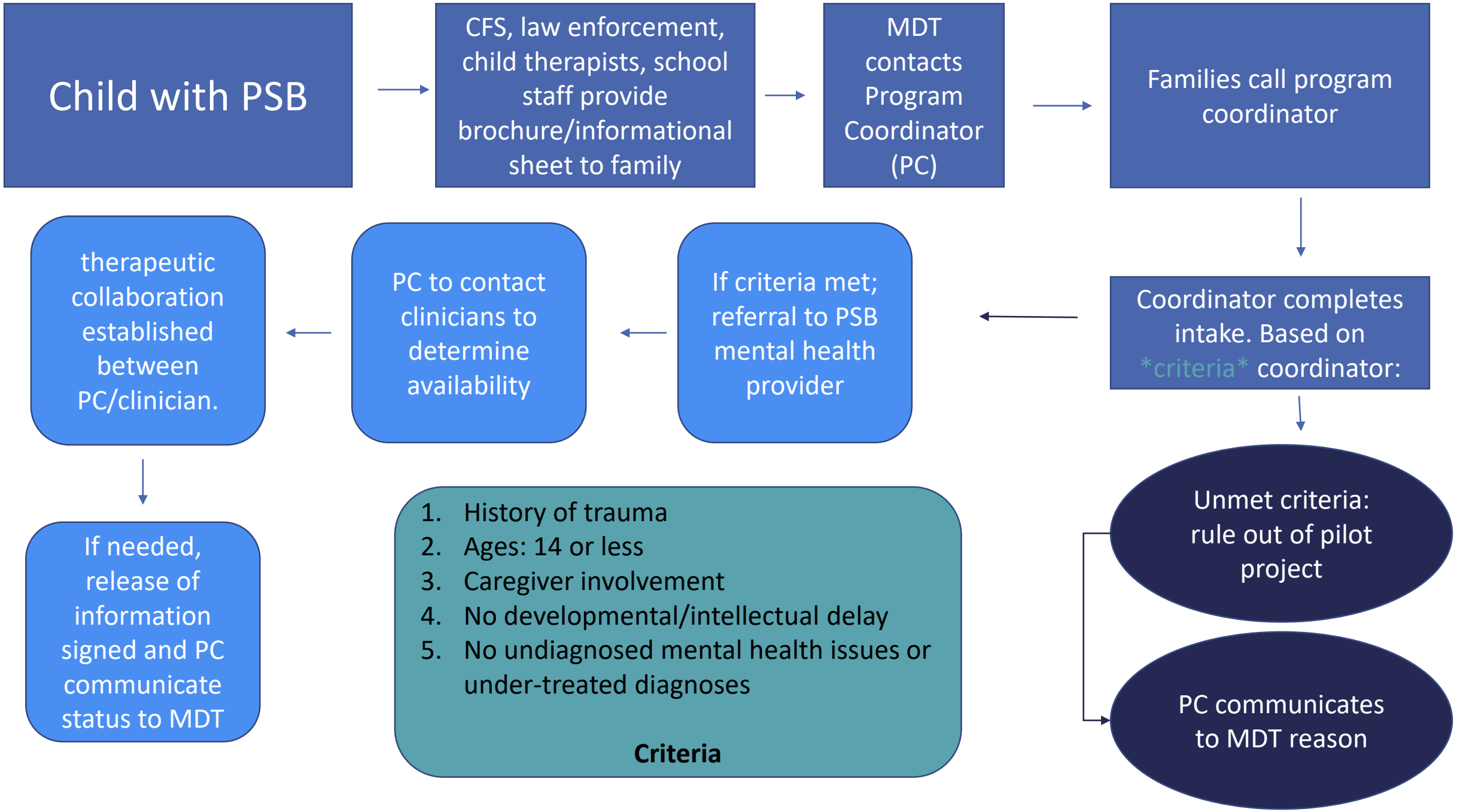
Trauma-informed response



Trainings	• Trauma-Focused Cognitive Behavioral Therapy for Problematic Sexual Behaviors (TF-CBT-PSB; September 2018)
Resources	• Caregivers, community members, schools • Explore individual/family needs
Program Coordination	• Program coordinator to assist in determining level of behavioral needs, determine clinician availability and provide therapeutic referral. Will also follow up with team members.
Data Collection and Analysis	• Collect and review children that present to child advocacy center, child welfare agency, or judicial system
PSB Diversion Program	• Families to complete 8-25 sessions of TF-CBT-PSB • Individualized safety plans • Referral to books, online resources

Program Implementation

Pilot Program and Future Plans


Child with PSB
CFS, law enforcement, child therapists, school staff provide brochure/informational sheet to family
MDT contacts Program Coordinator (PC)
Families call program coordinator
Coordinator completes intake. Based on *criteria* coordinator:
If criteria met; referral to PSB mental health provider
PC to contact clinicians to determine availability
therapeutic collaboration established between PC/clinician.
If needed, release of information signed and PC communicate status to MDT
Unmet criteria: rule out of pilot project
PC communicates to MDT reason
1. History of trauma
2. Ages: 14 or less
3. Caregiver involvement
4. No developmental/intellectual delay
5. No undiagnosed mental health issues or under-treated diagnoses
Criteria

What does the MDT need to know?

- Information gathered is confidential
  - Information not used in future proceedings
- Investigation is suspended
- Duty to report continues
- If the family drops out of the diversion program, the program coordinator communicates with MDT
- Team will consult relevant cases during case review (release of information signed by family)

Intake Form

Pilot Program **Problematic Sexual Behavior** **INTAKE SHEET**

DATE: TIME:	DATE: TIME:
PERSON CALLING:	PERSON CALLING:
AGENCY/RELATIONSHIP:	AGENCY/RELATIONSHIP:
PHONE NUMBER:	PHONE NUMBER:

NAME OF CHILD: _____ AGE: _____

DOB: _____

REFERRED BY: _____

	YES	NO
SAFETY PLAN _____	☐	☐
CAREGIVER INVOLVEMENT	☐	☐
Caregiver name(s): _____ _____		
Phone numbers: _____ _____		
HISTORY OF TRAUMA	☐	☐

NATURE OF REPORT (check all that apply):

- ☐ Sexual behaviors with other children
- ☐ Inappropriate use of technology
- ☐ Aggression, threat, force, and or/use of coercion
- ☐ Exclusive sexual Behaviors (e.g. excessive masturbation)
- ☐ Other (Please describe): _____

TO ASSESS FOR PSB, MARK ALL THAT APPLY:

Frequency	Developmental Considerations	Harm
☐ High frequency	☐ Occurs between children of significantly divergent ages/developmental abilities	☐ Intrusive behaviors
☐ Excludes normal childhood activities	☐ Behaviors are longer in duration than developmentally expected	☐ Includes force, intimidation, and/or coercion
☐ Unresponsive (i.e., does not decrease) to typical parenting strategies	☐ Behavior interferes with social development	☐ Elicits fear & anxiety in other children

ADDITIONAL NOTES: _____

_____

_____

_____

Client Initials: _____ DOB: _____ Age: _____

COMPLETED SCREENS AND ASSESSMENTS:

Screens	
☐ Child and Adolescent Trauma Screen (CATS – child self-report)	☐ Child and Adolescent Trauma Screen (CATS – caregiver report)
Assessments	
☐ Child Sexual Behavior Inventory (CSBI)	☐ Trauma Symptom Checklist for Children (TSCC)
☐ Trauma Symptom Checklist for Young Children (TSCYC)	☐ Caregiver Intake Assessment
☐ Child Intake Assessment	

SYSTEMS INVOLVED

1. YOUTH COURT: ☐ ☐
   Name _____ Phone: _____
2. CHILD & FAMILY SERVICES: ☐ ☐
   Name: _____ Phone: _____
3. LAW ENFORCEMENT:
   County or City: _____ Name: _____ ☐ ☐
4. COUNTY ATTORNEY'S OFFICE: ☐ ☐
   Name: _____ Phone: _____
5. MENTAL HEALTH AGENCIES: _____ ☐ ☐
   Names: _____
6. OTHER AGENCY INVOLVEMENT: _____ ☐ ☐
   Names: _____

Criteria (must meet all)

- Age 14 or less **Yes** ☐ **No** ☐
- Problematic sexual behavior **Yes** ☐ **No** ☐
- History of trauma **Yes** ☐ **No** ☐
- Caregiver involvement **Yes** ☐ **No** ☐
- Developmental/intellectual delay **Yes** ☐ **No** ☐ **If yes, no referral**
- Undiagnosed mental health issues or undertreated diagnoses **Yes** ☐ **No** ☐ **If yes, no referral**

Referral made based on met criteria: **Yes** ☐ **No** ☐

Clinician _____
If not, communicate reason to MDT ☐

Staff Signature _____

Date _____ **Time** _____

Screens and Assessments

Children ages 2-6: X_1 O_1 O_3 O_5 O_6 X_2
Children ages 7-12: X_1 O_2 O_3 O_4 O_6 O_7 X_2
Children ages 12-14: X_1 O_2 O_4 O_6 O_7 X_2

X_1 = Referral to Treatment	O_4 = Trauma Symptom Checklist for Children
X_2 = Trauma-Focused Cognitive Behavioral Therapy for Problematic Sexual Behaviors (15-25 sessions)	O_5 = Trauma Symptoms Checklist for Young Children
O_1 = Child and Adolescent Trauma Screen (Caregiver report)	O_6 = Caregiver intake
O_2 = Child and Adolescent Trauma Screen (child report)	O_7 = Child Intake
O_3 = Child Sexual Behavior Inventory	

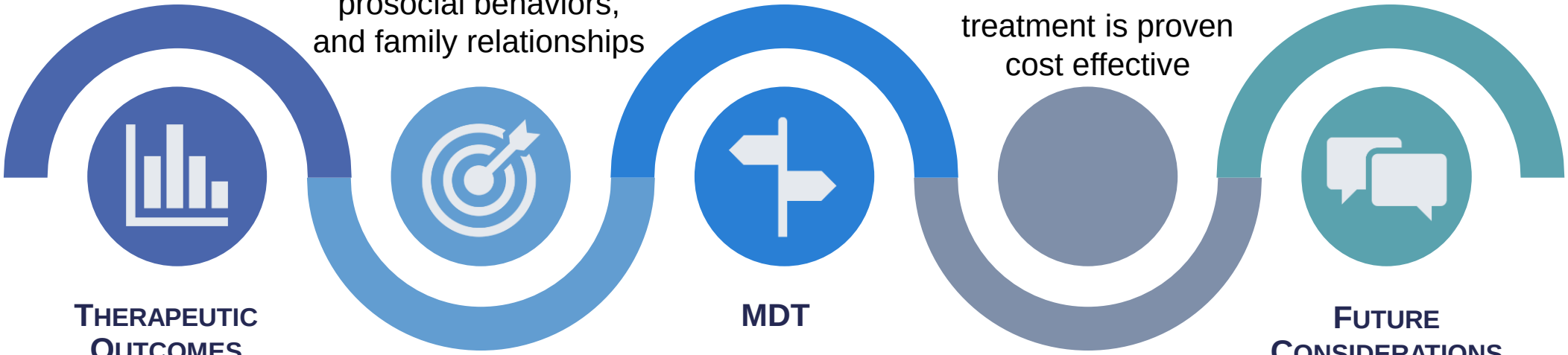
Diversion Program Outcomes

Relationships

Positive communication, increased support and prosocial behaviors, and family relationships

Economic Considerations

Decrease residential treatment costs. Short-term treatment is proven cost effective



Therapeutic Outcomes

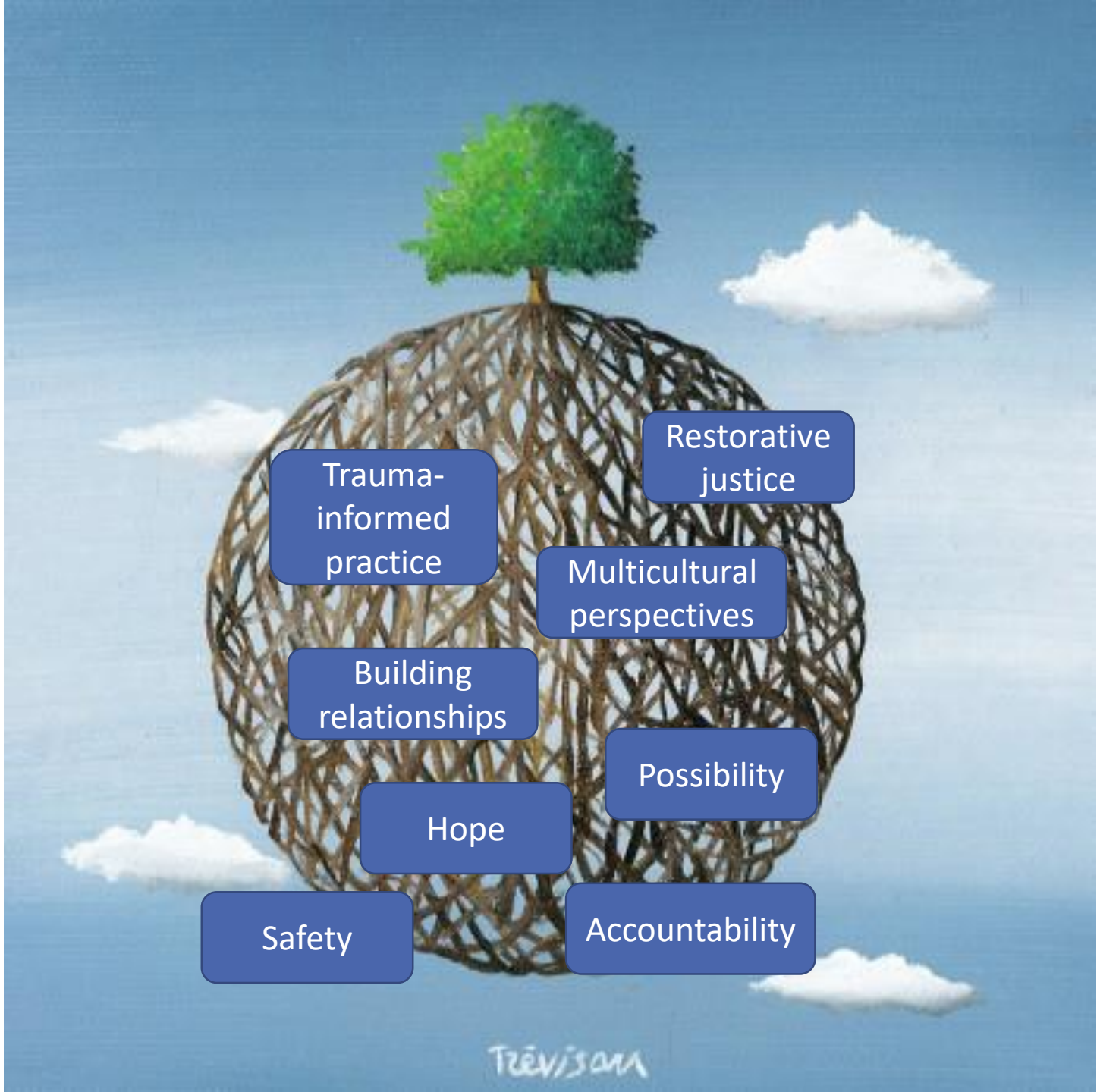
Increase confidence and resilience, reduce stigma, community involvement, and reduced isolation

MDT

Decrease burdens on law enforcement, criminal justice system, Child and Family Services.

Future Considerations

What does Missoula need? Future discussion could include how to support and respond to disclosure of childhood PSB long after PSB occurred; what else?


Restorative justice
Trauma-informed practice
Multicultural perspectives
Building relationships
Possibility
Hope
Safety
Accountability

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