A Specialized Sexual Behaviour Team: Reduction of sexually inappropriate behaviours in children/youth with complex mental health and developmental difficulties

A Final Report Submitted to the Centre of Excellence in Children’s Mental Health, Children’s Hospital of Eastern Ontario EDG #1319

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## A. Executive Summary

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The current project evaluates the multidisciplinary assessment services of a specialized Sexual Behaviour Team (SBT) for children/youth who display problematic sexual behaviour (PSB). As a result of the SBT assessment, treatment recommendations are made to clients, families, and existing home community service providers who share responsibility for implementation. The ultimate goals are to identify, understand, and reduce such behaviour through education and safety planning.

### The Purpose

Goals of the current evaluation:
- To evaluate SBT by 1) describing the clinical population served; 2) measuring changes in SBT client functioning from assessment to follow-up; 3) assessing the implementation of SBT recommendations and treatment plans; 4) identifying areas for improvement in SBT service;
- To build capacity for ongoing program evaluation;
- To establish SBT as a model of service delivery since no similar programs currently exist.

### The Program (word count = 113; max 150)

CPRI is located in London, Ontario and operates as a tertiary mental health facility for children/youth with complex mental health and developmental needs. Enhanced program evaluation and outcome measurement are priorities at CPRI and treatment approaches include both inpatient and outpatient multidisciplinary services. In 2003, in the Southwest Region Children's Mental Health review, CPRI was given the mandate to provide assessment and treatment services to children/youth, ages 6 to 18 years of varying functioning levels who demonstrated concerning sexual behaviours. A collaborative treatment model was developed and a multidisciplinary team of experienced clinicians was created (SBT). In this model, SBT provides assessment, consultation and education, coordinating with the client’s home community to provide treatment.

### The Plan (word count = 150; max 150)

Participants were children/youth referred to SBT over a five year period with consent to share their information externally for research purposes, N=81 (68 males); M age =13.00, SD = 2.66; range = 6 to 18 years. SBT clients included individuals whose problematic sexual behaviour was present in the past six months and were not currently involved in a legal investigation due to related sexual behaviour. A pre-post-service design was used. “Pre-service” referred to all information collected during the SBT assessment. “Post-service” referred to a follow-up time point 6 months after the date of a feedback meeting when the assessment results and treatment plan were communicated. New measures were created for this evaluation including a Clinician Interview Tool (CIT), Problematic Sexual Activities Checklist, and Treatment Progress Evaluation Tool. Standardized measures included the Child Behaviour Checklist (CBCL) and the
Behavioral and Emotional Rating Scale - Parent (BERS-2). A mixed-method approach was used.

**The Product** (word count = 237; max 250)

The pre-service data describe SBT clients as having high incidence of past maltreatment (abuse, neglect, witness to violence), a variety of clinically significant emotional and behavioural issues (CBCL), and low overall emotional and behavioural strengths (BERS-2 Parent). Sexual contact offenses were committed by 60% of clients (N=49). Other common PSB included crude sexualized language/gesturing (60% clients) and highly indiscriminate/risky sexual activity (60% clients).

Post-service CIT data provide support for the effectiveness of the SBT assessment and treatment recommendations, with the majority of clients (66%) displaying no further problematic sexual behaviours in the 6 months after SBT service. As well, contact offences were shown to decline noticeably at post-service, with 73% of clients no longer committing this type of offence toward another person.

The reduction of tangential symptoms (anxiety, aggression, etc.) and increase in positive strengths and functioning were more difficult to show with the current dataset due to a low N size at follow-up. Next steps include continuing with the program evaluation to increase the amount of parent-report data at 6 months post service to assess service effects.

Knowledge exchange to date includes four conference posters/presentations, presentations to community of practice members, students, and CPRI clinical staff. In addition, brochures for potential clients, parents, and community agents have been created to promote SBT as an evidence-informed service. Future plans include submission of the program evaluation for publication in a peer-reviewed journal.

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C. Introduction

The Child and Parent Resource Institute (CPRI) is a tertiary mental health facility in London, Ontario, Canada, that specializes in providing residential and outpatient services to children and youth that have been clinically referred. As a regional provider of highly specialized treatment services, CPRI is committed to developing effective and efficient evidence-informed treatment protocols. In 2003, in the Southwest Region Children’s Mental Health review, CPRI was given the mandate to provide services to children/youth, ages 6-18 years of varying functioning levels who demonstrated concerning sexual behaviour. The Sexual Behaviour Team (SBT) was thereby created, comprised of experienced clinicians specializing in social work, psychiatry, psychology, behavioural consultation nursing, and play and art therapy. After an extensive literature review was conducted to determine best-practice guidelines, no empirically-validated assessment or treatment protocols that closely fit the scope or mandate of the SBT were found. Compared to most programs, the SBT provides service to a wider range of clients in terms of age and complexity of mental health and developmental issues.

Evidence-Informed Approach and Training

The SBT clinicians underwent extensive training to ensure that a “state of the art” evidence supported assessment and intervention program was developed. Training was provided by various experts, including Dr. Jim Worling, an internationally acclaimed expert in the field, specializing in adolescents who sexually offend, and Geri Crisci, a well known clinician who works with children under 12 years of age with PSB. Site visits to the SAFE-T program at Thistletown Children’s Centre, the Griffin Centre in North York, and Windsor Regional Children’s Centre were also conducted.

The SBT is a collaborative treatment model developed to provide assessment, consultation, and education to the client, family, and home community service providers. Operating on the premise that specialized treatment addressing client, family, and community factors has been found to reduce inappropriate sexual behaviour in children/youth (e.g.,
Henggeler et al., 2009; Worling et al, 2010), the SBT makes individualized treatment recommendations after a comprehensive assessment has been completed. The SBT has been providing services since 2006 and is now conducting a program evaluation. Evaluation results have implications for prevention, assessment, treatment, and safety of children/youth at various levels of service. Most directly, the findings of this project will be used to improve SBT services. Further, as no similar programs currently exist, publication and presentation of SBT evaluation results can provide a provincial or national model of service delivery.

**SBT Service Components**

Primary components of the program include an intake procedure where clients’ appropriateness for assessment services is determined, and immediate safety concerns are addressed. Second, a thorough assessment is conducted by gathering information from clients, guardians, teachers, and involved community service providers. Third, the multidisciplinary team meets to create a clinical formulation as to the many factors that contribute to the problem behaviour and to determine the most appropriate recommendations. Fourth, a feedback meeting is arranged to deliver the comprehensive assessment and treatment recommendations to clients, guardians, and community service agents. Finally, a 6-months post-service follow-up meeting is held between clinicians, clients, guardians, and community service agents to evaluate clients’ progress, outcomes, and any barriers to implementing the recommendations (see Appendix A for a detailed program logic model).

**Purpose of Evaluation**

On average, 23 clients per year are served by SBT. While data collection has been a prominent component of SBT thus far, no prior evaluation of the program currently exists at CPRI. Intended target audiences for this program evaluation include clinicians, parents/guardians or other family members of children/youth with PSB, community service providers, community of practice members, and other mental health professionals.
The SBT assessment includes child and parent/guardian interviews, psychometric and psychiatric evaluation, sexuality awareness assessment, and trauma assessment. Treatment recommendations are made as a result of the SBT assessment; the clients, families, and existing home community service providers share responsibility for implementing these recommendations. The primary goals of the SBT are to: 1) identify the concerning behaviour as it deviates from typically developing sexual behaviour; 2) understand the behaviour and the many factors that contribute to the occurrence of the behaviour; 3) develop a safety plan to prevent the behaviour from re-occurring; 4) understand ways to manage and correct the behaviour; 5) identify strategies and environmental influences that will reduce the risk of the behaviour—such as implementing sexual behaviour rules and encouraging privacy and appropriate boundaries in the home; 6) identify areas of strength and protective factors in the client and family that will enhance the client's appropriate functioning and reduce the risk of continued sexual behaviour problems; 7) provide education about healthy sexual development to help the client return to a typical developmental path in their sexual development; and 8) identify the need for offence specific treatment tailored to the client’s unique strengths and risk factors.

The purpose of the current evaluation is to: 1) describe the clinical population served by SBT; 2) measure changes in SBT client functioning from assessment to follow-up; 3) assess the implementation of SBT recommendations and treatment plan; and 4) identify areas for improvement in SBT service. The secondary goals of this evaluation are to build capacity for ongoing program evaluation and to establish SBT as a model of service delivery.

**Collaboration and Stakeholders.**

The key stakeholders in this project include SBT clients and families, the SBT clinicians (i.e., direct care service providers), community service providers, and policy analysts. SBT clients and their families play a role by completing satisfaction questionnaires and participating in follow-up interviews. Clinicians, who have been involved in the planning of this project, and
who will receive project results on an on-going basis, will be asked to participate in a focus
group to identify strengths/weaknesses in service delivery and facilitating factors and barriers to
treatment recommendation implementation.

The SBT staff members have been involved in planning this evaluation and all new
measures developed for it. For example, a key question is whether treatment recommendations
made by the SBT have been implemented. Staff participated in the development of a Treatment
Plan Checklist (i.e., a standardized list of treatment recommendations) and Treatment Progress
Evaluation Tool, which is used to assess the extent to which recommendations are
implemented.

Process Outcome Evaluation Questions

Given that no similar programs currently exist, SBT may provide a provincial or national
model of service delivery and evaluation of treatment implementation. Specific outcome
questions pertaining to the evaluation include the following: 1) does involvement with SBT
reduce the risk of future or actual problematic sexual behaviour and increase protective factors;
2) does involvement with SBT reduce tangential symptomatology; 3) does SBT involvement
improve client functioning; and 4) does SBT involvement improve parent-child and family
relationships?

Summary of Research Literature

Problematic Sexual Behaviour (PSB) and exploitation of children/youth hold significant
emotional, personal, social, and financial costs (Moore, Talley, Franey, Crumpton & Geffner,
2005). Individually, victims of sexual perpetration display a range of symptoms such as guilt,
self-blame, social withdrawal, depression, family problems, low self-esteem, somatic
complaints, irrational fears, and difficulties with sexuality (Cahill, Llewelyn & Pearson, 1991;
Trocmé, et al., 2010). Further, victims report experiences with long-term consequences such as
anxiety, depression, suicidal ideation, difficulties in relationships, self-harm, prostitution, eating
disorders, sexual dysfunction, and even psychopathy (Trocmé, et al., 2010; Daversa & Knight, 2007; Palmer, Chaloner & Oppenheimer, 1992).

   Socially, PSB has been linked to concerns in adolescence such as conduct disorder, risky sexual behaviour, risk of contracting sexually transmitted infections, and unplanned pregnancy (Verweij, Zeitsch, Bailey & Martin, 2009). Additionally, children/youth with PSB are at higher risk to victimize other children/youth (Dirks, Treat & Weersing, 2010) since they are in close proximity on a consistent basis. For example, sexual offences committed between juveniles are more likely to occur at schools or in groups compared to offences that occur between adults and juveniles in these settings (Finkelhor, Ormrod, & Chaffin, 2009). In 2009, the National Center for Juvenile Justice reported that juveniles account for more than one third (35.6%) of those known to police to have committed sex offences against children under the age of twelve. Of those youth who are known to have sexually offended, 16% are younger than age 12. Further, juvenile offenders are more likely to victimize young children (i.e., under 12 years) than adult sex offenders (Finkelhor, Ormrod, & Chaffin, 2009).

   In Canada, children between the ages of 4-7 years have consistently represented the highest number of child maltreatment investigations since 1998 (Trocmé, et al., 2010), and in 2005 it was estimated that children/youth were five times more likely to experience sexual assault than adults (Canadian Centre for Justice Statistics, 2007). Financially, the costs of victimization are exponential. Overall, child abuse costs exceed 15 billion dollars in Canada per year (Little Warriors, 2010). Of this annual total, personal, social services, and health costs aggregate to 2.3 billion, 1.1 billion, and 2.2 million dollars respectively. While these numbers include all forms of child abuse, it is important to consider that child sexual abuse is not a mutually exclusive experience of other forms of abuse; there is a great degree of overlapping risk factors between children who experience alternate forms of maltreatment beyond sexual victimization (Daversa & Knight, 2007; O’Brien, 2010).
As suggested by the Association for the Treatment of Sexual Abusers (ATSA; 2001), best-practice guidelines for addressing the potential for sexual offending should include risk assessment; especially with respect to recidivism. While numerous efforts have been made to create assessment measures applicable to adult sex offenders (e.g., Hanson & Thornton, 1999, Hanson, 1997, Harris, Rice, & Cormier, 1998, Epperson, Kaul, & Hesselton, 1998, Hanson & Harris, 2000), fewer tools or protocols have been designed to address the risk of child/youth sexual offences [e.g., the Juvenile Sex Offender Assessment Protocol II (J-SOAP-II; Prentky & Righthand, 2003); the Estimate of Risk of Adolescent Sexual Offence Recidivism (ERASOR; Worling, 2004)]. Furthermore, investigations pertaining to the psychometric properties of adult assessment measures far outweigh those for child/youth assessment measures (Worling, 2004).

Prentky and Righthand (2001) designed the J-SOAP to code archival data. However, given the historical nature of its mostly static items, Worling and Curwen (2000) developed the ERASOR as they believed that the J-SOAP may not be sensitive to offence-specific treatment changes. The ERASOR is a risk-assessment tool that is used in clinical assessments and was designed to account for dynamic variables within specialized treatment for youth between the ages of 12-18 years. However, the ERASOR is only appropriate for use with adolescents who have committed chargeable offences, and as a result, has limited utility with clients of SBT.

Oneal, Burns, Kahn, Rich, and Worling (2008) published their initial psychometric efforts more recently for adolescents who sexually offend. A better understanding of children/youth’s needs prior to treatment was thought to enable service providers in delivering more effective treatment. Oneal et al. developed an inventory targeting treatment planning and progress. Nine dimensions were isolated as appropriate behavioural measures: inappropriate sexual behaviour; healthy sexuality; social competency; cognitions supportive of sexual abuse; attitudes supportive of sexual abuse; victim awareness; affective/behavioural regulation; risk prevention awareness; and positive family caregiver dynamics. From such dimensions, areas indicating the
most urgency could be treated in priority sequence. These tools are important since they indicate the necessity for further investigation on unique assessment/treatment approaches and the need for a greater understanding regarding how clients may present differently according to personal contexts. As noted by Finkelhor et al. (2009) there is a great variety of sexual behaviours that bring youth into clinical settings, and there is significant diversity in the motivations for such behaviours, including sexual curiosity, impulse control problems and compulsions reflecting poor judgement, as well as long standing patterns of violating the rights of others. Additionally, understanding interventions for PSB in children/youth and its positive impact on their behaviour may help to avoid future needs for more intrusive and costly treatments (Daversa & Knight, 2007; Rasmussen, 2005).

D. Methodology

Participants

Participants included 81 children/youth referred to the Sexual Behaviour Team (SBT) at the Child and Parent Resource Institute (CPRI) over a 5 year period, with parent/guardian consent to share their information externally for research purposes (84% male; M age =13.00, SD = 2.66; range = 6 to 18 years). The SBT offers service to those children/youth whose PSB is a current concern, but excludes any individual who is presently involved in a legal investigation due to related sexual behaviour. In addition, the SBT service does not assess or investigate any allegations of sexual abuse, nor assess children/youth who have been victims of abuse if they do not demonstrate problematic sexual behaviour. In our sample, 28% of clients were considered developmentally disabled. Contact offences (i.e., sexual activity with an unwilling partner or child at least 3 years younger), was a problematic behaviour for 60% of the SBT clients (N=49). All contact PSB were included in this rate, even those not violent in nature or at the age level (12 years +) or severity of to be a chargeable offence. Other common PSB at referral included crude sexualized language or gesturing (60% of clients), and highly indiscriminate/ risky sexual activity (60% of clients). Questionable internet activity (i.e.,
sexualized texting, excessive viewing/distributing of pornography) was common to 40% of clients. Less frequently noted PSB included voyeurism and acting upon self in a sexual way excessively or harmfully.

The clients served by SBT are extremely complex, with the majority having suffered prior maltreatment: 64% had experienced neglect and/or emotional abuse, 59% had exposure to domestic violence, 48% had experienced physical abuse, and also 48% had been victims of sexual abuse. In fact, only 13% of the clients had not experienced any of the maltreatment types and 22.5% had experienced only one type of maltreatment. Experience with multiple forms of maltreatment was more common for these children/youth in that 25% had experienced two types, 17% had experienced three types, and 22.5% had experienced all four maltreatment types (see Figure 1). This data may be an underestimate of the true abuse rates due to underreporting.

Design

A pre-service/post-service design was used. “Pre-service” refers to all information collected during the SBT assessment. “Post-service” refers to follow-up 6 months after the date of the feedback meeting when the assessment results and treatment plan were presented (see Appendix B for Outcome Evaluation Matrix). Descriptions of all measures are provided below in the section “Sources for Information and Data Collection”. A mixed-method approach was used. Although the study design and analyses are primarily quantitative in nature, qualitative data were also included to examine areas for quality improvement.

Procedure
**Intake.** Children/youth referred to SBT are screened at intake for appropriateness, then sent an Acceptance for Assessment letter and a pre-service package of measures for the parent/guardian to complete (see list below) if the client met the criteria for clinic involvement. When the pre-service packages are returned, the questionnaires are scored, data is entered into SPSS 19.0, and measures are then sent to the assigned clinicians. Next, a “Meet & Greet” is held with the client and parents/guardian to obtain informed consents/assent to service and to research. During this time the Clinician Interview Tool (CIT) is completed. Immediate safety concerns are also addressed during this initial “Meet & Greet”.

**Assessment.** Individual interviews are conducted by the various clinicians on the SBT. The child or youth typically participates in approximately 3 to 5 interviews in which they are asked general questions about family, friends, recreation, and school, as well as specific questions regarding the PSB. Parents/guardians are interviewed on 2 or 3 occasions to provide information about early developmental history, as well as attitudes, opinions, and concerns related to the PSB. Children/youth also participate in a psychological evaluation and an assessment related to their sexual knowledge. Depending on the presenting issues, the child/youth may also participate in a psychiatric and/or trauma assessment.

**Formulation.** All of the information gathered from the various measures and interviews is brought together at the formulation meeting. During this meeting the team considers the nature, severity, chronicity, and malleability of the PSB. In addition, the team determines the potential for continued PSB, considers the tangential symptoms that could be contributing to difficulties with social functioning, and assesses the client's individual strengths and interests. From this clinical information, the team prepares the Treatment Plan (a standardized list of SBT treatment recommendations from which SBT team members select appropriate recommendations based on client needs). Then a Coordinated Treatment Plan is completed to consolidate these findings and assign responsibility for implementing the recommendations.
**Feedback Meeting.** The Feedback Meeting is arranged for the SBT to meet with the client, family, and community agency staff, to discuss the comprehensive assessment results and complete the Coordinated Treatment Plan with discussions of how responsibility for implementing recommendations will be shared. This meeting is also an opportunity to establish the date of the 6-month follow-up meeting.

**6-Month Follow-up Meeting.** Six months following the assessment and the feedback meeting, an SBT clinician meets with clients, parents, and community service providers to review the clients’ progress (i.e. reduction, increase or persistence of PSB) and implementation of the SBT recommendations (i.e. whether they were met or there were barriers). Three weeks prior to the 6-month follow-up meeting the parents/guardian are sent a post-service questionnaire package (see list below). At the follow-up meeting, the Treatment Progress Evaluation Tool is completed to determine if recommendations were met and identify any obstacles, and satisfaction questionnaires were also completed by the client (with help if necessary by the intake coordinator who conducted the Meet & Greet, but was not directly involved in the assessment process), the parent, and agency. In addition, the CIT was completed again at this time.

**Focus Groups.** Two focus groups were conducted: one with SBT clinicians, and the other with home community service providers and community of practice members. The purpose of these focus groups was to better understand SBT service, in terms of barriers and facilitators of the SBT treatment plan and the overall perceived utility of the SBT model. Feedback was also requested regarding areas for improvement, and factors that contribute to success. The information obtained from these focus groups provided qualitative data as a means of establishing a framework for evaluation findings.

*Sources of Information and Data Collection*
A variety of parent/guardian report measures were used. The following are brief descriptions of these instruments (see Appendix C for copies of measures). Measures used at pre-service:

*Family History Questionnaire (FHQ).* The FHQ was developed by CPRI clinicians and is completed by the parent or guardian to provide information on the child/youth and family members’ physical and mental health history.

*Checklist of Significant Life Events (CSLE).* The CSLE was also created at CPRI and is completed by the parent or guardian to gather information on life events that could be stressful or have a major impact (positive or negative) on the child/youth (e.g., trauma, abuse, adoption).

Measures used at both pre and post service:

*Child Sexual Behavior Inventory (CSBI).* The CSBI is a parent-report measure, targeting sexual behaviours in children 2-12 years of age. Overall this tool is aimed at addressing 9 domains: 1) boundary problems, 2) exhibitionism, 3) gender role behaviour, 4) self-stimulation, 5) sexual anxiety, 6) sexual interest, 7) sexual intrusiveness, 8) sexual knowledge, and 9) voyeuristic behaviour. Internal consistency scores reflect strong retest and interrater reliability. The CSBI manual reports research into convergent, discriminant, and construct validity (Friedrich, 1997).

*Adolescent Clinical Sexual Behavior Inventory-Parent (ACSB).* The ACSBI is a parent/caregiver measure assessing a wide range of sexual behaviours in adolescents ages 13+ (Friedrich, Lysne, Sim, & Shamos, 2004). As this measure has not been validated the results are used qualitatively. It is designed as a screening device to highlight high-risk sexual behaviours. SBT uses this screening tool with permission for children 13 years of age and older, since validation studies of the ACSBI have not been completed.

*Behavioral and Emotional Rating Scale - Parent (BERS-2).* The BERS-2 is a “strength-based assessment”, parent/caregiver report addressing both behavioural and emotional
strengths of the child/youth. Its five core subscales (interpersonal strength, family involvement, intrapersonal strength, school functioning, affective strength) are rated on a 4-point Likert scale. High content, time and interrater reliabilities were reported for all 3 components. The manual reports numerous studies into the content, criterion, and construct validity of the measure (Epstein, 2004).

Child Behaviour Checklist (CBCL). The CBCL is completed by parents/caregivers and is widely used for the assessment of children/youth’s behavioral and emotional problems (Achenbach, 1992). The CBCL yields Internalizing and Externalizing scale scores, as well as a total score. Parents/caregivers are asked to respond to each item as “not true”, “sometimes true”, or “very true”, as it pertains to the child/youth during the past two months. The CBCL is reported to have good psychometric properties and has been identified as the “Gold Standard” in the assessment of children/youth with behaviour and socio-emotional problems (Achenbach & Rescorla, 2001).

Parent-Child Relationship Inventory (PCRI). The PCRI is a parent self-report inventory that measures parenting skill, attitudes, and relationship with the child/youth. Designed for use with parents of 3- to 15-year-old children/youth, the PCRI gives a clear, quantified description of the parent-child relationship as well as identifying specific areas in which problems may occur. The PCRI has been shown to exhibit strong internal consistency (0.70-0.82) and test-retest reliability (0.81) (Gerard, 1994).

Clinician Interview Tool (CIT). The CIT was developed at CPRI. It covers a range of areas related to the child/youth’s current social functioning, general behaviour/mood, and PSB. SBT clinicians use this tool to a) define sexually abusive behaviour in youth, b) identify tangential issues, c) guide treatment planning, and d) evaluate youth over time.

Evaluation Limitations

The SBT clinic encountered a significant obstacle that was completely unanticipated at the start of this program evaluation. The main outcome measure outlined in our proposal was to
be the Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing Sexually Abusive Children and Adolescents (MEGA). At the time of our submission, SBT was currently involved in a cross validation study for the MEGA. We had collected pre and post data for 57 clients using the MEGA, and had obtained research consent for 41 of the clients. Prior to submission of our grant proposal we had received permission from the author to use this data in our program evaluation. Shortly after receiving CoE funds and beginning the evaluation, the author completed data collection for the cross-validation study, and revoked this permission with instructions to cease and desist in collecting data using the MEGA and omit all subscales from our databases until formal publication. The author’s intention then became known that after publication scoring with a revised factor structure would be available for a fee per individual MEGA. We tried unsuccessfully to reach a compromise with the author to enable our MEGA data collection to continue until the end of the program evaluation, at minimum using only the raw items to guide clinician interviews. Our request was denied. To fill the gap left in our evaluation protocol, we created our own separate and distinct Clinician Interview Tool in order for clinicians to have a standard guide in collecting information for assessments and obtaining follow-up information. Although we are still able to use the raw data previously collected through clinician interview that was guided by use of the MEGA, we are unable to report on pre-post changes we projected using the MEGA subscales of Risk, Protective factors, Estrangement, and Persistent factors. By the end of the grant year the MEGA was still unpublished and thus the revised factor structure remained inaccessible. A substantial problem with losing access to the MEGA, of course, is that it has created inconsistencies in the data, so that not all clients have the same measure at all time points.

A second limitation of this study is that our pre-service and post-service data may be an underestimate of true rates of problematic sexual behaviour, contact offences, and abuse histories due to under-reporting of these extremely sensitive issues, as it was based on the limited sources of self- and family disclosure.
As anticipated in our original proposal, a third limitation involving data collection was that the standard measures collected prior to beginning this formal program evaluation are not consistent across all clients. However, it should be noted that this program evaluation will continue for 2-3 years past the funding period of this grant to increase sample sizes. In accordance with the Ministry of Children and Youth Services policy on privacy, and the CPRI administration’s own rules regarding low N sizes, we are only able to present percentages of respondents when dealing with samples of less than 25 participants.

E. Results

Recidivism. There were 67 clients who had reached the 6-month follow-up time point by the end of the grant period. The CIT conducted at 6 months post assessment and through casebook review for past clients was used to determine whether PSB were still occurring by the follow-up time point. Overall, the SBT services appeared to reduce PSB, with 66% of clients (N=44) showing no further or new PSB in the 6 months following the assessment, $\chi^2 = 6.58; p=0.01$ (see Figure 2). Recidivism for contact offences was also found to decrease by the 6-month follow up. Specifically, 73% of the clients presenting with contact PSB at referral did not repeat contact offences 6 months after receiving SBT services, $\chi^2 = 5.72; p=0.02$ (N = 30, out of 41 clients with one or more contact offences prior to the assessment; see Figure 3). There was no significant difference found using chi square tests between those clients with developmental disabilities and those with only mental health issues in terms of new or persistent PSB or recidivism of contact PSB 6 months after the assessment.

As indicated in the Outcome Evaluation Matrix (Appendix B), the CSBI and ACSBI were also intended to provide post assessment data on reduction of PSB. However, to date the number of participants with both pre and post data on these measures is too small to provide meaningful information. The evaluation of this clinic will continue past the granting period to obtain sufficient N’s in all relevant measures. An additional consequence of the low number of clients reaching the follow-up time point was that we were unable to evaluate the
implementation of SBT recommendations and treatment plan with the Treatment Progress Evaluation Tool developed at the start of the grant period, which was our third goal of this evaluation. The Treatment Progress Evaluation tool is continuing to be used by clinicians at the 6-month follow-up meeting to determine if treatment recommendations are met and record any barriers encountered. This valuable information will continue to be collected for inclusion in future knowledge dissemination.

**Tangential Symptoms.** Prior to the present year of program evaluation, the collection of standardized data for assessment purposes was variable across clients. We do have sufficient information to date to reliably describe this clinical population at referral, the first goal of our program evaluation. One-sample t-tests were conducted on pre-assessment CBCL subscales measuring social, emotional, and behavioural issues, using a test value of 65 (T-score value serving as a cut-off between normal and clinical impairment). SBT clients scored extremely high in many of the problematic areas, as shown in Table 1. When examining the strengths of these children and youth using the BERS-2 (Parent Report), we found that the mean score for SBT clients fell two standard deviations below this measure’s normed average (Test Value: Average M = 100, SD = 15): SBT clients’ BERS-2 Strength Index Scaled Score M = 70.50, SD = 17.34, t = -9.92, p < 0.001. When the grant period began one year ago, the standardized measures (CBCL, PCRI, BERS and ACSBI/CSBI) were added to 6-month post data collection. Twelve clients reached the post time point during this year; unfortunately the return rate for the post parent questionnaire package was 50%, with only 6 clients providing this data 6 months after SBT involvement was complete. We look forward to increasing our N to be able to test whether the tangential symptoms listed in Table 1 (CBCL) were alleviated and whether clients’ strengths (BERS-2) increased following SBT service.

Using clinician interview data, a mild improvement was found in the clients’ relationships following SBT service. Of the children/youth who were rated as having conflict in their relationship with parents before service on the CIT, 32% were rated as having an improved
parent/child relationship 6 months following SBT service, $X^2 = 4.82$, $p = 0.03$. In addition, a pattern emerged suggesting that clients who were rated as having poor peer relationships at assessment, approximately half developed positive relationships by the 6-month follow-up.

**Stakeholder Involvement.** Stakeholders were also involved in both in the process of this program evaluation as well as in knowledge dissemination. To identify areas for improvement in SBT service (our fourth goal), two focus groups were conducted in order to hear from the SBT team members themselves and the service providers in the community who have had experience with SBT. The first focus group comprised of SBT clinicians revealed a cohesive team that is supportive of each other, with respect for each team member’s strengths and contributions to the assessment process. The team acknowledged that their most important strength is communication between each of the members in order to produce the comprehensive assessments. The main obstacle during the assessment process identified by the team is scheduling appointments. Two main reasons for this were recognized: 1) it is difficult for clients and families to arrange transportation when they live a far distance away (CPRI has a large 17 county catchment area, with occasional clients outside the area), and 2) when the family members are uncomfortable talking about the sexual behaviours and issues they may cancel or fail to show up for appointments. To overcome these obstacles the team will travel to meet the clients in their home community, and also work to make the family understand that their involvement in the process is essential for their child to get the help they need. The team also prioritizes building a trusting relationship with the client and their family, which all agree takes time. After the assessment is complete, the feedback process can be lengthy as well. The team generally creates separate reports for the involved adults (biological parents, CAS, foster parents, group home, school) in order to respect the client and family’s privacy and give each person only the information and recommendations required to meet the best interests of the client and the family while balancing safety.
SBT’s services have evolved since the clinic began in 2007. Specifically, the clinicians are conducting more follow-up to assist the family and community agents to gain access to resources in order to implement the recommendations. As one team member noted, “I found at the beginning, I didn't feel good about just giving the recommendations and saying goodbye to the family. I think the fact that we're doing some follow up is good, you know, we try to reinforce to the family the importance of the recommendations and how that impacts the child or youth's future and their progress.” Indeed, in general, the team has found that they are following the youth and family longer and having continued contact with parents and community agencies. Team members identified the lack of resources as the main reason for the lack of follow-through on recommendations. The team sited that best possible outcomes occur when a) the client feels heard, b) there is a community service provider who understands and is an advocate, and c) when the family is invested. A consensus from the team members was that in the future, with more training and resources, they would like to see SBT offer treatment services in order to bridge the transition between SBT assessment and community services more effectively.

A second focus group was conducted with community service providers who have had experience with SBT’s services. Overall, the feedback was positive. The community agents expressed appreciation for having SBT at the table early in the process to help parents understand that an initial safety plan is needed and what that involves. Positive comments were also made about SBT’s website as a helpful source of information that is used in the interim while waiting for services, and during the information gathering time period. As well, the community service providers felt appropriately involved during the information gathering process for the assessment, and reported that they were able to also ask questions of the SBT clinicians during that time. A suggestion put forth was to always have the biological parents involved in the assessment process for those clients who are adopted or crown wards and either in foster care or group homes. It was suggested that it would be most beneficial in order to collect as much history as possible on these children/youth. “Digging deeper” and “reaching out” to this rich
information source was seen as, on occasion, missed when the biological parents were not currently involved in the child/youth’s life.

SBT received praise from the community service providers for the clear and tailored reports they provide to each of the involved adults. As one respondent said of the reports, “I find myself going back to them again and again and reviewing them and looking at what are the recommendations, so it’s useful at the time when you complete the assessment, but then it’s useful for a considerable time period afterwards as well.” A suggestion for the future was to provide more information on when the safety plan can be relaxed; that is, to identify the signs indicating that the PSB are no longer a significant concern. Providing the community with a progress evaluation tool or criteria that could be used after SBT’s involvement is finished would be beneficial. The members of the focus group also expressed appreciation for the connection SBT provides after the assessment is complete, in providing support to find the resources recommended in their report. An additional request was for SBT clinicians to provide in-service training for community service providers about risk assessment and safety planning, to promote a common language and provide some guidelines for first response when the community agents encounter youth with PSB.

Knowledge Exchange. Several knowledge exchange activities have taken place throughout the grant year, and further dissemination is planned. Information about the clinic with preliminary results were presented at four provincial, national, and international conferences during this year at forums in Toronto, Ontario and Barcelona, Spain, see Table 2. The conference posters and presentations were well received and met with interest from researchers and service providers alike. In addition, the clinic lead, Ms. Marshman, promoted SBT at a Community of Practice meeting in June 2011 in London Ontario, a meeting of clinicians in the South West Region of Ontario serving children and youth with sexual behaviour problems. Ms. Marshman also gave a presentation entitled, “Sexual Behaviour Issues in Youth with Developmental Disabilities” in April 2011 to teachers in the Bluewater School Board District
and again in June 2011 to a group of students in the Developmental Service Worker Program at Fanshawe College. An additional presentation was given at our own Clinical Services Meeting at CPRI in August to share information with fellow clinical staff.

In addition to community service providers, other SBT stakeholders include parents/guardians and clients. The CoE knowledge exchange funds have allowed us to promote SBT as an evidence-informed service by commissioning three brochures that are separately geared toward parents/guardians, potential clients (children/youth), and community agents. Each of the brochures are individually tailored with language suitable for each of the three target audiences and cover information on SBT as an assessment service, outline what to expect if involved with the clinic, and give some information on the success rate of the assessment and intervention services on PSB recidivism. Along the same lines, an informational poster was created that will be displayed when team members give presentations to students, educators, community of practice meetings, and other groups in the future.

Finally, two manuscripts are currently in progress. The first describes SBT’s program and evaluation for dissemination to the scientific community. The target journal for publication is the Canadian Journal of Program Evaluation. A secondary manuscript is also underway to further describe this unique tertiary population by comparing mental health characteristics and PSB of dually diagnosed (DD) and non-DD SBT clients. Potential target journals for the secondary manuscript include the Journal of Adolescence, the International Journal of Sexuality and Gender Studies, or Culture, Health and Sexuality: An International Journal for Research, Intervention and Care.

F. Conclusion and Recommendations / Next Steps

Discussion and Interpretation of Findings

The results of this evaluation indicate that children/youth with PSB present with complex issues and that assessment, education and safety planning services are effective in reducing PSB. Our data show that SBT clients have histories of multiple maltreatment types, and present
with a range of clinically significant mental health concerns in addition to the inappropriate sexual behaviours that led to their referral. Only 13% of all the children/youth in this sample had no history of maltreatment, while 64.5% had experienced multiple forms. The CBCL scores presented in Table 1 demonstrate the social, emotional and behavioural challenges faced by these children/youth. The clients’ scores in this sample fell in the clinical range on the CBCL in areas such as social problems, thought problems, rule breaking, aggression and externalizing problems. These children/youth also scored lower on the BERS-2 Strength Index when compared to a general population. This data indicates that SBT clients have greater social, emotional and behavioural problems than most children/youth and less areas of strength to balance their challenges. Given the complexity of abuse history and clinical behaviours of children with PSBs, an assessment team must be capable of recognizing these secondary issues and making appropriate referrals. These numbers further highlight the need for individualized treatment plans. Through comprehensive assessment, the SBT clinicians bring to light the many factors contributing to the complex mental health issues and the causes of the maladaptive behaviours. With this new and comprehensive awareness, a safety plan, and specific intervention and treatment strategies, the child/youth and their families receive identified interventions to reduce such troubling behaviours.. The key finding that there was a reduction in PSB and sexual contact offences for the majority of the clients in the 6 months following the assessment provides evidence for the effectiveness of SBT’s services.

A review of the literature produced no research assessing recidivism rates in a population comparable to those children and youth seen by the SBT. Most published studies on sexual PSB recidivism rates for youth utilize data purely on future arrests/ juvenile justice system involvement, dealing mainly with adolescents who have committed a chargeable sexual offence. (see review by ATSA Task Force, Chaffin et al. 2008). Thus, very little is known about recidivism rates for younger children/youth who sexually offend, and even less is known about treatment effects on the reduction of other types of PSB that interfere with the child/youth’s
functioning (i.e. sexualized language and gesturing, public exposure, engaging in risky sexual behaviour, excessive use of pornography).

In the extant literature, one of the highest recidivism estimates for young sex offenders comes from a recent report by Hagan and colleagues (2010), which indicated that 42% of violent juvenile sex offenders went on to re-offend. The adolescent population in the report were all involved in the criminal justice system and had been incarcerated for PSB that had escalated to the level of a chargeable offence. Treatment had been initiated for all of the young inmates, but none of the re-offenders had completed treatment. Worling et al. (2010) also conducted a study of adolescents who had been charged with a sexual offence, a 20 year prospective follow up. Results showed that only 9% of those adolescents who participated in at least 10 months of specialized treatment were charged with a new sexual offence during the follow up period. A comparison group of adolescents who did not receive specialized treatment were shown to have a recidivism rate of 21% for chargeable offences. This finding highlights the need for a full assessment prior to treatment recommendations in order to target the underlying causes of the PSB, rather that generically treating the symptom.

Our program is unique, and perhaps more inclusive, because it addresses a wide range of PSB, considers the problem behaviours of children and youth at various intellectual and developmental levels of functioning, and considers the persistence of PSB as reported by clients themselves, parents/guardians, and community agents. In contrast, the studies cited above did not include youth who were functioning below the borderline range of intellectual abilities, and relied only on juvenile justice system data that only includes youth over age 12 (as children under age 12 cannot be charged with a sexual offence). Our success rate for the cessation of general PSB in 66% of clients is commendable as it encompasses a wide range of problematic sexual behaviours by children and youth of varying developmental functioning levels. Likewise, our finding that 73% of clients who had presented with contact PSB did not continue to offend is significant. This “re-offending” data is all inclusive, incorporating even those
contact PSB which may not be violent in nature or at the age level (12 years) or severity of chargeable offence. In addition it is important to note that measurement is generally occurring before intervention or treatment has been completed, and in some cases even implemented (i.e. waitlists). Thus, this success rate is primarily due to bringing awareness of the underlying causes of the PSB to the client themselves and the involved adults, and the implementation of a safety plan that reduces the triggers and opportunities for PSB.

**Recommendations and Next Steps**

The SBT members and community agents provided excellent ideas for areas of improvement in the clinic during the focus groups. Although the team would like to increase their capacity to offer treatment services, given limitations imposed on the team by our tertiary care mandate and large catchment area this may not be attainable. Rather, it may be more appropriate to enhance services by tracking the youth's progress and maintaining support to those local agencies who provide direct treatment and intervention services to clients within their home communities. Community agents requested that as part of the treatment recommendations, SBT provide more information on when the safety plan can be relaxed. Follow up and monitoring strategies to track treatment progress are important next steps and would help toward this end.

This grant has been influential in building capacity within the SBT for program evaluation. The need for processes to obtain outcome data was recognized at the start of the granting period, serving as an impetus for the creation of several new tools. The Problematic Sexual Activities Checklist now enables the SBT clinicians to consistently document the presenting problems. The Treatment Plan Checklist and Coordinated Treatment Plan provide an outline of recommendations based on the assessment and assigns responsibility to the client, family, and community agent for implementation. The Treatment Progress Evaluation Tool guides clinicians in determining if recommendations were met by 6 months following the assessment. In addition, a Clinician Interview Tool provides a pre/post measure of client
functioning and recidivism. As well, the team implemented a consistent procedure to collect parent/guardian and youth consent to research, and child assent. Although the number of clients with complete data sets were low in the current report due to the length of time from referral to assessment (approximately 6 weeks), and then assessment to follow-up (6 months), the SBT will complete a long-term program evaluation that will allow for powered analyses. The CoE funding has also been instrumental in an electronic data capture plan that involved the purchase of Snap Surveys Software. Currently, licensing agreements are being finalized with the companies holding the rights to the standardized assessment tools used (i.e, CBCL, PCRI, BERS-2, CSBI), to allow for electronic data collection with these measures. As well, questionnaire design within the Snap program is in progress. It is projected that by the end of January 2012 the measures will be accessible to parents electronically so that pre packages can be completed on a laptop provided by CPRI when attending the “Meet & Greet” and follow-up packages can be completed in person at the 6-Month Follow-up Meeting. Transitioning from mailing packages to electronic entry will enable more timely access to the pre assessment information by SBT clinicians, and increase the compliance rate considerably for follow-up data.
G. References


Figure 1. Number of Types of Maltreatment for SBT Clients (neglect/emotional abuse, witness to violence, physical abuse, and/or sexual abuse)

- None: 13%
- One Type: 23%
- Two Types: 24%
- Three Types: 17%
- Four Types: 23%
Figure 2. Recidivism Rate for General PSB at 6 Months Post Assessment

Figure 3. Recidivism Rate for Contact Offences at 6 Months Post Assessment
Table 1. CBCL T-scores for SBT clients at the time of referral, tested against a clinical cut-off value of 65. *p < .05; ** p < .01; ***p < .001

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Table 2. SBT Knowledge Exchange at Conferences

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Appendix A: Logic Model
Appendix B: Outcome Evaluation Matrix
Appendix C: Copies of Measure

Note: Although sufficient data is not yet available for all of the following measures, this list represents the standard for each client by which parent-report and clinician interview data are collected, and treatment recommendations are made.

Problematic Sexual Activities Checklist

Clinician Interview Tool (CIT)

Parent Child Relationship Inventory (PCRI)

Child Behavior Checklist (CBCL)

Behavioral and Emotional Rating Scale (BERS-2)

Family History Questionnaire (FHQ)

Checklist of Significant Life Events (CSLE)

Child Sexual Behavior Inventory (CSBI) - for ages 6-12 years

Adolescent Clinical Sexual Behavior Inventory (ACSBI) - for ages 13+

Treatment Plan Checklist

Coordinated Treatment Plan

Treatment Progress Evaluation Tool

Client Satisfaction - Feedback meeting version; 6-Month Follow-up version

Parent Satisfaction - Feedback meeting version; 6-Month Follow-up version

Agency Satisfaction - Feedback meeting version; 6-Month Follow-up version