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

PSB Diversion Program
MSOTA Presentation
May 30, 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
What are your already formulated theories and beliefs around children with problematic sexual behaviors, diversion community programs, etc.

What are the strengths and weaknesses?
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. (Chaffin et al., 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

Typical

Harmful

Concerning

Problematic
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.

Early theories emphasized sexual abuse as the prominent cause of problematic sexual behaviors.

- Children who have been sexually abused do engage in a higher frequency of behaviors than children who have not.

How do these behaviors develop?
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 recidivism 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
### Diversionary Program

<table>
<thead>
<tr>
<th>Trainings</th>
<th>• Trauma-Focused Cognitive Behavioral Therapy for Problematic Sexual Behaviors (TF-CBT-PSB; September 2018)</th>
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</thead>
</table>
| 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 |
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 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

if needed, release of information signed and PC communicate status to MDT

PC to contact clinicians to determine availability

If criteria met; referral to PSB mental health provider

Unmet criteria: rule out of pilot project

PC communicates to MDT reason
What do multidisciplinary team members 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 SHEET

**Pilot Program**

**Problematic Sexual Behavior**

**INTAKE SHEET**

<table>
<thead>
<tr>
<th>DATE:</th>
<th>TIME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGENCY CALLING:</td>
<td>AGENCY CALLING:</td>
</tr>
<tr>
<td>AGENCY RELATIONSHIP:</td>
<td>AGENCY RELATIONSHIP:</td>
</tr>
<tr>
<td>PHONE NUMBER:</td>
<td>PHONE NUMBER:</td>
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</table>

**NAME OF CHILD:** ____________________  **AGE:** _______

**DOB:** ____________________

**REFERRED BY:** ____________________

**SAFETY PLAN:**

- YES  - NO

**CAREGIVER INVOLVEMENT**

- YES  - NO

**Caregiver names:** ____________________

**Phone numbers:** ____________________

**HISTORY OF TRAUMA**

- YES  - NO

**NATURE OF REPORT** (check all that apply):

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

**TO ASSESS FOR PSB, MARK ALL THAT APPLY:**

**Frequency**

- High frequency
- Occurs between children of significantly divergent ages/developmental levels
- Does not fit a typical age-related pattern

**Developmental Considerations**

- Normal childhood activities
- Behaviors are longer in duration than developmentally expected
- Unresponsive (i.e., does not decrease in frequency)

**Harm**

- Intrusive behaviors
- Includes force, intimidation, and/or coercion
- Behavior interferes with social development
- Elicits fear & anxiety in other children

**ADDITIONAL NOTES:**

______________________________

______________________________

______________________________

Complete the following sections:

**CLIENT INITIATE:**

**DOB:**

**Age:**

**COMPLETED SCREENS AND ASSESSMENTS:**

- Child and Adolescent Trauma Screen (CATS - child self-report)
- Child and Adolescent Trauma Screen (CATS - caregiver report)
- Child Sexual Behavior Inventory (CSBI)
- Trauma Symptoms Checklist for Children (TSCC)
- Trauma Symptom Checklist for Young Children (TSCLC)
- Child Intake Assessment

**SYSTEM INVOLVED**

1. **YOUTH COURT:**
   - Name: ____________________  Phone: ____________________
   - YES  - NO

2. **CHILD & FAMILY SERVICES:**
   - Name: ____________________  Phone: ____________________
   - YES  - NO

3. **LAW ENFORCEMENT:**
   - County of City: ____________________  Name: ____________________
   - YES  - NO

4. **COUNTY ATTORNEY OFFICE:**
   - Name: ____________________  Phone: ____________________
   - YES  - NO

5. **MENTAL HEALTH AGENCIES:**
   - Names: ____________________
   - YES  - NO

6. **OTHER AGENCY INVOLVEMENT:**
   - Names: ____________________
   - YES  - NO

**CRITERIA (must meet all):**

- Age 14 or less
- Problematic sexual behavior
- History of trauma
- Caregiver involvement
- Developmental/intellectual delay
- Undiagnosed mental health issues or underdiagnosed diagnoses

**Referral made based on set criteria:**

- YES  - NO

- If yes, with what agency?

**Staff Signature:**

**Date:** ____________________  **Time:** ____________________

Child on:

If not, communicate reason to MOT: ____________________

______________________________

______________________________

______________________________
<table>
<thead>
<tr>
<th>Screen/Assessment</th>
<th>Description</th>
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<tbody>
<tr>
<td>$X_1$ = Referral to Treatment</td>
<td>$O_4$ = Trauma Symptom Checklist for Children</td>
</tr>
<tr>
<td>$X_2$ = Trauma-Focused Cognitive Behavioral Therapy for Problematic Sexual Behaviors (15-25 sessions)</td>
<td>$O_5$ = Trauma Symptoms Symptoms Checklist for Young Children</td>
</tr>
<tr>
<td>$O_1$ = Child and Adolescent Trauma Screen (Caregiver report)</td>
<td>$O_6$ = Caregiver intake</td>
</tr>
<tr>
<td>$O_2$ = Child and Adolescent Trauma Screen (child report)</td>
<td>$O_7$ = Child Intake</td>
</tr>
<tr>
<td>$O_3$ = Child Sexual Behavior Inventory</td>
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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: $X_1 \ O_2 \ O_4 \ O_6 \ O_7 \ X_2$
Diversion Program Outcomes

**THERAPEUTIC OUTCOMES**
Increase confidence and resilience, reduce stigma, community involvement, and reduced isolation

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

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

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

**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
Building relationships
Hope
Safety
Restorative justice
Multicultural perspectives
Possibility
Accountability
References