Evidence In-Sight:

Children with sexual behaviour problems

Date: February, 2014
The following Evidence In-Sight report involved a non-systematic search and summary of the research and grey literature. These findings are intended to inform the requesting organization, in a timely fashion, rather than providing an exhaustive search or systematic review. This report reflects the literature and evidence available at the time of writing. As new evidence emerges, knowledge on evidence-informed practices can evolve. It may be useful to re-examine and update the evidence over time and/or as new findings emerge.

Evidence In-Sight primarily presents research findings, along with consultations with experts where feasible and constructive. Since scientific research represents only one type of evidence, we encourage you to combine these findings with the expertise of practitioners and the experiences of children, youth and families to develop the best evidence-informed practices for your setting.

While this report may describe best practices or models of evidence-informed programs, Evidence In-Sight does not include direct recommendations or endorsement of a particular practice or program.

This report was researched and written to address the questions:

- What are the best practices for working with children under the age of 12 who are exhibiting sexually inappropriate and intrusive behaviours?
- In particular, are there manualized, evidence-based programs (e.g., workbooks) to guide the implementation of practice recommendations in addressing these behaviours?

We prepared the report given the contextual information provided in our first communications (see Overview of inquiry). We are available at any time to discuss potential next steps.

We appreciate your responding to a brief satisfaction survey that the Centre will e-mail to you within two weeks. We would also like to schedule a brief phone call to assess your satisfaction with the information provided in the report. Please let us know when you would be available to schedule a 15-minute phone conversation.

Thank you for contacting Evidence In-Sight. Please do not hesitate to follow up or contact us at evidenceinsight@cheo.on.ca or by phone at 613-737-2297.
1. **Overview of inquiry**

This request originated with a large community-based child and youth mental health agency that provides intervention, public education, prevention and support services to children, youth and families in communities in northern Ontario. The agency is interested in best practices for working with children under the age of 12 who are exhibiting sexually inappropriate and intrusive behaviours. This behaviour is ongoing and goes beyond the normative touching that young children often display. This inappropriate behaviour is often directed toward a younger sibling, step-sibling or other younger child. The agency currently conducts safety planning with these families but has found that basic educational intervention is ineffective.

The agency is looking for guidance on best practices in the treatment of children under 12 who are behaving in sexually inappropriate ways. The agency is particularly interested in manualized, evidence-based programs (e.g., workbooks) to guide the implementation of practice recommendations.

2. **Summary of findings**

There are a variety of terms in the literature to refer to inappropriate sexual behaviours in children, including *sexual behaviour problems*, *sexually problematic behaviour*, and *problematic sexual behaviour*. For clarity, this report will use the term *sexual behaviour problems* (SBPs) to encapsulate these terms.

The evidence on service provision for children with SBPs has some key messages:

- The literature defines children with SBPs as children under the age of 12 who initiate behaviours involving sexual body parts that are considered developmentally inappropriate or potentially harmful to themselves or others.
- While the research base has grown over the last few decades, there is far more research on treating adolescents with SBPs than children, but practices suggested for adolescents should not necessarily be extended to services for children under 12.
- Sexual behaviour in children is conceptualized on a continuum from normative to problematic. Identifying SBPs involves examining where a child’s behaviour fits on that continuum and in relation to their developmental age and stage.
- The current research is confused by the existence of a variety of terms to refer to this issue. The range of terms and slight variations in their definitions, makes it harder to compare findings.
- There are many factors that contribute to the development and maintenance of SBPs. These factors span biological, familial, cultural and economic domains, and there is an interactive relationship between them.
- There is extensive research on the correlation between a history of sexual abuse and the development of SBPs in children. However, not all children with a history of sexual abuse develop SBPs and many children with SBPs have no known history of abuse.
- Children with SBPs are a very heterogeneous group. As a result, the research suggests working from an individualized approach and emphasizes the importance of a comprehensive assessment, as there is no treatment program that will best suit the needs of all children.
- Provided there is detection and effective intervention, children exhibiting SBPs are at a relatively low risk for future SBPs. Most interventions use a cognitive behavioural theory (CBT) approach, while some interventions
also have a trauma focus (including manualized trauma-focused CBT). The research points to the use of relatively short-term focused outpatient interventions.

- Few intervention programs have been systematically documented and assessed, and of those that have, few appear in the literature. This lack of treatment efficacy research points to the importance of evaluating any programs that are adapted for use and implemented in community agencies.
- Best practices include involving families and caregivers in service decisions and provision, avoiding the use of models developed for adolescents or adults, and collaborating with other service providers who work with the child and family.
- SBPs in children violate social norms by nature of their definition and the issue is laden with guilt, denial, embarrassment and shame for many families. The research points to the dangers of labelling and emphasizes the importance of viewing these behaviours as just one aspect of a child’s behaviour instead of a reflection of the child as a whole.

3. Answer search strategy

- Search Tools: Google, Google Scholar, University of Ottawa Library (Scholars portal, PubMed, AMED Allied and Complementary Medicine, Mental Measurements Yearbook, PsycINFO, Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) without Revisions), National Registry of Evidence-based Programs and Practices (NREPP), California Evidence-Based Clearinghouse for Child Welfare (CEBC)
- Search Terms: child, sexually problematic behaviour, sexual behaviour problem, sexualized behaviour, sexually reactive child, sexual aggression in children, inappropriate, child sexual behaviour, treatment program, intrusive, assessment, normative, problematic, sexual abuse

4. Children with sexual behaviour problems

Sexual behaviour problems (SBPs) in children do not represent a syndrome or a diagnosable condition, yet they are a socially and clinically concerning set of behaviours (Swisher, Silovsky, Stuart, & Pierce, 2008; Carpentier, Silovsky, & Chaffin, 2006). The literature characterizes sexual behaviour in children on a continuum, ranging from natural and healthy behaviours to problematic and anti-social behaviours (Gagnon, Begin & Tremblay, 2004; Kellogg, 2009; Hornor, 2004; Bonner, Walker, & Berliner, 2001; Hall, Matthews, & Pearce, 2002).

Children with SBPs vary by demographic characteristics, co-occurring clinical issues, social environments, degree of severity and intensity of behaviours, and potential risk to others. Some features are common across this population, but there is no universal profile or constellation of factors that characterizes children with SBPs (Chaffin et al., 2006; Swisher et al., 2008; Gagnon et al., 2004; Elkovitch, Latzman, Hanson, & Flood, 2009). Historically, preadolescent children were seen as asexual and any evidence of sexual behaviour was questioned as a symptom of sexual abuse (Elkovitch et al., 2009; Hornor, 2004). Current research illustrates that sexual behaviour in children can be normal, but it depends on where the child’s behaviour sits on the continuum.

Behaviours considered normal do vary across developmental levels, social environments and cultures, which may influence what is considered normative or problematic behaviour (Elkovitch et al., 2009). The research points to the importance of considering whether a child’s behaviour is common or rare for their environment, by examining the
behaviour in context, not isolation (Swisher et al., 2008; Chaffin et al., 2008; Gagnon et al., 2004; Elkovitch et al., 2009; Friedrich & Trane, 2002; Hornor, 2004; Lamb & Coakley, 1993; Hall, Matthews, & Pearce, 1998).

4.1 Definition
Sexual development begins at birth. It is common for children to engage in a variety of sexual behaviours starting in early childhood and the literature reports a range of sexual behaviours as normal for children as young as two years old (Swisher et al., 2008; Kellogg, 2009). Sexual behaviours that are considered normative include those that involve parts of the body considered to be private or sexual (e.g., genitals, breasts, buttocks), are exploratory in nature, and are not considered harmful (Swisher et al., 2008). Normative behaviours are typically limited to looking and touching and are considered to be motivated by curiosity instead of a preoccupation (Miranda, Biegler, Davis, Frevert, & Taylor, 2001). These behaviours occur spontaneously, infrequently, voluntarily and without strong feelings of anger or other negative emotions (National Child Traumatic Stress Network [NCTSN], 2009a). Normative sexual behaviour typically occurs among children of a similar age, size and developmental level, and can be addressed by adult intervention and increased supervision (Swisher et al., 2008).

While the literature uses many terms to refer to SBPs, there is agreement on the definition encompassed by these terms: children under the age of 12 who initiate behaviours involving sexual body parts that are considered developmentally inappropriate or potentially harmful to themselves or others (Swisher et al., 2008; Elkovitch et al., 2009; Carpentier et al., 2006; Silovsky, Niec, Bard, & Hecht, 2007). Sexual behaviours in children are considered problematic when they:

- involve aggression, force, threats or coercion,
- occur between children of different ages, size, and developmental levels,
- place the child at risk or cause harm to themselves or others,
- persist despite appropriate supervision and caregiver intervention,
- disrupt normal childhood activities, interests or development,
- occur at a greater frequency than would be developmentally expected,
- are accompanied by emotional distress or negative emotions, or
- involve animals (Swisher et al., 2008; Offermann, Johnson, Johnson-Brooks, & Belcher, 2008; Gagnon et al., 2004; Miranda et al., 2001; Kellogg, 2009; Hornor, 2004; NCTSN, 2009b; Pithers, Gray, Busconi, & Houchens, 1998).

4.2 Prevalence and incidence rates
There is no population-based data of children with SBPs, yet there has been an increase in reported numbers in recent decades. Swisher et al. (2008) suggest that this could be the result of an actual increase in incidence, more inclusive definitions of SBPs in children, greater awareness and reporting, or some combination.

A study of children ages six to 11 years old in the care of Quebec’s child protection services for child maltreatment or serious behaviour problems found that one in five children exhibited SBPs (Lepage, Tourigny, Pauzé, McDuff, & Cyr, 2010). Another study suggested relatively low rates of children with SBPs in the general population, indicating that typically less than three percent of children in community samples presented with SBPs (Elkovitch et al., 2009). Neither of these results can be used to determine an estimated rate of SBPs in the general population, but they indicate that for
some high risk groups (such as children with a history of maltreatment or those in the care of child protection services) it may be an issue that practitioners should be aware of and prepared to address.

SBPs in children occur across all age ranges, socioeconomic levels, cultures, living circumstances and family structures (NCTSN, 2009b). Children with SBPs as young as three years old have been described in the literature and some studies have found a higher prevalence of SBPs among younger children; this could be explained by maturity (in that many children grow out of these behaviours) or underreporting in older children (in that parents may not observe the behaviour, or older children may exercise more restraint and conceal the behaviour from adult view) (Elkovitch et al., 2009; Kellogg, 2009; McClellan et al., 1996). Few studies have explored gender differences, but one study did report that girls may be more likely than boys to be referred for treatment during preschool years, with the reverse in school-age years (Bonner et al., 2001). Some research reports greater numbers of male children than female children with SBPs, theorizing that males are socialized to externalize behaviours while females are socialized to internalize behaviours (Miranda et al., 2001; Ray & English, 1995).

Rates of SBPs in children are often based on referrals to child protection or treatment services and there may be gaps representing cases not reported, not referred for services, or not captured by shared data. Research also points to the possibility that rates may be underestimated due to the means by which information is collected, as rates are typically generated based on caregiver reports. Informant-reports such as these can be limited if some caregivers are reluctant to report their observations or have limited opportunities to observe their children, and retrospective studies have an inherent difficulty for individuals to recall clear memories of their early childhood (Elkovitch et al., 2009; Australian Childhood Foundation [ACF], 2005).

4.3 Nature of the issue
The use of the term sexual often implies that the motivation for the behaviour is sexual gratification or stimulation, but this is not necessarily the case. Behaviours may be related to curiosity, impulsivity, anxiety, imitation, attention-seeking, self-calming, or trauma-related symptoms (Swisher et al., 2008; Chaffin et al., 2008; CEBC, n.d.; NCTSN, 2009b; Silovksy et al., 2007). SBPs can include problematic masturbation (causing harm or damage), nonintrusive behaviours (such as a preoccupation with nudity or voyeurism), explicit sexual interactions with others (such as intercourse), or coercive or aggressive behaviours (Miranda et al., 2001; Elkovitch et al., 2009; Kellogg, 2009; CEBC, n.d.). Research on subtypes of SBPs is still in early stages (e.g., see Hall et al., 2002), though some research distinguishes between SBPs directed toward self (no other person involved) and SBPs directed toward others (at least one other person involved) (Lepage et al., 2010).

Life trajectory
The available evidence suggests that with completion of appropriate treatment, children with SBPs are at a very low risk for future SBPs in adolescence or adulthood (Swisher et al., 2008; Chaffin et al., 2008; Miranda et al., 2001; Elkovitch et al., 2009; Carpentier et al., 2006). This dispels a historical myth that children with SBPs are on a path to becoming adult sex offenders. While some adult sex offenders do report in retrospective studies that their aggressive sexual behaviour began in childhood (Gagnon et al., 2004; Ray et al., 1995), it is incorrect to assume that all or even a majority of children will continue their SBP into adulthood (Swisher et al., 2008; Carpentier et al., 2006). However, without detection and appropriate intervention, children with SBPs are typically unable and often unwilling to alter their behaviour (Chaffin et
The current research does not indicate which children with SBPs will develop ongoing patterns of sexual offending in adulthood (Hall et al., 1998).

**Contributing factors**

There is no simple explanation for why children develop SBPs, nor is there a clear pattern of factors that lead to the development or maintenance of SBPs. Historically, research was quite narrowly focused on the correlation between a history of sexual abuse and SBPs in children (Kellogg, 2009). The current literature explores additional contributing factors which span across several domains (biological, familial, economic and cultural), and the dynamic relationship between them. The main contributing factors discussed in the literature include:

- a history of maltreatment, including emotional, physical or sexual abuse, neglect, or exposure to violence (Swisher et al., 2008; Chaffin et al., 2008; Elkovitch et al., 2009; Miranda et al., 2001; Pithers et al., 1998; Lepage et al., 2010; Kellogg, 2009; NCTSN, 2009b),
- exposure to a traumatic experience such as a natural disaster or accident (Swisher et al., 2008; Elkovitch et al., 2009; NCTSN, 2009b),
- a family environment marked by inadequate supervision, multiple placements, a lack of consistency, or chronic distress (e.g., poverty, criminal arrests, mental health problems) (Swisher et al., 2008; Chaffin et al., 2008; Elkovitch et al., 2009; Gagnon et al., 2004; Miranda et al., 2001; Pithers et al., 1998; Lepage et al., 2010; Kellogg, 2009; NCTSN, 2009b),
- exposure to sexually explicit material or living in a highly sexualized environment (Swisher et al., 2008; Chaffin et al., 2008; Elkovitch et al., 2009; Miranda et al., 2001; Lévesque, Bigras, & Pauzé, 2012; Friedrich & Trane, 2002; Kellogg, 2009; NCTSN, 2009b), and
- factors within the child such as impulsivity, difficulty following rules, or poor coping skills (Swisher et al., 2008; Chaffin et al., 2008; Elkovitch et al., 2009; Gagnon et al., 2004; Miranda et al., 2001; Lepage et al., 2010; NCTSN, 2009b).

Studies on the correlation between maltreatment and SBPs in children are widespread. The research suggests that nearly all children referred for treatment for SBPs have experienced some form of maltreatment which might include abuse (emotional, physical or sexual), neglect, or exposure to violence (Elkovitch et al., 2009; Gray, Pithers, Busconi, & Houchens, 1999). Children who have been sexually abused are at an increased risk for developing SBPs — nearly 20% will develop SBPs (Swisher et al., 2008; Offermann et al., 2008; Lévesque et al., 2012; Friedrich, 1993). One study found that the onset of sexual abuse prior to the age of seven was significantly associated with greater SBPs, indicating that earlier sexual abuse is a greater risk factor for SBPs (McClellan et al., 1996). Termed sexually reactive by some (CEBC, n.d.), SBPs in these children are seen as a reactive response to the stress and anxiety caused by past abuse (Offermann et al., 2008). These children often have difficulty identifying and communicating their feelings, can be frequently confused and preoccupied with sex and sexuality, and often have an altered sense of boundaries (Offermann et al., 2008). These children may present with other trauma-related problems including posttraumatic stress disorder (PTSD), anxiety disorders or depression (Chaffin et al., 2008). For these children, assessing for problems commonly related to abuse or trauma may be particularly important to ensure trauma-informed care (Miranda et al., 2001; Lepage et al., 2010; Friedrich, 1993; Hornor, 2004; Rasmussen, 2013). However, a common misunderstanding is that all children demonstrating SBPs have been sexually abused. While a history of sexual abuse can certainly be a significant
Contributing factor in the onset of a child’s SBP, the majority of children who have been sexually abused will not develop SBPs (Swisher et al., 2008; Chaffin et al., 2008; Elkovitch, 2009).

Children with more intense SBPs tend to have more comorbid emotional and behavioural problems, including conduct disorder, hyperactivity, impulse dysregulation, attention deficit hyperactivity disorder, oppositional or aggressive behaviour, PTSD, anxiety and/or depression (Chaffin et al., 2008; Swisher et al., 2008; Gagnon et al., 2004; Kellogg, 2009; Gray et al., 1999; Baker et al., 2008). One study of 127 children with SBPs found that 96 percent had additional psychiatric diagnoses (Gray et al., 1999), demonstrating that SBPs are often part of an overall pattern of behaviour problems (Elkovitch et al., 2009; NCTSN, 2009b). Many children demonstrating SBPs also experience developmental and learning disabilities, and many demonstrate interpersonal skill deficits such as poor boundaries, socialization difficulties and lower levels of peer acceptance (Elkovitch et al., 2009; NCTSN, 2009b; Bonner et al., 2001).

Children who exhibit SBPs are more likely to experience parenting practices that reinforce problematic and aggressive behaviours while ignoring children’s positive social behaviours (Gagnon et al., 2004). Caregivers are likely to be more coercive and rejecting, use more violent discipline methods and demonstrate decreased monitoring and support (Elkovitch et al., 2009; Kellogg, 2009; Etgar & Shulstain-Elrom, 2009). They are also more likely to have suffered maltreatment themselves and to be experiencing their own psychological distress (Lepage et al., 2010). The research suggests a greater likelihood of insecure attachment between parents and children with SBPs (Chaffin et al., 2008; Swisher et al., 2008; Gagnon et al., 2004; Kellogg, 2009; Gray et al., 1999; Baker et al., 2008). Children from families marked by stability, support, problem-solving and a stronger parent-child relationship fare better (Elkovitch et al., 2009).

Regardless of the pathway to development of a child’s SBP, interventions supportive to the child and family are likely to lead to positive outcomes even if the original causes of the behaviour are unclear (Chaffin et al., 2008).

Barriers to identification

By nature of its definition, SBPs in children violate social norms and challenge societal beliefs about the innocence of children (ACF, 2005). Attitudes such as denial and minimization tend to play a significant role for children and families (Reicher, 2013; ACF, 2005). Caregivers may turn a blind eye to a child’s behaviour, have difficulty believing that their child could behave in this way, or feel embarrassment about what they may have exposed their child to (Pithers et al., 1998). Children naturally want to avoid punishment or criticism and denial can represent a defense mechanism from feeling shame or facing parental disappointment. While this may leave service providers stuck between facts and subjective truths (taking what the child or family says at face value or taking on a more investigative role), the research suggests that denial can be a rich source of information about the child or family, and the literature points to the importance of attentive and nonjudgmental listening to instill a sense of empathy and trust for the child and family (Reicher, 2013).

5. Best practices for planning and delivering services

Research on best practices for services for children with SBPs suggests using evidence-informed models of intervention, trained staff and effective intervention methods (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). The literature also points to the importance of matching services to client needs, collaborating with other professionals to coordinate service, and evaluating service effectiveness (McGrath et al., 2010).
5.1 Caregiver and family involvement

A consistent finding in the literature is that service success is linked to caregiver and family involvement in the treatment process. Effective interventions usually include working with caregivers and other family members in the child’s social ecology, which is critical for guiding which goals and strategies will be pursued with the key individuals in a child’s life (Chaffin et al., 2008; Gagnon et al., 2004; Miranda et al., 2001; Hall et al., 1998; Etgar & Shulstain-Elrom et al., 2009; Silovsky et al., 2007). The literature points to a wealth of information on the roles that caregivers play throughout treatment including close visual supervision, communication of clear roles and expectations, and enforcement of privacy, roles that are essential for the long-term success of treatment outcomes (Swisher et al., 2008).

Caregivers typically foster positive changes in a child’s behaviour by helping them integrate what they have learned and acquire more control over their own behaviour (Gagnon et al., 2004; Etgar & Shulstain-Elrom, 2009). The research also points to cases where a child might be temporarily in foster care and suggests that it is important for both foster parents and natural parents to be involved in treatment, if there is a plan to return the child (Ray, Smith, Peterson, Gray, Schaffner, & Houff, 1995).

Placement considerations

In many cases of children with SBPs, a sibling or step-sibling is the victim of the behaviour. These cases are particularly difficult to assess and appropriately respond to (Swisher et al., 2008). A large aspect of treatment of children with SBPs involves placement decisions in which service providers and the family must determine whether the child can remain in the home (Swisher et al., 2008). As with all treatment decisions, the best practice discussed in the research is to approach decisions such as these on a case-by-case basis. The research suggests first considering the impact on the victim sibling: some may have continued anxiety and struggle with living with their sibling due to fear of continued inappropriate behaviour, while other siblings may want to continue living with their sibling and demonstrate increased anxiety over the consideration of separation (Swisher et al., 2008). With appropriate caregiver supervision, safety planning and effective outpatient therapy (including services designed specifically for the victim sibling), most children with SBPs can remain in their home with other children without SBPs (Gagnon et al., 2004; Swisher et al., 2008).

5.2 Distinction between children, youth and adults

In the past, children with SBPs were considered younger versions of adolescents with SBPs and adult sex offenders, but research shows that this is a problem as there are unique differences between children and older age groups (Rasmussen, 2013). Children with SBPs are developmentally and socially unique and policies, assessment procedures and treatment approaches developed for adolescents and adults are inappropriate for children (Swisher et al., 2008; Rasmussen, 2013).

Whereas adolescent and adult sex offenders are predominantly male, there are a substantial number of young girls as well as young boys among children with SBPs (Chaffin et al., 2008; Elkovitch et al., 2009). Assessment techniques such as the measurement of sexual arousal and the use of lie detectors are not appropriate for children (Chaffin et al., 2008; Rasmussen, 2013), and exploring victim empathy, patterns of grooming and offense cycles are beyond the cognitive abilities of most young children (Swisher et al., 2008). Children’s SBPs typically respond well to appropriate treatment, and their behaviour changes over time as they develop and their environments change. As a result, long-term, restrictive treatments (such as residential programs) are generally not best practice for children, which is in contrast to treatment
for youth or adults (Swisher et al., 2008; Carpentier et al., 2006; Ownbey, Jones, Judkins, Everidge, & Timbers, 2001). Most importantly, treatment recommendations for children with SBPs should be time-limited and closely monitored with their development (Swisher et al., 2008; Carpentier et al., 2006). Since children with SBPs are at low risk for future sex offenses if appropriate services are provided, delinquency and criminal court responses should be reserved for older youth and adults. Children with SBPs should be conceptualized as in need of family services, not as sexual predators, abusers, sexual offenders, or perpetrators (Swisher et al., 2008).

**Legal system involvement**

Under the age of 12, a child who demonstrates SBPs would not fall under the jurisdiction of the Youth Criminal Justice Act and would not be chargeable under the Criminal Code of Canada (Costin, Schuler & Curwen, 2009; Gagnon et al., 2004). Cases of children with SBPs are often brought to the attention of the legal system in the context of child maltreatment or because a caregiver has failed to protect another child in the family (Swisher et al., 2008). For cases brought before the courts, the research suggests that it is important for the court to provide oversight to an agency working closely with the family, to ensure that the child is properly assessed and receives adequate treatment (Swisher et al., 2008).

**Public policy**

The literature speaks to current and historical debates in public policy on the use of registries, mandatory reporting and segregation of children with SBPs. While this demonstrates the delicate balance of the best interests of the child and family and that of the community, it also sheds light on the importance of differentiating between children with SBPs and adolescents or adult sex offenders. Lumping children with SBPs into the same category as adolescents and adults has, in some arenas, affected how the legal system, the child welfare system and other public institutions address children with SBPs (Swisher et al., 2008; Elkovitch et al., 2009; Carpentier et al., 2006). In some jurisdictions, children with SBPs are segregated within treatment programs specifically for sex offenders (Swisher et al., 2008; Carpentier et al., 2006). In other jurisdictions, legislation sets a standard age at which reporting to a public sex offender registry is mandatory. Often this age limit is reduced and offense categories are expanded (Swisher et al., 2008; Carpentier et al., 2006). The research points to such policies offering little or no community protection while subjecting children to potential stigma and social disadvantage (Chaffin et al., 2008; Swisher et al., 2008; Elkovitch et al., 2009).

**5.3 Child welfare system**

The research suggests that children with SBPs are often involved in the child welfare system due to maltreatment or a caregiver’s inability to properly supervise the child or follow-up with needed mental health care. Caregivers also might place their child in care due to their discomfort with the child’s SBP (Baker et al., 2008).

The involvement of children in the child welfare system can have far-reaching implications, particularly as it relates to foster placements and permanency planning (Swisher et al., 2008). Children with SBPs are more likely to be in foster care or multiple placements, which in itself can be a contributing factor for the development and maintenance of SBPs, creating a cyclical pattern (Swisher et al., 2008; Elkovitch et al., 2009; Baker et al., 2008; Lévesque et al., 2012). Despite this dilemma, the research agrees on certain conditions in which service providers and families should consider removing a child from the home: when the child continues to engage in severe sexual behaviours toward other children despite treatment efforts, when caregivers are unable or unwilling to carry out their roles to provide a safe
environment, or when the presence of the child is causing distress to other children in the home (Chaffin et al., 2008). If a child does need to be removed from the home, less restrictive alternatives (e.g., foster care or living with a relative) should be explored, and the new caregiver should have all the essential information about the child’s needs and be willing to participate in therapy with the child (Swisher et al., 2008).

Reunification can be considered after improvement in the child’s behaviour or the original caregiver’s ability to provide a healthy environment with appropriate supervision (Swisher et al., 2008). Reunification is more successful when it is done through a gradual process with continued monitoring of a safety plan and with continued treatment for both the child and family (Swisher et al., 2008).

5.4 Labelling
People react strongly to the issue of SBPs because the problems are sexual in nature (NCTSN, 2009b). Labelling children with SBPs can have far-reaching and long-term effects on their development. Service providers working with children with SBPs and their families should take every precaution to avoid referring to these children as deviant, perverted, offenders, perpetrators, molesters, predators, or destined to persist in sexual activities (Chaffin et al., 2008; Swisher, 2008). Branding such as this can delay permanency planning and complicate decision-making. For example, foster parents may be unwilling to consider fostering a child who has been labelled as a sex offender. Labelling risks creating a self-fulfilling prophecy and social burdens for the child (Chaffin et al., 2008).

SBPs are only a small part of a child’s behaviour and should not overshadow the view of the whole child (Hoffman, Beneke, Kuhn, & James, 2013). The literature points to the importance of separating a child’s SBP from the child themselves so as to not project shame on the child (Offermann et al., 2008). For example, service providers increasingly use the term children with sexual behaviour problems because it labels the behaviour and not the identity of the child (Chaffin et al., 2008).

5.5 Collaboration
Services should ideally be coordinated to address a behaviour as complex as SBPs in children (Ray et al., 1995; Gagnon et al., 2004; Pithers et al., 1998). There are typically many systems involved in these cases, including the family, the child welfare system, the school and sometimes a foster family. Working within and across each of these systems is integral to surrounding the child and family with support and preventing unnecessary disadvantages and family burden (Chaffin et al., 2008). Costin, Schuler and Curwen (2009) state that “effective intervention requires cooperation and collaboration among individuals and agencies, as well as a unified goal of protecting victimized individuals and the community” (p. 12). Unfortunately, due to resource limitations, most agencies and communities can offer only very brief treatment, without a comprehensive assessment (Office of the Provincial Advocate for Children and Youth, 2005). Given this, and the fact that many families in need may move from one agency to the next for support, there is a significant need for a network of resources and service providers surrounding each child and family (Office of the Provincial Advocate for Children and Youth, 2005).

6. Assessment and intervention
Given that children with SBPs vary by age, culture, socioeconomic level, living circumstances and family structures, assessment and intervention decisions need to be made on a case-by-case basis (Hall et al., 1998). An individualized
approach points to the importance of considering culture. Offermann et al. (2008) state that it “has been well
documented in the literature that beliefs about sexuality, nudity, discipline practices, family behaviors, and parent-child
relationships significantly influence a child’s response to and progress in treatment” (p. 183). In order to protect the
therapeutic alliance and prevent additional stress on the child and family, it is important for service providers to
understand a family’s cultural beliefs, using this to inform all phases of treatment planning (Offermann et al., 2008). It is
important to consider each child individually and use assessment tools to determine the best approach for each family
given their situation.

6.1 Assessment
Early assessment of children with SBPs is an essential practice (Gagnon et al., 2004), but the scope of each assessment
varies from case to case. The assessment helps determine if a child’s behaviours are normative or problematic, and
helps service providers and families plan the best treatment approach.

Assessment information can be obtained through a combination of clinical assessment (including a basic behavioural
and psychosocial history from caregivers and an interview with the child) and the administration of a simple assessment
tool (Chaffin et al., 2008). The assessment should capture information about the type, frequency, duration, level of
intrusiveness, harm, use of coercion, and circumstances of a child’s SBP (Swisher et al., 2008). The research also points
to the importance of ecologically-focused assessments, to capture a picture of the context surrounding the child’s SBP
(Chaffin et al., 2008). An assessment should include recommendations for supervision, the treatment plan, expectations
of the caregiver and/or family in treatment, and a plan to address any co-occurring issues (Chaffin et al., 2008). Given
that a child’s environment and development change over time, an assessment should not be considered valid beyond
one year from the time it was conducted and the assessment should give more weight to recent events and issues
(Hoffman et al., 2013).

Evidence-based assessment tools have been demonstrated to help evaluate the nature and extent of a child’s SBP and
can be useful for monitoring progress and tracking outcomes (Chaffin et al., 2008). Formal assessments of young
children rely almost solely on informant reports and are therefore completed by the child’s caregiver. This can be
problematic, as caregivers may be reluctant to disclose their observations or may not have a clear picture of the child’s
behaviour if they have had limited opportunities to observe their child (Elkovitch et al., 2009; ACF, 2005). The following
five assessment tools are used most in the literature:

Child Sexual Behavior Inventory (CSBI)
This measure evaluates the presence, frequency and intensity of sexual behaviours (both normative and problematic) in
children over the past six months. It has been validated for use with caregivers (including foster parents) of children ages
two to 12 years old (Lepage et al., 2010; Chaffin et al., 2008). It addresses nine domains: boundary problems,
exhibitionism, gender role behaviour, self-stimulation, sexual anxiety, sexual interest, sexual intrusiveness, sexual
knowledge, and voyeuristic behaviour (Swisher et al., 2008). For more information on this tool, see the Centre’s
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*Child Behavior Checklist (CBCL)*  
The CBCL is a widely used general screen for childhood behaviour problems and social competence measured over the past six months. It measures factors such as depression, somatic complaints, hyperactivity, sexual behaviour, aggressiveness, and delinquent behaviour. The CBCL has been validated for use with caregivers of children ages four to 18 years old. For more information on this tool, see the Centre’s Measures Database:  

*Child Sexual Behavior Checklist (CSBCL)*  
This measure lists behaviours related to sex and sexuality in children, explores environmental issues that can increase SBPs, gathers details of children’s sexual behaviours with other children, and lists problematic characteristics of children’s sexual behaviours (Chaffin et al., 2008). Instruments such as the CSBCL can help assess contributing factors and identify environmental intervention areas (Chaffin et al., 2008). For more information on this tool, see Johnson & Aoki, 1993.

*Trauma Symptom Checklist for Children (TSC-C)*  
This measure evaluates trauma symptoms in children ages seven to 16 years old and examines six subscales: anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns. For more information on this tool, see the Centre’s Measures Database:  

*Trauma Symptom Checklist for Young Children (TSCYC)*  
This measure assesses children ages three to 12 years old and evaluates caregiver perceptions of trauma symptoms across eight subscales: anxiety, depression, anger/aggression, posttraumatic stress – intrusion, posttraumatic stress – avoidance, posttraumatic stress – arousal, dissociation, and sexual concerns. For more information on this tool, see the Centre’s Measures Database:  
http://www.excellenceforchildandyouth.ca/resource-hub/measure-profile?id=267#.

6.2 Intervention  
Research demonstrates that intervention for children with SBPs is complex and requires a specialized approach. Treatment programs for children with SBPs vary in duration, intensity, restrictiveness and focus (Carpentier et al., 2006; Hall et al., 2002). There is no one-size-fits-all approach that can provide for or meet the unique needs of every child and their family. However, there are particular components of treatment known to be effective.

Interventions predominantly fall in one of two categories: treatments targeting the SBP, and treatments targeting the effects of child sexual abuse including the SBP (CEBC, n.d.). There is agreement in the literature that SBPs can often be treated effectively with relatively short-term (three to six months) outpatient cognitive behavioural therapy (CBT) with an education component for children and caregivers (Swisher et al., 2008; Chaffin et al., 2008; Lévesque et al., 2012; Carpentier et al., 2006; NCTSN, 2009b). CBT is the most commonly evaluated treatment approach for children with SBPs and typically includes two components: therapy and support for the child and caregivers, as well as education on sexuality, social skills, self-control, self-esteem and parenting skills. One longitudinal study following children with SBPs in a 12-session group CBT program (with 10-year follow-up data) found that the CBT group (which included behaviour modification and psychoeducational components) had significantly fewer future sex offenses than a play therapy group (two percent vs. 10 percent) (Carpentier et al., 2006). The research suggests that CBT should be considered a primary
treatment approach for SBPs except in unusually severe cases or cases with significant comorbidities, such as a known trauma history (Chaffin et al., 2008).

When a child has significant comorbidities, their SBP may be just one of several intervention targets. For example, when a neglectful or chaotic family environment is present, interventions focused on creating and maintaining a safe and stable environment should be considered (Swisher et al., 2008). When a child’s SBP is part of an overall pattern of disruptive or oppositional behaviour, the literature points to programs like Parent-Child Interaction Therapy, The Incredible Years, Barkley’s Defiant Child Protocol, or Triple-P (Swisher et al., 2008). Finally, when it is suspected that a child’s SBP is a trauma-related symptom, the research points to trauma-focused cognitive behavioural therapy (TF-CBT) (Chaffin et al., 2008).

Most interventions are meant to stop the child’s SBP from getting worse, prevent future victimization, and foster the development of more appropriate social behaviours (Gagnon et al., 2004). The research notes that the number of evidence-based programs designed specifically for children is far more limited than that available for adolescents so many programs have been adapted and customized to suit individual case needs (Gagnon et al., 2004). Regardless of chosen intervention, treatment should be delivered by mental health professionals who have the training and experience necessary to work with children with SBPs (Costin et al., 2009).

**Modality**

Intervention durations vary in length from 12 weeks to 24 months (with 60- to 90-minute weekly sessions), although treatment effectiveness is indicated by reduced symptoms, not just the passage of time (Gagnon et al., 2004). Most treatment programs for children with SBPs include a combination of individual, family, and group therapy, where possible.

Group therapy is the most frequently employed treatment modality (Gagnon et al., 2004). Groups are assembled based on developmental age – preschool (three to five years old), school-age (six to nine years old) and preadolescent (10 to 13 years old) – and some authors point to the importance of same-sex groups while others see the feasibility of mixed-sex groups, a reality that is rarely seen in group therapy for adolescents (Gagnon et al., 2004). The research suggests that group therapy allows children to develop bonds, share experiences and experience positive socialization as they explore aspects of SBPs that affect the whole group (Etgar & Shulstain-Elrom, 2009; Gagnon et al., 2004). Through group therapy, caregivers are able to establish a support system and develop a better understanding of the issues surrounding SBPs including parenting skills and child sexuality (Gagnon et al., 2004; Pithers et al., 1998).

Individual therapy is often used when group therapy is not available (e.g., due to low numbers) or when a child cannot attend group therapy due to cognitive impairment or a major mental health problem. It is also the preferred modality when a child presents with SBPs not involving others (e.g., compulsive self-stimulation) (Gagnon et al., 2004). In individual therapy, the child can form a trusting relationship with the therapist, deal with previous trauma and more thoroughly explore problems specific to the child (Etgar & Shulstain-Elrom, 2009; Gagnon et al., 2004). Through individual therapy, caregivers can identify and express their feelings and gain an awareness of any issues that may influence the persistence of their child’s SBP (Gagnon et al., 2004).
Family therapy is typically offered in addition to group and individual therapy and involves siblings who have been affected either implicitly or explicitly (Gagnon et al., 2004). Family therapy facilitates communication, addresses cognitive distortions learned within the family and focuses on strengths and tools that the family already has (Gagnon et al., 2004).

Community-based outpatient treatment has advantages, including reduced costs, maintaining the child’s social attachments and regular activities, and enabling families and caregivers to more readily participate in treatment (McGrath et al., 2010; Swisher et al., 2008).

Inpatient and residential treatment approaches have not been as thoroughly evaluated. The literature points to a number of disadvantages to inpatient treatment: it is harder to involve the caregiver, it is more difficult to change the child’s thought process (as changes in behaviour can be attributed to changes in their social environment), it can be quite expensive and it potentially exposes the child to other severe behaviour or mental health problems (Swisher et al., 2008). However, the research also points to circumstances that warrant consideration of residential or inpatient treatment including when the child is actively suicidal or homicidal, when they demonstrate aggressive SBPs that persist despite treatment and close adult supervision, or when they have other severe mental health or behaviour problems such that they are unable to function in the community (Swisher et al., 2008).

**Safety planning**
Safety plans are discussed at length in the literature as a standard and integral component of treatment, particularly if the child with the SBP is remaining in the home with other children. For most, this includes basic common sense guidelines such as rules for the child, roles for the caregivers and guidelines that the family as a whole agrees to. Information shared in this manner is less stigmatizing for the child with the SBP and sets the groundwork for developing (or maintaining) a healthy, safe environment (Swisher et al., 2008). Each family needs to customize a plan to fit their individual situation and this plan should be developed with oversight and guidance from a service provider. Safety plans should be kept in place for the duration of a child’s treatment and should be re-evaluated regularly. See Swisher et al., 2008, for a sample safety plan.

**6.3 Evidence-informed interventions**
The number of treatment programs for children with SBPs has increased in recent decades, but few empirical studies have been done to inform and support these programs. There is very limited peer-reviewed treatment outcome data available. Service providers can adopt best practices and use their clinical experience to contribute to an evidence-informed practice. The experience of service providers working with the family, and the use of an evidence-based assessment tool, help ensure the intervention meets the needs of the child and family.

The following are evidence-informed interventions discussed in the literature. Not all of the following interventions have been evaluated for treatment outcomes and not all include implementation guides. Please consult the supporting research or contacts for more information.
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**Cognitive-Behavioral Therapy (CBT) – preschool group**
*Target population:* Children ages 3-6 years old and their caregivers.

*Modality:* Group therapy (five to seven children in a closed group, 12 to 14 weekly 90-minute sessions); can be provided to individual families when group therapy is not an option.

*Description:* This program consists of a family-oriented psychoeducational and supportive treatment group. Children are taught private part rules and abuse prevention skills in the context of safety rules. Boundaries, emotional regulation, coping skills and basic impulse control strategies are taught and practiced during and between sessions. Caregivers are taught about sexual development and how to supervise children, teach and implement rules at home, communicate about sex education and reduce behaviour problems utilizing parent training strategies. Each week, the child and caregivers use activities to help them apply or practice the skills and information taught.

*Research support:* This program has been evaluated and there is peer-reviewed treatment outcome data available. For more information, see Silovsky et al., 2007, or [http://www.cebc4cw.org/program/children-with-sexual-behavior-problems-cognitive-behavioral-treatment-program-preschool-program/](http://www.cebc4cw.org/program/children-with-sexual-behavior-problems-cognitive-behavioral-treatment-program-preschool-program/).

*Implementation:* There is a manual and training available.

*Contact:* Jane F. Silovsky, PhD; Jane-silovsky@ouhsc.edu, (405) 271-8858.

**Cognitive-Behavioral Therapy (CBT) – school-age group**
*Target population:* Children ages 6-12 years old and their caregivers.

*Modality:* Group therapy (open-ended, 60- to 90-minute weekly sessions; children are able to graduate in four to five months); can be provided to individual families when group therapy is not an option.

*Description:* This program consists of a family-oriented psychoeducational and supportive treatment group. Children are supported to acknowledge their previous sexual behaviour rule-breaking, learn coping and self-control strategies, and develop a plan of how they are going to keep these rules in the future. Caregivers are taught how to supervise children, teach and implement rules at home, communicate about sex education, and reduce behaviour problems utilizing parent training strategies. Each week, the child and caregivers use activities to help them apply or practice the skills and information taught.

*Research support:* This program has been evaluated and there is peer-reviewed treatment outcome data available. For more information, see Carpentier et al., 2006, or [http://www.cebc4cw.org/program/children-with-sexual-behavior-problems-cognitive-behavioral-treatment-program-school-age-group/](http://www.cebc4cw.org/program/children-with-sexual-behavior-problems-cognitive-behavioral-treatment-program-school-age-group/).

*Implementation:* There is a manual and training available.

*Contact:* Jane F. Silovsky, PhD; Jane-silovsky@ouhsc.edu, (405) 271-8858.

**Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)**
*Target population:* Children ages 3-12 years old with a known trauma history who are experiencing SBPs and significant PTSD symptoms (regardless of whether they meet the full diagnostic criteria for PTSD).

*Modality:* Typically delivered in individual therapy and conjoint therapy with caregiver (12 to 18 weekly 60- to 90-minute sessions); can be delivered in groups (six to 10 clients or caregivers per group).

*Description:* This program consists of a child and caregiver psychotherapy hybrid treatment model incorporating trauma-sensitive interventions with CBT, family and humanistic principles to address symptoms resulting from a specific trauma experience. Essential components must be implemented for each child, following the order of the PRACTICE acronym: Psychoeducation and parenting skills, Relaxation techniques, Affective expression and regulation, Cognitive coping,
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Trauma narrative and processing, In vivo exposure, Conjoint parent/child sessions, and Enhancing personal safety and future growth. Each week, caregivers are given assignments to practice the treatment components at home, both alone and to reinforce and practice with their children.


Implementation: There is a manual (Treating Trauma and Traumatic Grief in Children and Adolescents) and training available (10-hour online introductory training, two to three days on-site training, ongoing consultation).

Contacts: Judith Cohen, MD; jcohen1@wpahs.org, (412) 330-4321. Esther Deblinger, PhD; deblines@umdnj.edu, (856) 566-7036. Anthony Mannarino, PhD; amannari@wpahs.org, (412) 330-4312.

Safety, Mentoring, Advocacy, Recovery and Treatment (SMART) model

Target population: Children ages 3-11 years old with a known history of sexual abuse who are experiencing SBPs.

Modality: Individual, group and family therapy (50-minute sessions; number of sessions per week is based on risk, specific needs and family stability; recommended duration is 12 to 18 months).

Description: This program consists of a structured, phase-based treatment using trauma theory, multi-systematic family therapy and CBT. The premise of the SMART model is that SBPs stem from emotional responses to prior child sexual abuse causing the child to form cognitive distortions about the self, others and the world around them. Treatment focuses on safety and stability, affect and behaviour regulation, formation of a meaningful trauma narrative, and acquisition of new coping skills and strategies. SMART promotes the use of psychoeducation, safety contracting, monitoring and skill building, and utilizes a specialized workbook to guide treatment. SMART targets the family unit and explores the development of a family narrative that addresses the impact and difficulties associated with caring for a child with a SBP and a history of abuse.

Research support: There is outcome data available for this program. For more information, see Offermann et al., 2008, http://www.nctsnet.org/sites/default/files/assets/pdfs/SMART_fact_sheet_3-21-07.pdf, or http://www.cebc4cw.org/program/safety-mentoring-advocacy-recovery-and-treatment/. We did not find any peer-reviewed treatment outcome data.

Implementation: There is a manual and training available.

Contact: Betsy Offermann, LCSW-C; offermann@kennedykrieger.org, (443) 923-5907.

Trauma Outcome Process Assessment (TOPA) model

Target population: Children ages 4-19 years old.

Modality: Individual therapy.

Description: This model consists of CBT with experiential methods (art therapy, play therapy, sand tray, role play, drama and relaxation) designed to help children recognize how SBPs connect to past sexual abuse or trauma, take responsibility for maladaptive behaviours, and make adaptive choices when faced with triggers. Therapists take a directive role by creating a safe therapeutic environment and work with caregivers to ensure the home environment supports and maintains the child’s treatment gains. The model presumes that responses to trauma are dynamic and fluid, influenced by a priori risk and protective factors and current stressors or resources.
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Research support: For more information, see Rasmussen, 2000, or http://www.cebc4cw.org/program/trauma-outcome-process-assessment-model/. We did not find any peer-reviewed treatment outcome data.

Implementation: There is no manual available; there is training available.

Contact: Lucinda Rasmussen, PhD, LCSW; lucindarasmussen@cox.net, (619) 301-8231.

Interventions for children with sexual behavior problems: Research, theory and treatment

Target population: Children ages 7-12 years old.

Modality: Individual, family and group therapy (60-minute individual or family therapy sessions per week; five to 10 participants in 60-minute weekly groups).

Description: This program incorporates elements of TF-CBT and integrative eclectic therapy (IET). Treatment is tailored and directed based on an assessment of the unique characteristics of the child and family. This program aims to help and heal the child and family using a wide array of activities to foster key life skills such as safety planning, relationships skills, emotional expressive skills and empathy, cognitive coping, and self-regulation. The framework addresses issues in eight focus areas: safety, attachment and support systems, affective regulation, cognitive distortions, gradual exposure, social skills development, psychosexual education, and self-perception and personal identity.

Research support: For more information, see http://www.cebc4cw.org/program/interventions-for-children-with-sexual-behavior-problems-research-theory-and-treatment/. We did not find any peer-reviewed treatment outcome data.

Implementation: There is no manual available (same name as program title); there is no training available.

Contacts: Lesley Lundeberg, MSW, LCSW; llundeberg@utah.gov, (801) 898-6231. Ryan Grant, MSW, LCSW, RPT-S; ryang@vmh.com.

When Children Abuse

Target population: Children ages 5-12 years old.

Modality: Group therapy (six participants divided by age and sex in 90-minute weekly groups) and individual therapy as needed. Many aspects of group therapy can be adapted for use in individual therapy only.

Description: This program uses a CBT approach with simultaneous educational and treatment groups for caregivers. The program’s goal is to treat the whole child (not just the behaviour) with the best tools available. The program consists of issue-related modules that can be tailored to address the needs of the child, the behaviour and the circumstances (e.g., building self-esteem, managing anger, problem solving skills, victimization and trauma issues, perpetration issues, building empathy, sexuality and sex role stereotyping); not all clients need exposure to each module. The program is associated with two companion manuals, From Trauma to Understanding (by William D. Pithers) and Steps to Healthy Touching (by the same authors as When Children Abuse).

Research base: For more information, see http://www.cebc4cw.org/program/when-children-abuse/. We did not find any peer-reviewed treatment outcome data.

Implementation: There is a manual and training available.

Contact: Carolyn Cunningham, PhD; playshrink@gmail.com, (818) 845-5679. Kee MacFarlane, MSW; (619) 723-6305.

6.4 A sample of Ontario programs

Specialized Sexual Behaviour Team (SBT), Child and Parent Resource Institute (London, ON)

This community-based program is operated by the Ministry of Children and Youth Services to support children and adolescents ages 18 and under. After an intake and comprehensive assessment has been completed, a multidisciplinary
team meets to create a clinical formulation as to the many factors that contribute to the problem behaviours and to determine the most appropriate recommendations. The SBT operates under the premise that children who receive intervention do very well and are able to stop their SBP, but it has to be the right intervention, which requires a thorough understanding of the problem. For more information, see http://www.cpri.ca/content/page.aspx?section=33 or contact Mary Ellen Marshman, Clinic Lead (SBT), at Mary-Ellen.Marshman@ontario.ca.

**Sexual Treatment Outpatient Program (STOP), Pathstone Mental Health (Hamilton-Niagara region, ON)**
This community-based program supports children and adolescents ages four to 18 years old. Intervention begins following a thorough assessment and can include group, individual and family counselling. Either in conjunction with, or subsequent to counselling, several supplementary therapies including assertiveness training, social skills, self-esteem and anger management are incorporated into the treatment plan. Discharge occurs only when all treatment goals have been met. This treatment plan can take from six months up to two years to complete. There is a manual and training available for this program. For more information, see http://www.pathstonementalhealth.ca/services/high-risk-services or contact Bill Helmeczi, Director of Mental Health Services, at bhelmeczi@pathstone.ca.

**Child and Youth Trauma Services (CYTS), Community Child Abuse Council of Canada (Hamilton-Niagara region, ON)**
This family-oriented treatment is based on TF-CBT and offers services from a multidisciplinary team to children and adolescents ages two to 18 years old with a known history of sexual victimization and children ages 12 and under with SBPs. Treatment is individualized to the needs of the child. The child is supported and engaged in different ways to help them better understand themselves, their strengths and struggles, the impact of abuse, and changes they would like to make. The trauma focus helps the child express their feelings openly and learn new ways to solve problems. For more information, see http://www.childabusecouncil.on.ca/progams-a-services/assessment-a-treatment/87-ccac-main/128-children-and-youth-trauma-services-cyts.html or contact Nancy Falls, Clinical Director, at nfalls@childabusecouncil.on.ca.

**7. Next steps and other resources**
For more information on treatment resources for children with SBPs, including workbooks for children and manuals for professions, consult the Safer Society Foundation: http://www.safersociety.org/resources/for-professionals/resources-for-treating-offenders/resources-for-treating-teens-and-children/. As with all resources lacking peer-reviewed outcome research, these resources should be evaluated to assess how they could best meet the needs of children with SBPs.

Knowing what works and receiving training on an evidence-informed practice or program is not sufficient to actually achieve the outcomes that previous evaluations indicate are possible. A program that has been shown to improve mental health outcomes for children and youth but that is poorly implemented will not achieve successful outcomes (Fixsen et al, 2005). In order for a program to be evidence-informed, it needs to be applied with fidelity to the design and it needs to be implemented using supportive “drivers” related to staff competency, organizational leadership and organizational capacity. These drivers include assessing and monitoring the outcomes of your practice using evaluation or performance measurement frameworks, which are particularly important when there is insufficient evidence in the literature to guide clinical decisions. Choosing a practice is an initial step toward implementation, but the implementation drivers are essential to ensure that the program reaches appropriate clients, that outcomes are successful and that clinical staff members are successful in their work.
The Ontario Centre of Excellence for Child and Youth Mental Health has a number of resources and services available to support agencies with implementation, evaluation, knowledge mobilization, youth engagement and family engagement. For more information, visit: http://www.excellenceforchildandyouth.ca/what-we-do or check out the Centre’s resource hub at http://www.excellenceforchildandyouth.ca/resource-hub.

For general mental health information, including links to resources for families: http://www.ementalhealth.ca
References


