ESTABLISHING A CONSISTENT CAC/MDT RESPONSE TO YOUTH WITH PROBLEMATIC SEXUALIZED BEHAVIOR IN NH

September 30, 2021

The Granite State Children's Alliance received funding for this project through the Children's Justice Act Grant, administered by the New Hampshire Department of Justice.

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Executive Summary

CRIMES AGAINST CHILDREN RESEARCH CENTER

September 2021

Improving the Response to Youth with Problematic Sexualized Behavior in NH

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The Granite State Children's Alliance collaborated with the Crimes against Children Research Center on a project to improve the CAC/MDT response to youth with problematic sexualized behavior (YPSB) in NH. These are youth who have engaged in sexually abusive behavior with other youth. This project included online surveys and telephone interviews with professionals working with this population in NH and a national scan of best practice.

INTRODUCTION

Not only do YPSB cases represent a significant proportion of sexual offenses, but also these cases are extremely challenging. Nationally, juveniles account for more than one-third (36%) of sexual offenses committed against minors and known by police[i]. The table below shows the percentage of YPSB cases of all referrals at Children's Advocacy Centers (CACs) by county over a three-year period (6/1/2018 - 7/30/2021).

County	Total number of referrals	Number of YPSB referrals	% of YPSB referrals
Strafford	480	108	23%
Coos	118	23	19%
Grafton	495	82	17%
Belknap	459	78	17%
Rockingham	1087	168	15%
Cheshire	411	61	15%
Carroll	338	48	14%
Sullivan	412	57	14%
Hillsborough	1393	153	11%
Merrimack*	2135	201	9%
Total	7328	979	13%

* Total number of referrals includes adult cases.

Below, we summarize what we heard from professionals in NH about barriers working with this population; a national scan of best practices; and recommendations to improve the response in NH.

BARRIERS

We conducted an online survey with 64 professionals in NH and telephone interviews with 21 professionals in NH. Participants identified the following barriers and challenges working with this population.

→ The lack of consistency and accountability

"Need a protocol that would lay out the steps to ensure all cases are responded to consistently."

"The lack of a statewide standard has led to a lot of confusion."

→ Team challenges because no one agency is in charge.

"There is no agency for police to refer these cases to so that services are received."

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"Need better communication with other disciplines and better way to share information."

"There always seems to be a breakdown in communication. No one really knows what is going on."

Access to services is too limited. Need an easier way to get services.

"There is no good system to get YPSB and families services."

"Justice system is short sighted. These kids need intervention."

"Need a special track in the juvenile justice system that focuses on getting YPSB and their families services."

Lack of mental health services for YPSB

"The lack of any sort of genuine services specific to sexual reactive behavior feels inadequate."

"Wish there were enough counselors who specialize in this area."

Lack of training on this issue

"The lack of knowledge of YPSB is the most serious gap in the professional response."

"We need training so that all MDT members understand the dynamics and how to best service victims and YPSB."

BEST PRACTICES

"The process of identifying and responding to PSBs among youth and children is often fragmented and inconsistent across the country. CACs are leaders in supporting families impacted by child abuse through coordinated multidisciplinary response and care. This uniquely qualifies CACs to coordinate effective interventions for this population."
https://learn.nationalchildrensalliance.org/psb

12 and younger
- The MDT approach and the CAC model are ideal vehicles for a comprehensive systems approach to cases of children with PSB and their families

13 and older
- Community-based interventions for adolescents with PSB produce more positive youth, family, and community outcomes at a fraction of the cost of incarceration-based strategies.

In November 2020, the Southern Regional CAC and the Oklahoma Commission on Children and Youth published a white paper on Children with Problematic Sexualized Behavior: Recommendations for MDTs and CACs.[ii] The report focused on children aged 12 and younger and describes the MDT approach and the CAC model as best practice for responding to PSB.

Consistent with the goal of treatment rather than a punitive approach for adolescents aged 13 to 18, the Association for the Treatment of Sexual Abusers as well as others advocate for a strong rehabilitative focus to effective policy and practice.[iii]

The National Children's Alliance has developed a number of resources to assist CACs working with this population. For more information, see https://learn.nationalchildrensalliance.org/psb

CACs across the county fund mental health treatment for YPSB cases using VOCA funds,

County funds, Juvenile Justice, state funds such as Department of Youth Services, United Way, and local foundations.

RECOMMENDATIONS

Based on conversations with professionals in NH and across the country, we identified five recommendations to improve the response to YPSB in NH. We then asked professionals in NH (N=37) to grade how NH is doing and offer suggestions on how to get to an A.

Recommendation#1: Educate everyone involved with YPSB

Take the time to educate everyone involved, especially teachers, law enforcement, and judges so that everyone understands when and how therapy is beneficial. Many CACs we talked to across the country said do not underestimate the amount of outreach needed to change perspective and increase diversion. Many people said that therapists think they do not want to work with this population and that it takes time to understand this population before offering training to therapists.

Grade: C How to get to an A?

- Require a "juvenile academy", a training course for police, prosecutors, MDT members, school guidance counselors, judges, and juvenile justice professionals
- Dedicate resources to support educational materials, such as webinars and online resources
- Establish annual outreach and education that is supported by the Attorney General's office, County Attorneys, and DHHS

Recommendation #2: Designate lead agency and have community response protocol in place

We heard that successful strategies were to establish one lead agency for these cases, to have clear protocols to ensure a consistent response, and to have MDTs that include a wide array of professionals, such as probation, school, and family court. We heard that counseling is less likely to occur unless there is an agency to oversee this, can help engage caregivers and explain the benefits of therapy.

Grade: C- How to get to an A?

- Attorney General's Office designates lead agency and standardizes protocol
- Incorporate National Children's Alliance Best Practices for YPSB, including creating MOUs across agencies

Recommendation #3: Create a committee focused on this issue

Several CACs across the country have statewide or local committees, whereas others have invested in local cheerleaders on this issue across each discipline. Others have specialized probation officers, specialized therapists, and specialized prosecutors.

Grade: C- How to get to an A?

- Provide funding and time to develop statewide committee(s)
- Dedicate resources and training to support a few representatives from all disciplines and build from this core group

Recommendation #4: Establish and expand specialized mental health services

One of the most consistent themes was to establish easy and straightforward paths to therapy. Many CACs provide the link to treatment for initiators and victims of PSB. We heard an important part of engaging families with therapy is having a clinical supervisor/case manager who can understand barriers to therapy and educate families about the benefits of therapy.

Grade: C- How to get to an A?

- Invest in specialized training and education
- Provide support to community mental health services

Recommendation#5: Establish and expand diversion programs

Several CACs mentioned they have informal or formal diversion programs that are successful, with recidivism rates all around 3%. Many CACs said there has been a shift to more diversion over time as people learned about the effectiveness of a rehabilitative focus rather than a punitive one.

Grade: D+ How to get to an A?

- Provide resources and training to establish evidence-based programs
- Establish clear response protocols with time frames

Key factors shifting the focus to a treatment orientation for responding to YPSB[iv].

- Educate policy makers about recidivism and evidence-based treatment that documents positive outcomes for youth.
- Develop clear policies for schools so schools know where to refer to and children receive services.
- Address some policies at state level, i.e. mandated reporting, and others at local level.
- Allocate funding for specialized YPSB training and services.

ACKNOWLEDGEMENTS

We are grateful to the professionals who participated in this research and for the grant support we received from the Children's Justice Act Grant, administered by the New Hampshire Department of Justice. Contributors included Joy Barrett and Nicole Ledoux at the Granite State Children's Alliance, the NH network of Children's Advocacy Centers, and the Division for Children, Youth, and Families.

[i] Finkelhor, D., Ormrod, R., & Chaffin, M. (2009). Juveniles who commit sex offenses against minors. Office of Juvenile Justice and Delinquency Prevention. https://www.ojp.gov/pdffiles1/ojjdp/227763.pdf

[ii] Sites, J. & Widdifield, J. (2020, November). Children with Problematic Sexualized Behavior: Recommendations for MDTs and CACs. Southern Regional Children's Advocacy Center and Oklahoma Commission for Children and Youth. http://www.ncsby.org/sites/default/files/NCAC%20Children%20with%20PSB-%20MDT%20Recommendations.pdf

[iii] Association for the Treatment of Sexual Abusers (2012). Adolescents Who Have Engaged in Sexually Abusive Behavior: Effective Policies and Practices. https://www.atsa.com/adolescents-engaged-in-sexually-abusive-behavior

[iv] Kelly, A., Shawler, P., Shields, J. & Silovsky, J. (2019). A qualitative investigation of policy for youth with problematic sexualized behavior. *Journal of Community Psychology*, 47, 1347-1363.

Key Contributors

The Granite State Children's Alliance collaborated with the Crimes against Children Research Center on a project to improve the CAC/MDT response to youth with problematic sexualized behavior (YPSB) in NH. Key contributors included:

- Wendy Walsh, Ph.D., Research Associate Professor, Crimes against Children Research Center, University of New Hampshire
- Joy Barrett, Chief Executive Officer, Granite State Children's Alliance
- Nicole Ledoux, Victim Service Quality Assurance Director, Granite State Children's Alliance
- NH Network of Children's Advocacy Centers
- Division for Children, Youth, & Families
- Division for Children, Youth & Families, Juvenile Justice

Purpose

Youth who have engaged in sexually abusive behavior with other youth, i.e. youth with problematic sexual behavior (YPSB), not only represent a significant proportion of sexual offenses, but also these cases are extremely challenging. Nationally, juveniles account for more than one-third (36%) of sexual offenses committed against minors and known by police (Finkelhor, Ormrod, & Chaffin, 2009). A 2018 Granite State Children's Alliance assessment of the most significant areas of concern for CACs statewide showed that the inconsistent response to cases of sexual assault of a child, committed by a juvenile, was an area of great concern in each county.

The purpose of this project was to explore how to better serve child victims and youth with problematic sexualized behavior (YPSB) in NH.

The goals of the project were to:

1. Understand general dynamics of YPSB cases. This involved offering two trainings to professionals in NH.
2. Understand characteristics of YPSB cases in NH. This involved conducting a statewide assessment of YPSB cases.
3. Hear experiences of professionals. This involved conducting online surveys and in-depth telephone interviews with professionals in NH working with this population, including law enforcement, juvenile probation officers, prosecutors, clinicians, DCYF, advocates, CAC professionals, and healthcare partners. The goal was to understand current practices, existing challenges, and gaps in services.
4. Conduct a national scan to identify best practices working with this population. This included reviewing the National Children's Alliance work in this area, conducting a literature review, and talking to CACs and professionals across the country working in this area.

5. Develop recommendations for NH to improve the response to YPSB. Based on conversations with professionals in NH and across the country working in this area, we identified five recommendations to improve the response to YPSB in NH.

Training to Understand General Dynamics of YPSB Cases

Two trainings were offered to professionals in NH working in this field. The trainings were:

Critical Issues in Sibling Sexual Abuse by Geraldine Crisci, MS

This workshop reviewed the literature and clinical features of sibling sexual abuse. Topics included: separation of victim and offender, joint interviews with victim and offender, the roles of key service providers (police, protective services, probation, and mental health). The critical role of full family participation in the assessment and treatment process was outlined. Case examples demonstrated a working model to address issues of safety, loyalty, engagement, and minimization.

Sex Offenders: What Every Multi-Disciplinary Team (MDT) Member Should Know by Cory Jewell Jensen, MSW

This workshop reviewed theories about the etiology of pedophilia and development of pro-offending attitudes, plus the more typical patterns of sexual offending (rape, sexual assault & computer crimes against children) committed by juvenile and adult sex offenders. Using videotaped interviews with various sex offenders, common pathways to developing deviant sexual interests and criminal sexual behavior patterns were highlighted. Other areas of focus included offender descriptions of "grooming" tactics, inhibited disclosure, detection and reporting. Video clips illustrated some of the specific skills used by police to enable offenders to confess, along with recommendations for specific interview comment/questions from 26 veteran child abuse detectives from 10 law enforcement agencies in Oregon.

Characteristics of YPSB Cases in NH

To understand characteristics of YPSB cases in NH, CACS compiled characteristics of YPSB cases over a three-year period and tracked additional data about these cases over a one-year period. DCYF created two data reports of YPSB reports received at Central Intake. The first report included reports between January 1, 2019 and June 30, 2020 and the second report included reports between January 1, 2020 and June 30, 2021. Thus, there is a six-month overlap between the two reports.

Using the DCYF data for a one and half year period, we can estimate the number of cases DCYF would see during a 3-year period and compare it to the number of cases at CACs. As shown below, it is estimated that CACs see three times as many victims and initiators in YPSB cases.

Number of Victims and Initiators in YPSB Cases at DCYF and CACs

	DCYF	CACs
Number of victims in YPSB cases during a 3-year period	294	979
Number of initiators in YPSB cases during a 3-year period	332	1024

Characteristics of Cases at CACs

Over a three-year time-period (July 1, 2018 to June 30, 2021), CACs in NH were involved with *979 victims* in YPSB cases. This included *1024 initiators* in YPSB cases. During this time-period, CACs were involved with 7,328 cases of child abuse. This is the number of all referrals to a CAC. Not every referral receives an interview, but often other services are recommended and connections are made for caregivers. Thus, YPSB cases represent 13% of all cases.

Three CACs (Merrimack, Rockingham, and Hillsborough) each had well over 100 cases during this three-year time-period.

Number of Cases during Three-Year Time-Period

County	Total number of referrals	Number of YPSB referrals	Percentage of YPSB referrals
Strafford	480	108	23%
Coos	118	23	19%
Grafton	495	82	17%
Belknap	459	78	17%
Rockingham	1087	168	15%
Cheshire	411	61	15%
Carroll	338	48	14%
Sullivan	412	57	14%
Hillsborough	1393	153	11%
Merrimack*	2135	201	9%

* Total number of referrals for Merrimack includes adult cases.

Understanding the characteristics of YPSB cases is important for developing effective response systems. See Appendix A for full report about YPSB case characteristics seen at CACs. During a three-year period, CACs saw 979 victims and 1,024 initiators in YPSB cases. The fact that 35% of victims in YPSB cases seen at CACs were between the ages of 13 and 15 and 20% are 6 or younger has implications for ensuring that therapy for these age groups is available. Having access to therapy for teen initiators of YPSB is important given that 45% were between 13 and

15 years old and 31% were between 16 and 17 years old. Most (57%) were acquaintances of their victims. The fact that one in five (21%) were siblings shows how complicated these cases are. The majority (68%) were male initiators and female victims, and one in five (20%) were male initiators with male victims. Younger victims and those living in the same household as initiators were significantly less likely to disclose compared to older victims and victims living in different households as initiators.

The open-ended comments by CAC staff highlight how complex these cases can be. Some caregivers were supportive and appropriately concerned, while others were shocked, conflicted and expressed self-blame and guilt. Other caregivers were dismissive of the allegation and expressed disbelief that something had happened. The comments highlight the importance and responsibility of the multidisciplinary team to support caregivers through the process of obtaining mental health services for victims and initiators.

Three CACs (Merrimack, Rockingham, and Hillsborough) had just over half of YPSB cases and would be viable candidates for piloting a program to expand access to mental health for YPSB.

Characteristics of Cases at DCYF

During a one-and-a-half year period (January 1, 2020 to June 30, 2021), there were 154 accepted referrals of YPSB cases including 166 unique initiators and 147 unique victims. See Appendix B for full report about YPSB case characteristics seen at DCYF. There was a range of victim ages in YPSB cases: 28% of victims were 6 and younger, 12% of victims were between 7 and 9, 25% of victims were between 10 and 12, 30% of victims were between 13 and 15, and 5% of victims were between 16 and 17. Most initiators (55%) in YPSB cases were between 13 to 15 years old. Although most were close in age, some cases had a large age difference. About half of initiators lived in the same household as victims in YPSB cases. A minority of accepted referrals had founded assessments. Half of the initiators (12 out of 24) of founded assessments had prior involvement with DCYF as an alleged victim.

Experiences of Professionals in NH

The purpose of the online and telephone surveys was to understand what is working, existing challenges, gaps, and suggestions for improvement.

Online Survey

All professionals who registered for an online training on sibling abuse received an invitation to participate in an online survey about improving the response to youth with problematic sexualized behaviors in NH. Between June 2, 2020 and June 22, 2020, 116 people were invited to participate and 64 people completed the survey (55% response rate). Participants included CAC professionals, law enforcement, DCYF, mental health providers, and other professionals such as juvenile probation officers.

Below we highlight some of the key findings of the online survey. See Appendix C for full report of findings.

- **What is working well for victims of YPSB?** The majority of participants (76%) said that what was working well for victims of YPSB was the CAC/MDT response. Participants noted the team approach to victims and services, agency collaboration, and the timeliness of forensic interviews.
- **What is working well for initiators of YPSB?** Responses were more varied as far as what was working well for youth with problematic sexualized behaviors. Approximately one-third of participants (35%) mentioned the CAC/MDT response. Many participants noted that the MDT response varies by location, by age of the YPSB, or by the age difference of youth. Instead of mentioning what was working well, 25% of participants mentioned what is lacking in the professional response, with the consensus that there is a need to do better. About one-quarter of participants (23%) mentioned meeting the mental health needs of YPSB as something that is working well.
- **What is the most serious gap in the professional response to these cases?** Approximately one-third of participants (35%) said that the most serious gap was that agencies struggle with understanding what to do with youth that perpetrate on other youth. Participants mentioned the lack of consistency, that each case seems to be treated differently, and lack of accountability. Many participants noted that because of agency criteria, youth often do not have appropriate follow up and "*don't fold into local services*." A few participants specifically mentioned that police do not take these cases seriously and are reluctant to get involved. The following quote illustrates the struggle.

  > *Because the youth with problematic sexualized behavior often fall in an age range that falls below what would constitute any legal action being taken (i.e., juvenile petition being filed, or even criminal charges) then there is often no definite action that is taken by any agency.*

  A quarter of participants mentioned the lack of mental health options for youth as the most serious gap in the professional response. Participants mentioned the lack of qualified, experienced treatment options with many noting the cost of services and the location of services as additional barriers.
- **What are some other challenges?** Nearly one-third (30%) of participants mentioned the lack of resources for YPSB, 28% mentioned the lack of a consistent response, and 24% mentioned the need for education on this topic.
- **What area most needs to be improved?** Based on ranking what areas are most in need of improvement, by far the area most in need of improvement was treatment for YPSB. Treatment for victims also received high to moderate ratings in need of improvement.
- **Who needs to be more involved with these cases?** The top three responses were therapists (32%), MDT (25%), and juvenile justice (21%).
- **What recommendations do you have to ensure there is a consistent and coordinated response for these cases in NH?** The top three recommendations to improve the

response were statewide protocols (33%), training for all professionals involved with these cases (26%), and consistent communication by the MDT (26%). Other recommendations included better access to mental health therapy for YPSB (17%), such as mandating counseling and designating agency contacts to work on these cases (13%). The following quotes are examples of recommendations to ensure that there is a consistent and coordinated response for these cases in NH.

> *Statewide protocols would be super helpful. It feels like there is an inconsistent response across all counties, and having a document or a manual or set of protocols to refer all disciplines to would be helpful.*
>
> *Need for a protocol that would lay out the steps that need to be taken in a case to ensure all the cases were responded to consistently.*
>
> *When it comes to issues as serious as youth with problematic sexualized behaviors there is never enough training and collaboration between professionals.*
>
> *Continued contact between all of the professionals involved in these cases.*
>
> *I think that no matter the age of the YPSB, children should be placed into comprehensive intervention programs for their age.*
>
> *I think that there should be specialized workers for these cases so that it is taken seriously and a protocol in place for these cases for workers to follow.*

Telephone Interviews

CAC directors in NH provided names of the top three professionals in their area with expertise handling these cases. Directors were asked to include a diverse mix of professionals including law enforcement, prosecutors, clinicians, DCYF, and advocates. An initial email invitation was sent to 32 professionals on August 10, 2020. Between August 11, 2020 and September 15, 2020, 21 people completed the interview. The response rate was 66%.

Below we highlight some of the key findings of the online survey. See Appendix C for full report of findings.

- **What is the hardest thing about these cases?** Participants described the resistance and emotional aspect for families, team challenges working with these cases because no one agency is in charge, and the lack of services.

> *Really, any case with a juvenile, the biggest barrier is the parents, either they don't believe it or they are in denial. This makes it hard because parents have to comply with the conditions.*
>
> *I wish there was a debriefing, need communication for these cases. With youth with problematic sexualized behavior, no one really knows what is going on.*

- **How to improve the identification and referral process?** The main theme was that additional training is needed, with training for teachers and law enforcement most commonly mentioned. Other themes were to streamline the referral and investigation process and that intervention should occur early in the process.

> *Need to better understand what is age appropriate versus not.*
>
> *Police should not be able to choose, should be automatic referral to CAC.*
>
> *Get families involved with services sooner.*

- **How to improve DCYF?** By far the most consistent theme was that access to services is too limited and often there is not a clear path for families to get services. Another theme was that better communication is needed between DCYF and other agencies is needed. A handful of participants also noted that DCYF's goal is reunification but that this is not always appropriate.

> *Hate to see CPS close investigation and family goes back to old ways.*
>
> *Need to share information. Can't share what services exist, can't brainstorm about what is needed.*

- **How to improve treatment for youth with problematic sexualized behaviors?** The two main themes were to improve awareness of providers and to increase services. Awareness had to do with professionals needing a list of approved providers with expertise in this area. Increase in services had to do with the cost of evaluations making it difficult to obtain services and the fact that there are limited options for treatment.

> *Wish there were enough counselors who specialized in this area.*

- **How to improve treatment for victims?** The two main themes for improving treatment for victims were the lack of services and difficulty with access to services.

> *Community mental health centers need to identify who would be good to work with this population.*

- **How to improve CAC response?** Some participants mentioned that CACs help with referrals, noting that CACs are limited to treating victims, but that a team approach is needed for YPSB.

> *A team approach is best for these cases. CACs are so knowledgeable and the more people involved the better.*

- **How to improve community services?** The main theme was that there needed to be better access for services. Comments varied as far as what types of services were needed. Suggestions included that these youth need more oversight to ensure their home life is safe and stable; that the types of services should expand, such as group work and in-home services for families; and that how services are coordinated should be improved.

  > *Community health centers are heavily relied and sorely understaffed, underpaid and overworked. Need to better integrate with these centers.*

- **How can advocacy services for victims in court be improved?** Generally, participants felt that the juvenile system should allow prosecution-based advocates in court and that advocates could be one of the biggest supports for youth. One participant wondered whether the AG could loan their advocates, and another wondered whether an advocate role could be combined with a guardian ad litem for victims. Another participant said that parents are frustrated during the investigation because they say nothing is being done and that we need to help families understand the process in a more black and white way, such as providing a step-by-step handout for families.

  > *These kids do not have anyone speaking up for them.*

- **How to improve the juvenile justice response?** The most consistent theme was that the bar needs to be lower so youth can get services earlier and that a justice system response is not always helpful. The other theme was that there needs to be a better multidisciplinary response that includes Juvenile Probation and Parole Officer (JJPO).

  > *Justice system is short sighted. These kids need intervention. We are doing a disservice for these kids, then they turn up in the adult system.*

- **How to improve the law enforcement response?** The two main themes were lack of knowledge among police officers, especially in rural or smaller departments, and the lack of collaboration, especially with DCYF. Some of the participants expressed frustration that there is no agency for police to refer to, like a justice center or CAC, so that services are received. This gap often results in a lack of a consistent response.

  > *It would be nice if we had some people to refer these to - to get them services, like a family justice center, CAC, and community-based support and say to families not DCYF and voluntary services.*

- **What other areas need to be improved?** Responses to this open-ended question were wide ranging. Participants mentioned that additional training is needed, especially for prosecutors, and that family dysfunction plays such a big part of these cases that it complicates the process. A few participants noted that it should be easier to get services for families who need them. This included difficulties regarding not meeting criteria for voluntary Children In Need of Services (CHINS) and competency to difficulties offering and receiving services when there is no disclosure.

National Scan of Best Practices

The national scan consisted of the following activities:

1) Summary of National Children's Alliance work in this area,
2) Literature review of best practice for responding PSB,
3) Conversations with CACs and other professionals across the country working with this population

National Children's Alliance

In 2019, the National Children's Alliance (NCA) conducted a survey in collaboration with the National Center on the Sexual Behavior of Youth (NCA, 2019). The response rate was 39%, with 351 CACs out of 893 completing the survey. The results highlight a number of issues when working with this population.

- Many participants had a number of **incorrect assumptions** about this population.
    - 49% of participants believed pre-pubescent children with PSB need long-term treatment
    - 67% of participants believed adolescents with PSB need long-term treatment
    - 44% of participants believed pre-pubescent children with PSB need to be placed in residential care
    - 64% of participants believed adolescents with PSB need to be placed in residential care
- The majority of participants believed families will not follow through with treatment without court involvement.
    - 65% of participants believed families of pre-pubescent children won't follow through without court involvement
    - 72% of participants believed families of adolescents with PSB won't follow through without court involvement
- One-third of participants said that CPS and LE do not consider this group as a population they are mandated to respond to.

NCA has been very active in this area, with a number of resources online (briefly described below), as well as a sub-committee on PSB. This committee is working on developing training on this issue for law enforcement as well as a decision tree for MDTs for different situations

depending on the age of the children, and how many children are involved (e.g., a tree involving one child touching, multiple children, younger kids, and one for older kids).

NCA recognizes the need for CACs to assist with improving the response to this population as illustrated by the following statement on their website:

> *"The process of identifying and responding to PSBs among youth and children is often fragmented and inconsistent across the country. CACs are leaders in supporting families impacted by child abuse through coordinated multidisciplinary response and care. This uniquely qualifies CACs to coordinate effective interventions for this population."*
> (https://learn.nationalchildrensalliance.org/psb)

A number of resources are available online to assist CACs working with this population, including sample MOUs. For more information, see https://learn.nationalchildrensalliance.org/psb

Resources include:

- *Effective Treatment for Youth with Problematic Sexual Behaviors.* A two-page overview of the best practices and treatment models.
- *Youth with Problematic Sexual Behaviors Best Practice Documents Overview.* Includes guidelines to create agreements, sample consent, home safety plans, and additional guidelines and considerations to discuss and employ with teams.
- *Where We Begin: CACs and Youth with Problematic Sexual Behaviors.* This fact sheet provides guidance on building the response to PSB and the key role CACs play.
- *What We Can Do: Understanding Children and Youth with Problematic Sexual Behaviors.* This fact sheet provides an overview of PSB and information on the continuum of childhood sexual behaviors and criteria for PSB, the role of language and science, and next steps for communities.
- *What Happens Now: Facing Sexual Behavior Problems with Your Child.* This fact sheet provides guidance for caregivers and answers questions family members may have.

The national scan also included a literature review, as described below.

Literature Review

Before summarizing best practices for 1) children 12 and younger with PSB, and 2) adolescents with PSB, it is important to recognize that research consistently finds that sexual recidivism (e.g. either a charge or conviction for a new sexual offense) is relatively low.

The National Children's Alliance fact sheet (2017) on PSB states, "Research has demonstrated that sexual recidivism decreases substantially when effective treatment is provided" (p.2). The fact sheet highlights:

- The ten-year recidivism rate after a 12-session outpatient cognitive behavior group treatment is just 2%;
- Children ages 7-12 years have a 98% long-term success rate; and
- Youth ages 13-18 years have a 97% long-term success rate.

Other research also shows low recidivism. A comprehensive analysis examined 106 studies published between 1943 and 2015 involving 33,783 cases of adjudicated juvenile sexual offenders (Caldwell, 2016). Results showed a weighted mean base rate for sexual recidivism of 4.92% over a mean follow-up time of 4 ½ years. The year of initiation of the study predicted the sexual recidivism rate, with studies conducted recently, between 2000 and 2015, having a recidivism rate of 2.75%; 73% lower than the rate of 10.3% reported by studies conducted between 1980 and 1995.

Furthermore, it is notable that if these youth reoffend, they are far more likely to do so with nonsexual offenses than with sexual offenses (Caldwell, 2016).

Best Practice for Responding to Youth 12 and Younger with PSB

In November 2020, the Southern Regional CAC and the Oklahoma Commission on Children and Youth published a white paper on Children with Problematic Sexualized Behavior: Recommendations for MDTs and CACs (Sites & Widdifield, 2020). The report focused on children 12 and younger and states:

> "*Together, the MDT approach and the CAC model are ideal vehicles for the provision of the resources needed for the development and implementation of an integrated and comprehensive systems approach to cases of children with PSB and their families*." (p. 3, Sites & Widdifield, 2020).

The report clearly describes the MDT approach and the CAC model as best practice for responding to children with PSB. The report notes that

> *"Many communities do not have identified treatment providers or programs that specialize in children with PSB, but that it is critical for families to have access to professionals who are trained to provide individualized case management, including safety planning and identifying potential treatment needs of the children involved."* (p. 5, Sites & Widdifield, 2020).

Sites and Widdifield (2020) state that without a written protocol that outlines a clear process for handling cases involving children with PSB, there is a high level of uncertainty on how to respond. To assist with this, they describe suggestions for training professionals to understand this population, adapting NCA standards to work with children with PSB, developing a protocol, engaging families, conducting clinical assessments, and providing treatment to children with PSB and their families.

The Association for the Treatment of Sexual Abusers (ATSA) Task Force on Children with Sexual Behavior Problems (2005) also endorses collaboration among involved agencies, authorities and providers during all phases of a case, and recommends that policies be developed that allow and promote collaboration. The Task Force describes collaborations as including but not limited to treatment providers, child welfare workers, foster parents, parents, schools, childcare providers, juvenile justice staff, and courts. The Task Force (2005) recognizes that children with sexual behavior problems are a diverse population with diverse needs and that decisions should be case-by-case, as described below.

> *"Because of this diversity, any fixed, single policy or intervention plan may miss the mark for a significant number of children and families. This principle is especially true when it comes to out-of-home placement decisions. The Task Force believes that children with sexual behavior problems do not require automatic out-of-home placement, even in cases where a child has sexually victimized another child in the same home."* (p. 27, ATSA Task Force, 2005)

The Task Force (2005) further states, that making appropriate treatment available to these children is in the public's interest.

Best Practice for Responding to Youth 13 and Older with PSB

A common response to juveniles adjudicated of a sexual offense is to send them into a prolonged sexual deviancy treatment program typically modeled after those used for adults. This is despite the fact that adult programs are usually not trauma informed for treating adolescents. Furthermore, some researchers suggest that residential treatment creates harmful side effects for many youth by increasing their risk of victimization, exacerbating criminality, and interfering with developmental and social milestones that move youth toward appropriate social behaviors (Letourneau & Borduin, 2008).

Research consistently demonstrates that community-based interventions for adolescents with PSB produce more positive youth, family, and community outcomes at a fraction of the cost of incarceration-based strategies. A report by Paul Stern (n.d.) called An Empirically Based Approach for Prosecuting Juvenile Sex Crimes concludes:

> *"Many researchers in this field believe that good quality, empirically based treatment for adolescents can be effective for almost all youth who have engaging in sexually aggressive behavior. Others recognize that a small number may be beyond the reach of even the most skilled care providers* (p.28)."

Consistent with the goal of treatment for adolescents 13 to 18 rather than a punitive approach, the Association for the Treatment of Sexual Abusers (ATSA, 2012) states that:

> *"Effective public policy and practice for adolescents who have engaged in sexually abusive behavior involves a strong rehabilitative focus."* (p.5)

The Center for Sex Offender Management (CSOM) (which is a partnership among the U.S. Department of Justice's Office of Justice Programs, National Institute of Corrections, and the State Justice Institute) highlights strategies in its publication called Enhancing the Management of Adult and Juvenile Sex Offenders: A Handbook for Policymakers and Practitioners (CSOM, 2007). CSOM (2010) states that jurisdictions should employ a deliberate, strategic, and collaborative model for managing and reducing risk that includes three fundamental components:

1) Individualized supervision and treatment based on an assessment of a youth's risks, needs, and strengths;
2) Comprehensive community-based, family-focused, and evidence-based treatment attentive to the needs of the victim and their families; and
3) Intensive and specialized treatment for the small number of youth who present serious and persistent risks for future sexual offending.

Low intensity outpatient treatment for adolescents. Much has been written about the effectiveness of treatment for PSB, and it is beyond the scope of this report to summarize this literature (see for example Stern, n.d.; ATSA, NCSBY, NCA).

Evaluations of PSB-CBT to address the needs of adolescents indicate success. PSB-CBT for adolescents aged 13 and 14 produced large reductions in PSB as well as improvements in nonsexual behavior problems, emotional problems, and trauma symptoms (Silovsky et al., 2019). The majority of adolescents aged 13 to 18 (63%) referred to PSB-CBT completed treatment, which is a higher completion rates than typically seen in adolescent outpatient mental health treatment (Jenkins et al., 2020). Furthermore, the study found adolescents who completed PSB-CBT demonstrated a trend towards statistical significance in reduction of PSB (Jenkins, et. al., 2020). Perhaps most salient for policymaking is the finding that legally involved youth completed treatment at a rate of nearly five times that of youth without legal involvement. The authors highlight the importance of developing "holistic community responses" to address child PSB, with multidisciplinary partnerships that can mandate engagement in treatment in the least restrictive environment. The results support further exploration of low intensity, outpatient treatment interventions for adolescents with PSB. A subsequent study found that graduation rates did not vary by severity of offense type (Jenkins & Shier, 2020).

Cost effectiveness of treatment. A comprehensive study across six sites found an average per-youth cost of PSB-CBT of approximately $3,500 and reported a cost-effectiveness ratio in which an expenditure of $3,500 would be associated with a 2-unit decrease in PSB (Dopp et. al., 2020). Cost effectiveness ratios were $1,772 per youth for problem sexual behavior and ranged from $2,867 to $4,899 per youth for secondary outcomes. Results suggest that inclusion of extensive individual therapy and case management services by PSB-CBT therapists results in inferior cost-effectiveness of the model. The authors recommend that programs emphasize the

standard PSB-CBT group-based services for youth and caregivers to maximize clinical and cost-effectiveness.

In addition, state-specific assessments also show cost effectiveness. A comprehensive report, Improving Illinois' Response to Sexual Offenses Committed by Youth: Recommendations for Law, Policy & Practice, concludes that youth who sexually offend can be effectively treated in the community and estimates that Illinois could save between $60,000 to $100,000 annually in reduced incarceration costs per youth by increasing access to treatment (Illinois Juvenile Justice Commission, 2014). NAFI CT reports that $1 spent on Multisystemic Therapy for Youth with PSB saves $48 (Munschy, n.d.). The specialized community-based supervision and treatment program in Lucas County, Ohio reports that 250 youth participated in the program and that program costs for YPSB were reduced from over a million dollars spent per year to under one hundred thousand (as cited in Illinois Juvenile Justice Commission, 2014).

Summary

In addition to the literature previously mentioned, the National Center on the Sexual Behavior of Youth has developed a wealth of resources on this issue (see https://ncsby.org/content/what-problematic-sexual-behavior). Some of the resources include:

- When Sexual Behaviors in Youth are Problematic or Illegal: A Web-Based Resource for Evidence-based Decision-Making
- Clinical Decision Making
- Standards of Care

The focus on a treatment orientation for this population is a significant change in policy and practice. Because of this significant change, a comprehensive study was conducted with 219 practitioners in eight communities to examine polices and policy reforms associated with a treatment orientation for community-based management systems of youth aged 10 to 14 with PSB (Kelly et al., 2019). The researchers noted that development of policy for youth with PSB is in the infancy stage and there is a dearth of research on existing policies to determine impact.

This study reported the following key factors as leading to shifts in policies for youth with PSB: (a) Education of policymakers about recidivism and evidence-based treatments that document positive outcomes for youth with PSB. (b) National legislation that impacts youth with PSB. (c) Shifts in juvenile justice practices to focus on treatment and rehabilitation. (d) A focus from the National Children's Alliance for CAC to serve youth with PSB. (e) The provision of grants provided by OJJDP and SMART (Kelly et al., 2019).

Improving policy and practices for youth with PSB also included the following points (Kelly et al., 2019):

- Schools having a clear policy. Participants felt that schools were often the first to be aware of youth with PSB but often did not have policies or procedures for handling PSB

once it was identified. The lack of clear policy within and across agencies hindered the ability for schools to know how to respond and for children to get services.

- Shifting from juvenile justice and court practices for handling cases of PSB to cases directed to community-based treatment. For example, in some cases, communities agreed to diversion programs for younger children with first time involvement in the justice system.
- Addressing some policies at the state level. Participants suggested it is more effective to address how child welfare addresses mandated reports at the state level, while other issues would be better managed locally.
- Allocating funding for services. Participants reported the need for additional policy efforts to support EBT for PSB. Participants also reported that state Medicaid programs and community EBT initiatives should recognize the specialized treatment and training requirements. Other participants mentioned the need for braided funding from multiple state social service agencies. Youth with PSB often present with multiple needs and this should be a consideration when determining services.

The findings of this comprehensive study support the benefits of having active MDTs that prioritize within and cross-agency policies and procedures on management of cases involving of youth with PSB (Kelley et al., 2019).

How CACs and Other Professionals across the Country are working with this Population

We used multiple methods to identify best practices at CACs and other programs. First, we identified CACs who wrote open-ended comments on the 2019 NCA survey about working with this population in an innovative or in-depth way. NCA then sent emails to these 18 CACs describing this project and saying we wanted to learn more about what they are doing. Eight CACs responded to this request. Second, Michelle Miller at NCA and Jane Silvosky at the National Center on Sexual Behavior of Youth recommended additional CACs to talk to who are working in this area. Lastly, professionals in NH who completed the online survey as part of this project recommended CACs doing work in this area. As a result, we contacted and received information from 25 agencies, and we conducted phone interviews with 31 professionals from 22 agencies. See Appendix E for a list of contacts for the national scan.

Below we describe common themes regarding the assessment, therapeutic response, resolution, and other lessons learned. See Appendix F for an overview of four innovative CACs.

Assessment

Nearly everyone we talked to said it is important to take the time to educate the whole team so that everyone understands when and how therapy is beneficial. Many people said they underestimated the amount of **outreach needed**. Outreach included the need to educate juvenile justice psychosexual evaluators, prosecutors, and judges. Many people mentioned that

it takes time to change people's perspective, and that over time there has been an increase toward diversion; we heard that first you need to build enthusiasm for treatment.

A number of years ago, one CAC worked, with the help of law enforcement, to start to make changes to decriminalize this behavior. There was pushback, however, from prosecutors as well as chronic law enforcement leadership turnover, resulting in a shift of priorities. As a result, this CAC shifted gears and instead decided to focus on revamping the **forensic interview protocol for child suspects**, using the Michael Lamb NICHD protocol. They saw that they could not make a big change but found something they could improve.

Another CAC worked to change **legislation**. Before the legislation change, there was an informal process as to whether law enforcement and CPS would review these cases. In 2012, a government task force was created with a PSB sub-committee. In 2015, legislation was changed to require CPS to get involved. However, they still struggle with having a consistent response even though they have this legislation, especially in the rural parts of the state. The statute is for children under 14; older children are referred to law enforcement. They have a voluntary diversion and if this group is not violent and if they agree to counseling, and then drop out, they may use charging as a way to get back in counseling. However, they find that once they get into treatment, they want to be there. They have found parents have the highest satisfaction for this type of treatment.

This group had to go back to the legislature to ask for additional money to train caseworkers due to the high number of calls. They realized that screeners did not know how to distinguish between problematic behaviors from developmentally appropriate behavior. They had originally planned on having specialized caseworkers receive these calls but that is not a consistent practice and only one area in the state is doing this. Overall, they found that law enforcement and CPS were eager for a change although there is statewide variation in how consistent these policies are followed.

In another state, CPS screens these cases out. However, all sexual abuse cases have to go to the DA and then the DA refers these to the CAC.

<u>Therapeutic Response</u>

Before offering training to therapists, a number of people suggested taking time to **educate therapists** about working with this population. It is important to reach out to therapists because many therapists think they do not want to work with this population. We heard that it takes time to understand this population and get buy-in from therapists to work with this population. Part of the outreach that CACs mentioned was reaching out to individual clinicians to reassure them and to reduce fears about working with this population. One CAC noted they trained therapists first, but then did not have any referrals. This CAC mentioned that they would have done things differently by getting buy-in first from MDT members before training therapists.

Even with outreach and education, some people noted it is difficult to find therapists to work with this population. To help compensate for this, a number of people said they work with universities to recruit interns. Another strategy mentioned was to use **tele-mental health** services to help close the gap with specialized therapists. One person noted that there was more cohesion using tele-mental health with this population than anticipated and it was less different than they initially thought it would be. Others mentioned advantages of tele-mental health with this population such as using videos, clip art, and the chat feature. However due to family dynamics and lack of access to internet services, we realize this is not an option for many cases.

Several people mentioned that it is extremely valuable to have **multiple therapeutic options.** A number of CACs we talked to had received training on the Problematic Sexual Behavior - Cognitive-Behavioral Therapy (**PSB-CBT**). This is a comprehensive family-based clinical treatment intervention for children with problematic sexual behaviors and adolescents with illegal sexual behavior, led by staff at the University of Oklahoma Health Sciences Center.

Most CACs started offering therapy to **younger kids first** (12 and under) because it is an "easier sell." Many have expanded to serving older kids over time, although just as many mentioned that the therapeutic options available for older kids are not trauma informed or they are extremely limited. It was clear that there is still some work to do to serve older youth. One example of this is a CAC that successfully implemented a PSB-CBT program for 7- to 12-year-olds. This CAC recently expanded to serving up to 14-year-olds; however, right now 15- to 17-year-olds go to juvenile court and receive adult sex offender treatment, which is not trauma informed.

Another CAC had a very similar situation. This CAC is providing PSB-CBT to children ages 7-12 and said that the younger children often get referred to treatment, but 13 and older face criminal charges and a psychosexual evaluation. This CAC has been working in their community to change the mindset of staff about PSB, and it has been helpful to show the benefits of a therapeutic response. However, the main issue is the lack of access to training. This CAC felt the Oklahoma training requirements and the one ½-year waitlist for training deter people. Another issue they have found is that therapists do not want to work with this population. This CAC only has one PSB-CBT therapist in their community and there are no services for children under seven, even in the surrounding communities.

A few people mentioned that an issue with the PSB-CBT learning collaborative is that you cannot scale it up. For example, one CAC, who has used it, felt that it needs to be modified because it is the "gold tier" and it is hard to sustain because of all the requirements, and it is expensive. CACs who received this training mostly received grants from OJJDP and mentioned that without that grant it would be challenging to pay for and sustain the training. They have found that it is hard to keep up with the training requirements for the model and recommend looking at multiple models and that it is not realistic to rely solely on this model. Many people

mentioned that it is still hard to find therapists to attend training even when they have funds for the training.

A number of people mentioned that TFCBT with PSB add on may be a more feasible and realistic way to get treatment in all areas of a state, especially rural areas. As far as **funding** mental health treatment, many CACs mentioned using VOCA funds, County funds, Juvenile Justice, state funds such as Department of Youth Services, United Way, and local foundations to pay for therapy. Several people mentioned that they describe work with YPSB as prevention in grant proposals.

Resolution

Several CACs mentioned they have **informal or formal diversion programs** that are successful, with recidivism rates all around 3%. All programs mentioned that it took time to educate those involved including judges, psychosexual evaluators, and prosecutors on the effectiveness of a rehabilitative focus rather than a punitive one.

Two programs were especially noteworthy because 1) they have been in existence for quite some time, and 2) serve a wide age range of youth. One program, the Juvenile Probation Treatment Program in Montclair, NJ was created about 30 years ago and is a deferred disposition program. It has a 3% recidivism rate 5 years post discharge. Youth may complete treatment as a conditional probationary sentence and upon the successful completion of their probation period may have their charges dismissed. Funding from the program is through the county by the Youth Services Commissioner via family court. The program is not part of the CAC. It is post-adjudication but they are planning on expanding the program to non-court cases. They "scare the parents" that this is the one chance to get their child into treatment. One probation officer supervises all juveniles in the county. This officer talks to parents about treatment and they have 90% participation in the program.

Another CAC developed a diversion program in 2007 because so many youth did not meet the criteria for detention or residential treatment and as a result were not receiving any treatment. This is an intensive outpatient treatment program, the STARS program, which is a sub program of the CAC. For lower risk youth, the judge mandates youth into the program. Higher risk youth go to the juvenile detention center and receive ABSOP – Alabama Based Sex Offender Program. The STARS program serves 10-12 kids a year and is a one-year program, although some stay in the program for 3 years. The program can mandate treatment until the youth is 21 years old. It is in 5-6 CACs out of 25 CACs in AL. Most youth in the program are adjudicated. The difficulty is finding therapists who are trained to work with this population. The program is funded by Alabama Juvenile Justice, the Department of Youth Services and United Way. The program also provides services for parents. After 14 years of providing treatment, the program has a 98% success rate for sexual offenses and over 85% have not been involved with law at all. Participants are followed up to 10 years with law enforcement in order to determine if they have committed further sexual offenses.

Other Lessons Learned

The age of children served varied, with many programs only focused on children 12 and younger. Several people said it is easier to **start gradually** and get buy in to serve younger children first before moving to serve adolescents. Few programs served the entire age range of children, especially initially. All the CACs that received training on the OK collaborative mentioned that the work conducted to obtain community buy in initially was valuable to starting to shift the mindset from punitive to rehabilitative. Several people said it was valuable to identify who will be the **cheerleader for the program**. At least four CACs mentioned they either have MDT sub-committees that include people from the state or have workgroups focused on this population. One CAC mentioned that it was important to have a "community change team." One program invested in two champions among the detectives who can then advocate for the services to the other detectives.

A number of programs have **specialized professionals**, such as specialized probation officers and prosecutors, to work specifically with this population. A number of programs have specialized therapists that work solely with this group.

In Summary, a number of innovative CAC programs exist working to improve the response to YPSB. Key attributes of successful programs related to assessment include comprehensive outreach to educate all professionals, deciding what is feasible to accomplish and changing objectives based on the climate and stakeholders, and focusing on legislation and how these cases are referred to agencies. Key attributes of therapy include taking the time to educate therapists about working with this population before offering training to therapists, offering multiple therapeutic options, and starting with children 12 and younger first. Other aspects of successful programs included developing informal or formal diversion programs, starting gradually, having a cheerleader for the program, and having specialized professionals who work with this population.

Recommendations to Improve the Response to YPSB

The online survey and phone interviews with professionals in NH paint a clear picture of a response system to YPSB in need of improvement. A useful tool from the University of Oklahoma Problematic Sexual Behavior – Cognitive Behavior Treatment Community Readiness Guide outlines key topics, considerations and suggestions related to agency readiness and factors that impact success in providing the PSBCBT Program (for more information see Silvosky et al., 2014). The elements they suggested assessing are:

- Referral sources and process -----"Successful programs start serving children with problematic sexual behavior as quickly as possible after the clinical training. This is most likely to occur when agencies already have existing referrals of children with problematic sexual behavior (or referral sources). Collaborative relationships with child protective services, child advocacy centers, schools, law enforcement, and juvenile

justice (particularly if you are serving older youth) are key to sustainable programming." (pg.3)

- Community collaboration -----"Agencies that are able to implement and sustain the PSB-CBT model typically have strong working relationships with community partners that already serve children with problematic sexual behaviors, such as child welfare, juvenile justice, child advocacy centers, law enforcement, and the schools." (pg. 5)
- Caregiver participation -----"Agencies that are able to successfully implement and sustain the PSB-CBT model have strong caregiver involvement in the treatment program. In fact, caregivers are required to attend and participate in each group session." (pg.7)
- Previous success with Evidence-Based Practices -----"Agencies which are successful in implementing the PSB-CBT model often have experience in and have successfully implemented and sustained other evidence-based treatments for children and their caregivers." (pg. 9)
- Assessments -----"Agencies that are able to sustain the PSB-CBT program utilize empirically-supported assessments throughout services to develop the initial treatment plan, evaluate progress in treatment, improve services, and guide treatment decisions, and treatment outcomes." (pg.11)
- Logistics-----"Agencies that are able to sustain the PSB-CBT program have been able to successfully address logistical concerns associated with providing a group treatment program in the community." (pg.13)
- Family/Cultural considerations -----"Agencies that are able to sustain the PSB-CBT program are generally knowledgeable about the families they will serve in their community and they carefully consider familial and culturally relevant topics prior to implementing a new program." (pg.15)
- Sustainability-----"Sustainability includes: (a) funding for the services; (b) funding for outreach and community collaborations; (c) personnel committed to maintaining the program; and (d) within-agency trainers to support sustaining and expanding the program." (pg.17)

Based on conversations with professionals in NH and across the country working in this area, we have identified five recommendations to improve the response to YPSB in NH. To better understand how NH is responding to this population, multidisciplinary professionals were invited to participate in an online survey and were asked to grade how NH is doing for each recommendation and to identify what would help achieve the recommendation. Participants (N=37) included CAC professionals, law enforcement, DCYF, mental health, and other professionals such as juvenile probation officers. Below we summarize themes from these professionals on how to help achieve an A for each recommendation. See Appendix G for all suggestions by professionals.

Recommendation #1: Educate everyone involved **Grade: C**

One of the most consistent themes from talking to CACs across the country was to take the time to educate everyone involved so that everyone understands when and how therapy is beneficial. Many CACs said not to underestimate the amount of outreach needed to change perspective and increase diversion. In addition to educating law enforcement officers, this includes educating school professionals, juvenile justice psychosexual evaluators, JJPO, prosecutors, and judges. MDT members should be able to differentiate between sexually reactive behavior and sexual initiation. Several JJPOs we talked to in NH said they received no training in this area.

Before offering training to therapists, we heard that it is important to take time to educate therapists about working with this population. Many people we talked to said that therapists think they do not want to work with this population and that it takes time to understand this population. We heard some programs received grants for training and trained therapists first, but then did not have any referrals because of lack of understanding and buy in from team members.

What NH professionals working in the field believe would help achieve an A in educating everyone involved:

- Require a "juvenile academy": a training course for police, prosecutors, MDT members, school guidance counselors, judges, and juvenile justice professionals
- Dedicate resources to support educational materials, such as webinars and online resources
- Establish annual outreach and education that is supported by the Attorney General's office, County Attorneys, and DHHS

Recommendation #2: Designate a lead agency and have a community response protocol in place

Grade: C-

Many professionals working with population in NH mentioned that these reports were being screened out, especially for out-of-home cases. We heard that youth are not receiving any services and that "We see a revolving door with these kids." Successful strategies at CACs were to establish one lead agency for these cases. NCAC's recent report as well as NCA's Best Practices on this topic clearly describes that the MDT approach and the CAC model as best practice for responding to children with PSB (https://learn.nationalchildrensalliance.org/psb, Sites & Widdifield, 2020). We heard that counseling is less likely to occur unless there is an agency to oversee this and can help engage caregivers and explain the benefits of therapy. Research consistently demonstrates that community-based interventions with a rehabilitative

focus for adolescents with PSB produce more positive outcomes at a fraction of the cost of incarceration-based strategies.

What NH professionals working in the field believe would help achieve an A in designating a lead agency and having a community response protocol in place:

- Attorney General's Office designates lead agency and standardizes protocol
- Incorporate National Children's Alliance Best Practices for YPSB, including creating MOUs across agencies

Recommendation #3: Create a committee focused on this issue **Grade: C-**

Several CACs across the country have statewide or local committees, whereas others have invested in local cheerleaders on this issue across each discipline. Others have specialized probation officers, specialized therapists, and specialized prosecutors. One program invested in two champions among the detectives who can then advocate for the services to the other detectives. Some programs have MDT sub-committees focused on PSB. Some online survey participants mentioned the need to create dedicated workers across agencies to work on these cases.

What NH professionals working in the field believe would help achieve an A on this issue:

- Provide funding and time to develop statewide committee(s)
- Dedicate resources and training to a few representatives from all disciplines and build from this core group

Recommendation #4: Establish and expand specialized mental health services **Grade: C-**

One of the most consistent themes was to establish easy and straightforward paths to therapy. Many CACs provide the link to treatment for initiators and victims of PSB. Some CACs mentioned working with local universities and using tele-therapy to increase access to therapists. We heard an important part of engaging families with therapy is having a clinical supervisor/case manager who can understand barriers to therapy and educate families about the benefits of therapy. Successful CACs expect resistance from caregivers and take time to work with caregivers such as using motivational interviewing. Another successful strategy working with caregivers was reassuring them that arrest was not the goal; behavior change was, and that therapy could help avoid this behavior in the future. Several CACs suggested

starting gradually and mentioned that it is easier to get buy-in to first serve younger children before moving to serve adolescents.

Some of the professionals we talked to in NH said that it is important to recognize that the family is experiencing a crisis. Rather than give them a referral that may have a wait list or not really fit what they need, it is more beneficial to have a list of mental health providers who specialize in this area and meet the family where they are with understanding the benefits of therapy. Several CACs across the county mentioned the need for multiple treatment models. Some said that it is not feasible to scale up the Oklahoma learning collaborative and that TFCBT with PSB add on may be a more feasible way to scale up.

What NH professionals working in the field believe would help achieve an A in establishing and expanding specialized mental health services:

- Invest in specialized training and education
- Provide support to community mental health services

Recommendation #5: Establish a diversion program **Grade: D+**

Several CACs mentioned they have informal or formal diversion programs that are successful, with recidivism rates all around 3%. Many CACs said there has been a shift to more diversion over time as people learned about the effectiveness of a rehabilitative focus rather than a punitive one. Some noted success with requiring probation officers to be active participants in developing assessment-based individualized case plans. The emphasis is to make access to treatment as easy as possible and to equip courts and communities to intervene effectively with individualized, family-focused services and supervision. It is important to develop protocols that provide for pre-adjudication evaluation to inform decision-making and to ensure that evidence-based treatment is broadly available regardless of adjudication status.

What NH professionals working in the field believe would help achieve an A in establishing a diversion program:

- Provide resources and training to establish evidence-based programs
- Establish clear response protocols with time frames

In conclusion, one of the most consistent comments we heard from professionals in NH was that there is little to no state investment in this issue. It was clear that resources and leadership are needed to provide the opportunity for professionals to learn more about this important issue and for professionals to receive specialized training so that more youth with problematic sexualized behavior have access to trauma-informed therapy in a timely manner.

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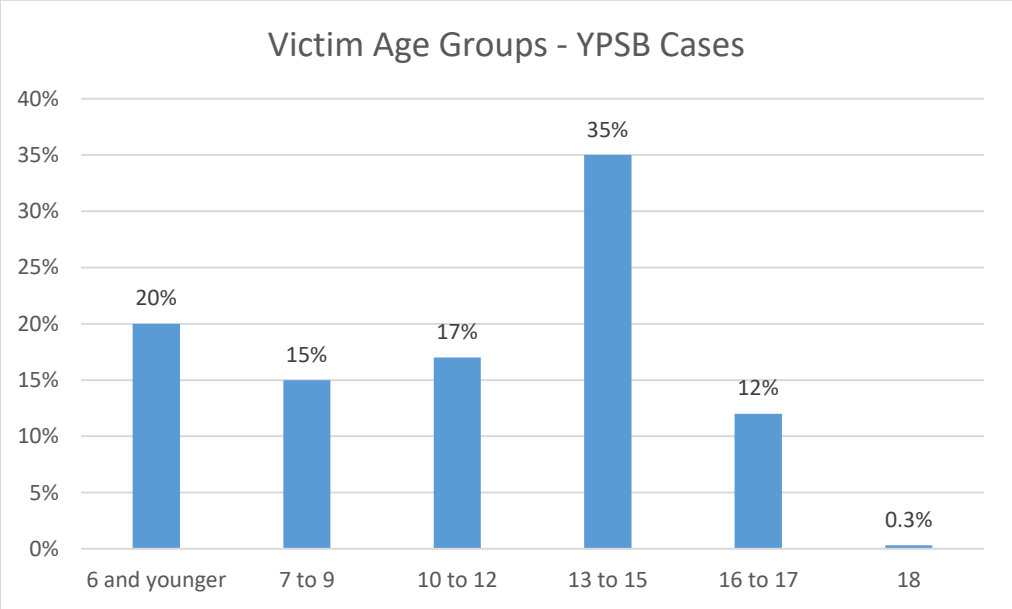
Appendix A: Characteristics of YBSP cases at CACs in NH

Over a three-year time-period (July 1, 2018 to June 30, 2021), CACs in NH were involved with *979 victims* in YPSB cases. This included *1024 initiators* in YPSB cases.

Characteristics of Victims of YPSB Cases[1]

The average age of victims of YPSB cases was 11.1 (standard deviation = 4.1). The youngest was 2 and the oldest was 18. One in five (20%) were 6 or younger, 15% were between 7 and 9, 17% were between 10 and 12, one-third (35%) were between 13 and 15, and 12% were 16 or 17. The majority (75%) of victims of YPSB cases were female.

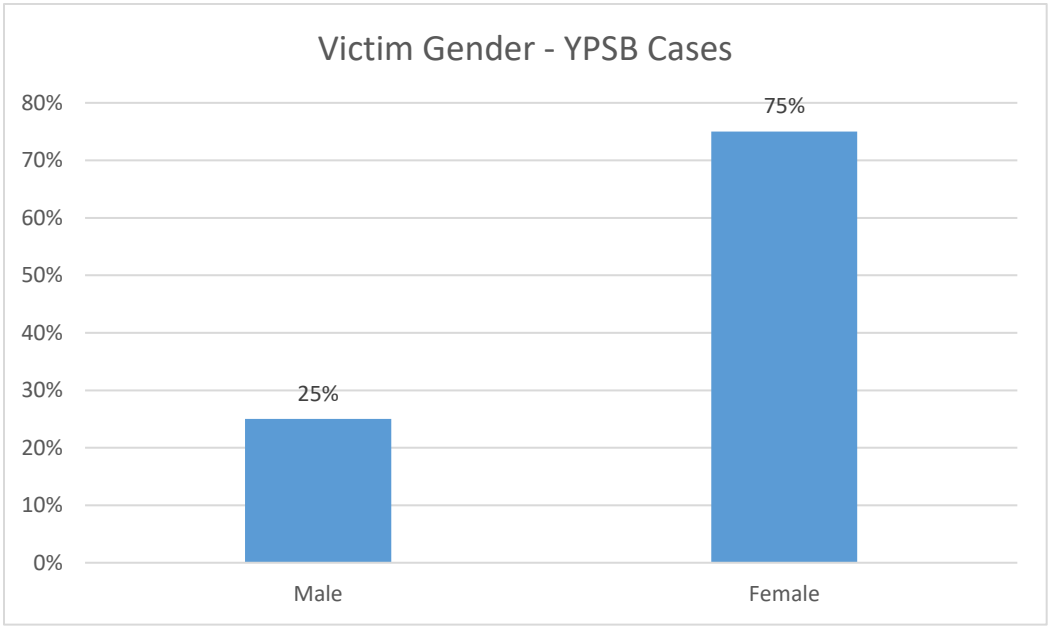


[1] Victim missing data: Age n = 20, Gender n = 11

Number of Victims by Age

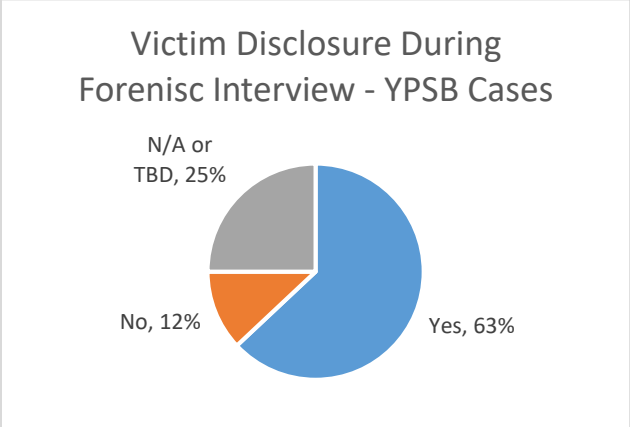
Victim Age – YPSB Cases	Number of Victims
2	1
3	22
4	43
5	64
6	62
7	45
8	51
9	43
10	49
11	53
12	69
13	92
14	123
15	121
16	76
17	42
18	3

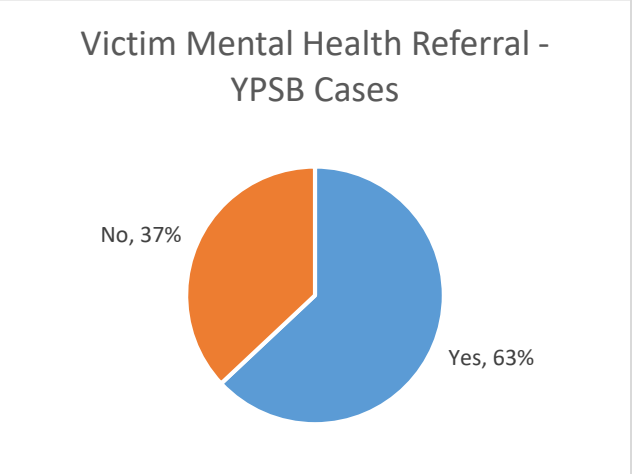
- 192 victims were 6 and younger
- 139 victims were between 7 and 9
- 171 victims were between 10 and 12
- 336 victims were between 13 and 15
- 118 victims were between 16 and 17
- 3 victims were 18



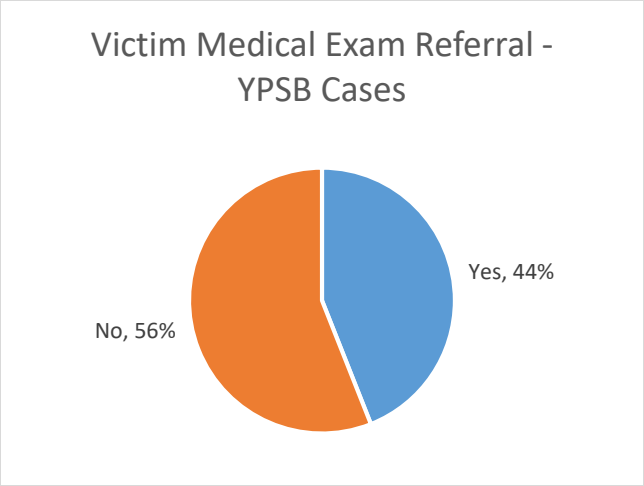
Victim Disclosure and Referral for Services[2]

The majority of victims (63%) in YPSB cases had a disclosure during the forensic interview. About one in ten victims (12%) in YPSB cases did not disclose during the forensic interview. Approximately one-quarter (25%) were N/A or TBD. Two-thirds of victims (63%) in YPSB cases received a mental health referral and 44% received a medical referral.





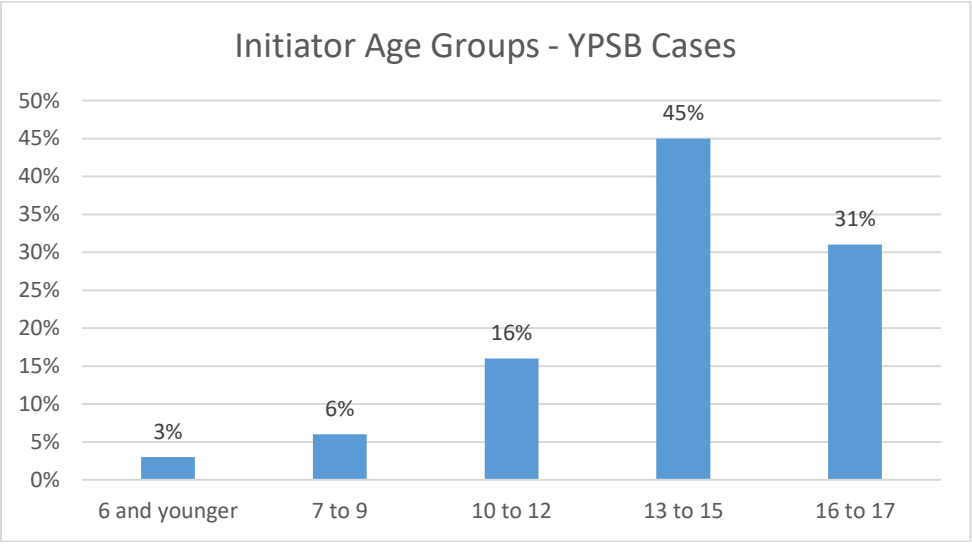
[2] Victim missing data: disclosure n = 10, mental health referral n = 10, medical referral n=10



Age of Initiators of YPSB Cases[3]

The average age of initiators in YPSB cases was 13.0 (standard deviation = 2.8). The youngest was 1 and the oldest was 17. Only 3% were 6 or younger, 6% were between 7 and 9, 16% were between 10 and 12, nearly half (45%) were between the ages of 13 and 15, 31% were between 16 and 17. The majority (76%) of initiators in YPSB cases were 13 or older. Initiators less than 13 had significantly younger victims compared to initiators 13 or older, 7.27 years compared to 12.34 years[4].

Most initiators in YPSB cases were close in age to their victims, with 41% of initiators one year younger to one year older than their victims and 24% of initiators were 2 to 3 years older than victims were.

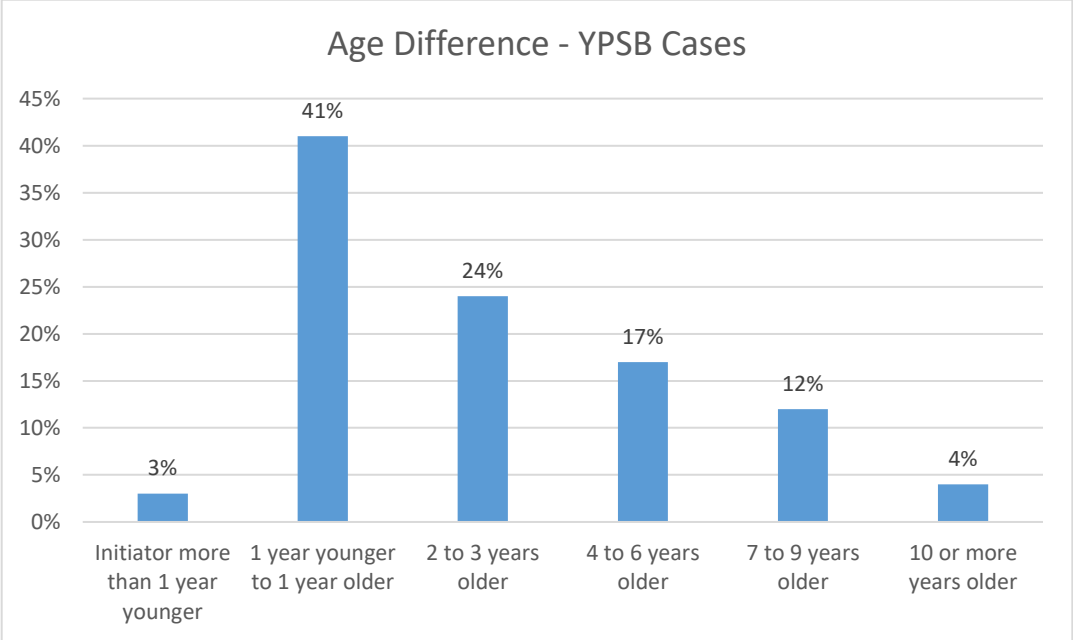


[3] Initiator missing data: age n = 1, gender n = 9, relationship n = 3, same household n=11
[4] $t(1009) = 20.13$, $p = .0001$

Number of Initiators by Age

Initiator Age – YPSB Cases	Number of Initiators
1	1
2	0
3	1
4	2
5	6
6	17
7	19
8	21
9	20
10	22
11	49
12	92
13	119
14	162
15	174
16	153
17	165

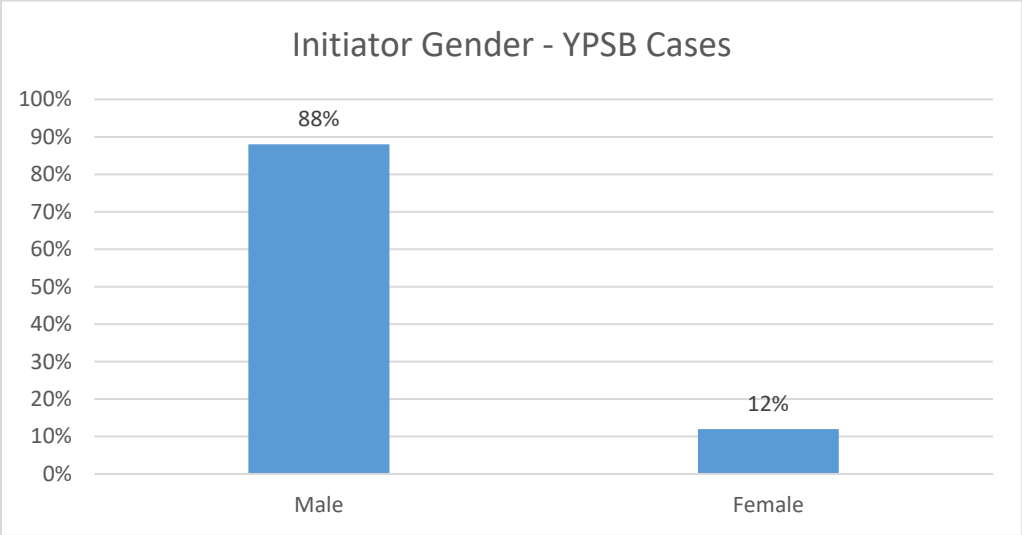
- 27 initiators were 6 and younger
- 60 initiators were between 7 and 9
- 163 initiators were between10 and 12
- 455 initiators were between 13 and 15
- 318 initiators were between 16 and 17

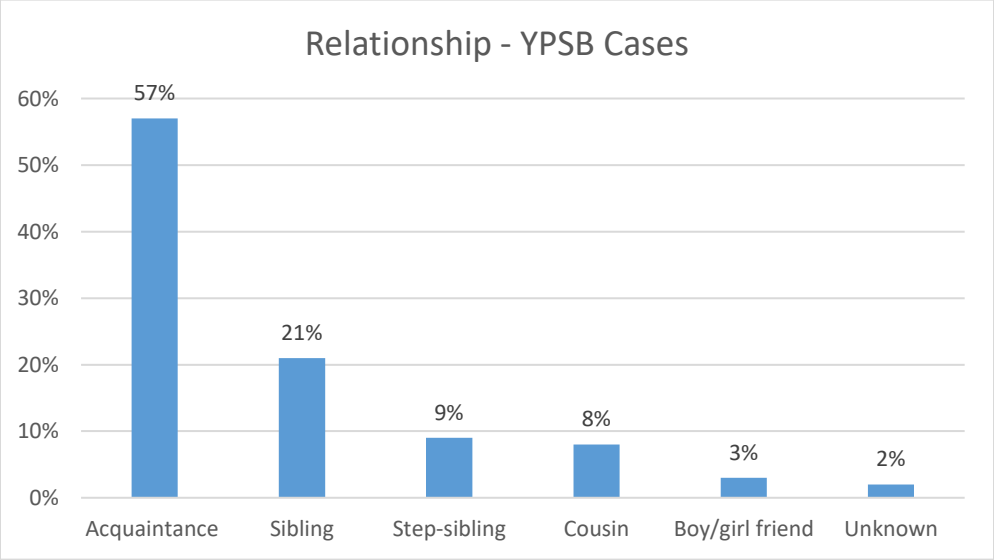


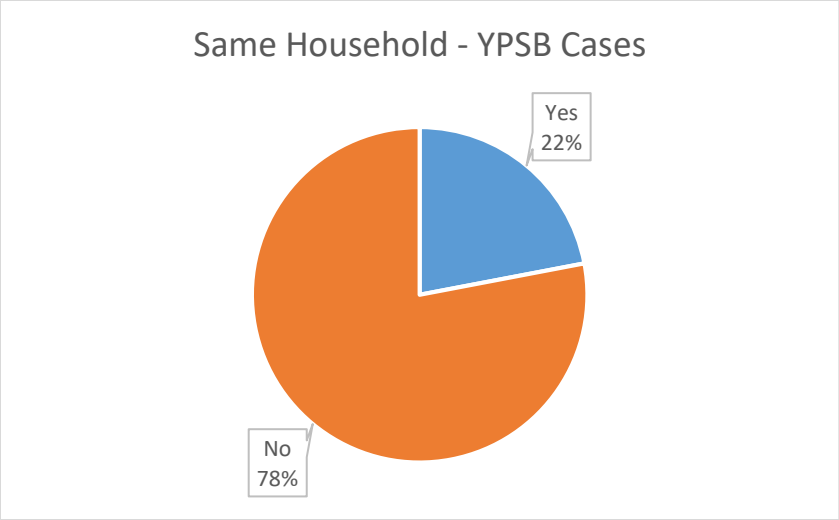
- 27 initiators were more than 1 year younger than victims
- 410 initiators were 1 year younger to 1 year older
- 245 initiators were 2 to 3 years older
- 175 initiators were 4 to 6 years older
- 116 initiators were 7 to 9 years older
- 38 initiators were 10 or more years older

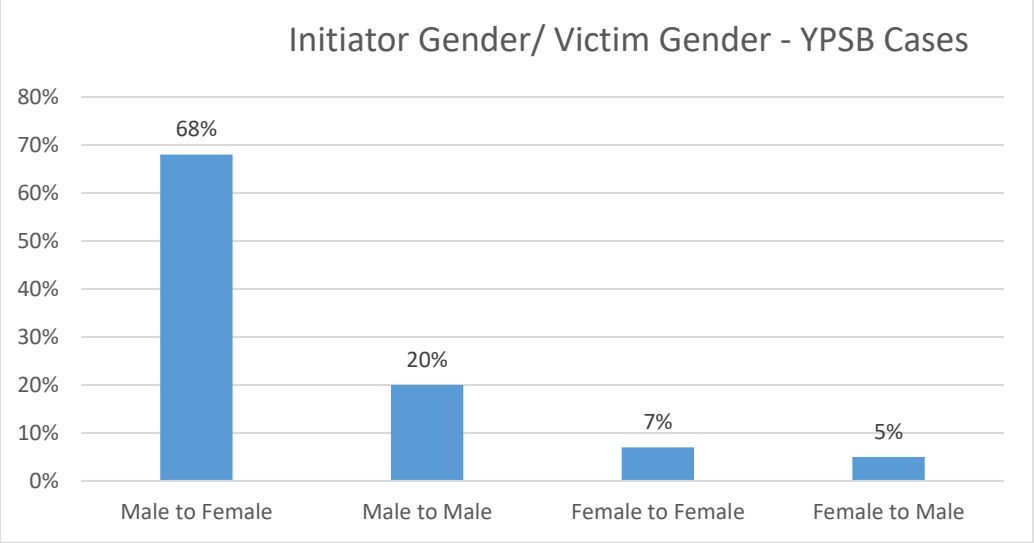
Characteristics of Initiators of YPSB Cases

The majority (88%) of initiators were male. Just over half (57%) of initiators in YPSB cases were acquaintances and 21% were siblings. One in five (22%) of initiators lived in the same household as victims. Approximately one quarter (27%) of YPSB cases had same sex initiators and victims. Most cases (68%) were male initiator to female victim, 20% were male initiator to male victim, 7% were female initiator to female victim, and 5% were female initiator to male victim.









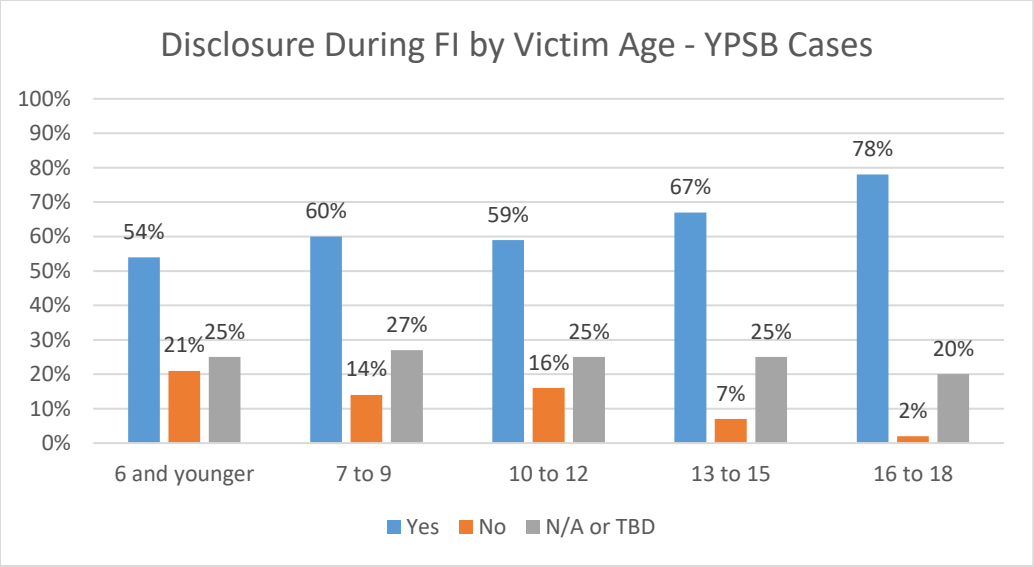
Is Disclosure Related to Case Characteristics?

Overall, 63% of victims in YPSB cases disclosed during a forensic interview; this is similar to the disclosure rate overall at CACs in NH. It is important to keep in mind that disclosure is often a process and may take time to occur.

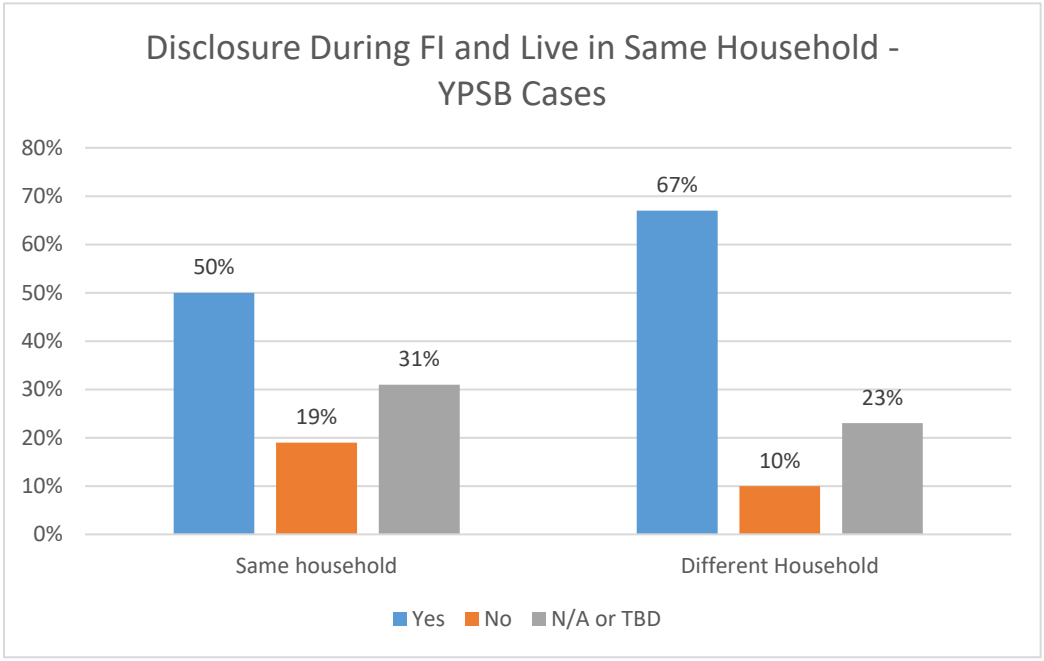
- There was no significant difference in disclosure whether the initiator was 13 and older or younger than 13[5].
- There was no significant difference in disclosure when the victim and initiator were the same or different gender[6].

[5] X^2 (2, N = 1022) = 3.979, $p > .05$.
[6] X^2 (2, N = 1021) = 4,767, $p > .05$.

- Older victims of YPSB were significantly more likely to disclose during a forensic interview than younger victims, with 78% of victims aged 16 to 18 disclosing compared to 54% of victims aged 6 and younger[7].



- Victims in YPSB cases living in different households than initiators were significantly more likely to disclose during a forensic interview (67%) compared to those living in the same household as the initiator (50%)[8].



[7] X^2 (8, N = 1010) = 44.004, p < .001.
[8] X^2 (8, N = 1010) = 44.004, p < .001.

Additional Data

During a one-year period, from July 1, 2020 to June 30, 2021, CACs collected additional information on 265 YPSB cases. There are a number of limitations about this additional data that need to be kept in mind. First, this additional information was not collected on a consistent basis for all YPSB cases. Second, even when CACs submitted these additional forms the extent to which there was missing data for these variables varied tremendously, with between 2 to 131 questions missing information. Therefore, this additional data should be considered exploratory.

- Of the 263 cases with data, nearly one-third (29%) had multiple victims.
- Of the 255 cases with data, one-third (33%) had initiator interviews requested.
- Of the 83 with initiator interviews requested, 82% were completed.
- Of the 134 cases with data, 25% of initiators were also prior victims.
- Of the 195 cases with data, 34% had a mental health referral for the initiator and 7% of initiators were already in counseling.

Caregivers' Reaction. As part of this additional data collected during a one-year period, we asked CAC staff to complete an open-ended question about the caregivers'reaction. Most comments said caregivers were supportive, protective, and appropriately concerned, while others noted that caregivers were upset, felt guilty that they did not know or had a difficult time accepting the reported information or were dismissive.

Comments below highlight examples of the range of caregiver's reactions as reported by CAC staff.

Supportive. Many caregivers were appropriately supportive (but sometimes only one caregiver was when there were two caregivers for one youth.)

> *Appropriately concerned. Reached out for assistance and connected their child with community resources.*
>
> *Both parents came and acted very appropriately.*
>
> *Very concerned and appropriate.*
>
> *Supportive.*
>
> *Mom was upset but appropriate. Dad did not believe anything happened.*
>
> *All caregivers were supportive and wanted to make sure initiator got help needed to prevent future behaviors.*

Upset

Upset and protective.

Caregiver was very upset looking for assistance how to deal with situation.

Caregiver was feeling very overwhelmed and feeling helpless and lost.

Shocked or conflicted. Caregivers felt distress, guilt, self-blame, were skeptical, and afraid DCYF would remove their child.

Caregiver was deeply distressed, lots of self-blame and wanted team to know she was unaware of abuse and was afraid DCYF would remove her child.

Parents were upset and worried that they had done something wrong. Relieved when they heard it was only a one-time incident.

Shocked, defensive of initiator, and not understanding this could happen.

Shocked and feels guilty did not know about it.

Parents expressed fear of DCYF removing the kids and were adamant at the CAC that it was not a problem because they supervised the kids.

Very overwhelmed and feeling helpless and lost.

Parents were concerned their son would now have a record and didn't want to believe the allegation.

Caregiver had difficult time accepting the reported behavior.

Caregiver of victim was hesitant about informing parent of initiator because she did not want to put stress on their family.

Dismissive. Some caregivers were defensive and dismissive.

Mom reported that she had spoken to her son and one of the victims and that the issue was addressed. She declined to allow her son to be interviewed.

Dismissive and angry for victim "disrupting" the home. Victim went to live with grandparents.

Concerned but thinks it was boys being curious about body parts.

Mom defensive and blames victim.

Caregiver believes sexual touching was more experimental instead of sexual assault because child did not say no. Sexual assault was term child used when she talked to school.

Caregiver had experienced recent trauma and did not discourage consensual sexual relationship.

Caregiver upset they put safety procedures in place.

Disbelief and blamed the other juveniles involved.

A second open-ended question asked about **other relevant information.** When staff completed this question, comments ranged from the fact that there is an ongoing law enforcement investigation, to describing characteristics of the case, to mental health struggles for the victim, to the fact that there was no disclosure.

<u>Ongoing law enforcement investigation.</u>

Initiator did confess to this and others. He will be arrested by police.

Ongoing PD involvement.

Planning to file statutory charges has prior juvenile victim.

Law enforcement looking at report of other possible victims.

<u>Characteristics of the case.</u>

Family is upset that boys will get away with it since all under 18 and are very upset.

Similar aged cousin and victim feels as though nothing will happen to him because a teen too. Mental health struggles for victim.

Both victim and initiator interviewed at the CAC before. Initiator in system multiple times. Team has concerns how parents are reacting based on multiple involvement with the system.

16-year-old male comes from a broken home had been invited to victim's family to hangout to get to do different things. On multiple occasions told victim they should kiss and be boy/girlfriend. Victim would say no we can't. Victim disclosed multiple assaults.

Victim was threatened with release of her pictures if she didn't comply with initiator's request.

Victim reported sexual activity was consensual.

15-year-old past boyfriend of 14-year-old victim pressured her into having intercourse two times.

Mental health struggles for the victim.

Victim hospitalized for suicidal ideation and other struggles several months after assault, later disclosed sexual assault by brother and father during therapy.

Mental health struggles for victim, very worried about information getting to friends, feels she would not be believed.

Mental health struggles due to victim safety at school.

No disclosure.

Initiator disclosed to JPPO and stepmother that he sexually abused his little sister a year ago, then recanted. Victim did not disclose.

Initiator disclosed to JPPO and stepmother that he sexually abused his little sister a year ago, then recanted. Victim did not disclose.

A sibling case and victim in the interview just kept saying "he didn't touch me today" but would not give any more details. Both children described to be lower functioning.

Child did not want to talk about touching at all at the CAC.

No disclosure but family had prior confirmed case with DCYF that touching was happening. Victim did want to appear to cause more trouble for mom.

Victim is autistic and declined to speak because "he didn't want to upset anyone" both were under influence of alcohol during incident.

These reflections by CAC staff highlight how complex these cases can be.

Appendix B: Characteristics of YBSP cases at DCYF in NH

DCYF created two reports for this project – the first included YPSB cases from January 1, 2019 to June 30, 2020, the second included YPSB cases from January 1, 2020 to June 30, 2021.

STATE OF NEW HAMPSHIRE

Department of Health and Human Services
Division for Children, Youth and Families 12/18/2020

Introduction

This data request has been prepared with information around Youth with Problematic Sexualized Behaviors (YPSB). All information is anchored on dates occurring from January 1st 2019 through June 30th 2020. Masking on different levels is used when counts are low to protect privacy. This data was prepared in response to your specific requests, and should not be generalized to answer other questions, even if similar to this request, given the complexity of these measures.

Reports Received at Central Intake Jan. 1st 2019 – Jun. 30th 2020

The table below provides base information around accepted reports received at Central Intake where an alleged perpetrator was aged 17 or under on the date the referral was received and was linked with allegations of sexual abuse.

Count Accepted Referrals	Count Unique Alleged Perpetrators	Count Unique Alleged Victims
164	153	185

Of those accepted reports, the alleged victims can be categorized into the below age group withcounts:

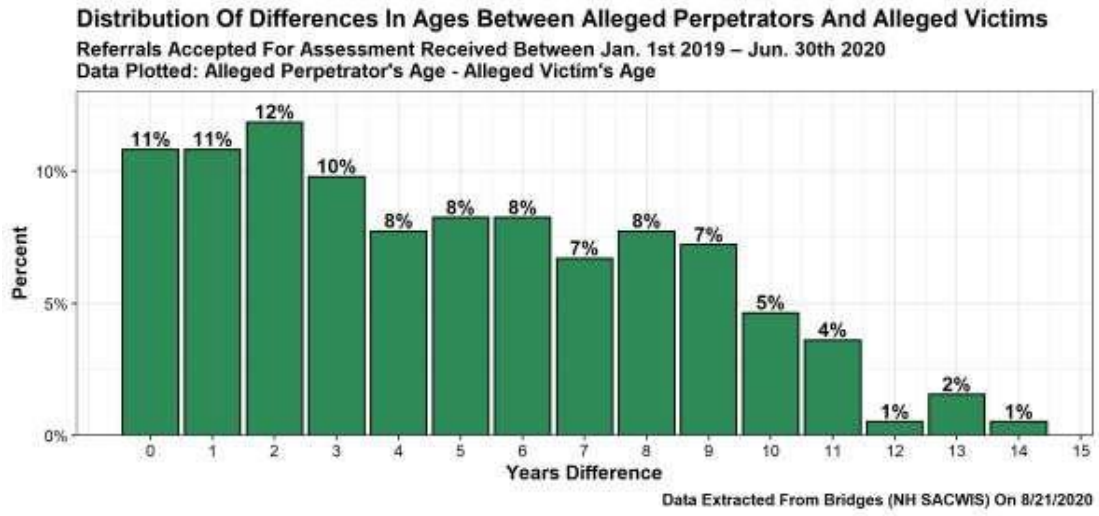
Alleged Victims By Age	Count
0	Less Than 5
1	Less Than 5
2	Less Than 5
3	7
4	13
5	17
6	13
7	15
8	13

Alleged Victims By Age	Count
9	13
10	18
11	14
12	13
13	15
14	12
15	13
16	5
17	Less Than 5

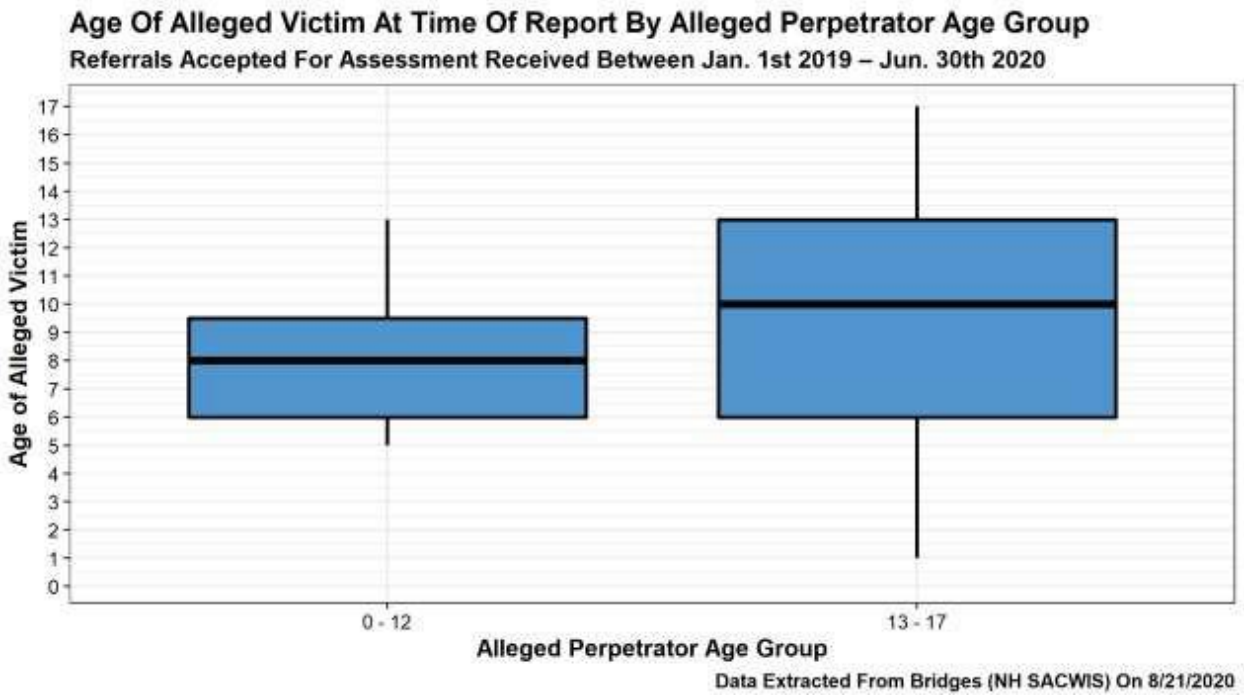
Of those reports, the alleged perpetrators can be categorized into the below grouping:

Alleged Perpetrators By Age	Count
Less Than 12	4
12	16
13	35
14	30
15	23
16	24
17	22

The plot shown below expresses the absolute value difference in the ages of the alleged perpetrators and their alleged victims across all age groups. Just over 50% of the incidents have age differences at four years or less apart.



The boxplot below can be used to describe the distribution of alleged victim ages at the time theaccepted report was received at Intake. The plot is split by the ages of the alleged perpetrator groups; 0 – 12 and 13 – 17. For the 0 – 12 age range for alleged perpetrators, the median age of the alleged victim was 8, while the interquartile range was between 6 and 9.5. For the 13 – 17 age range for alleged perpetrators, the median age of the alleged victim was 10, while the interquartile range was between 6 and 13.

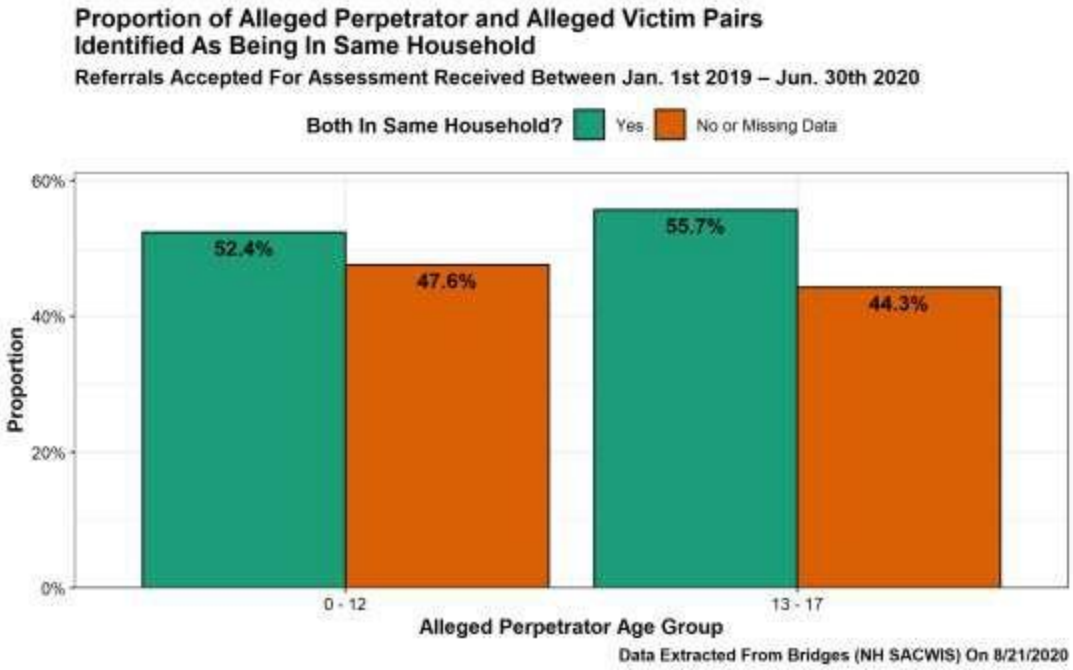


The table below provides information for household makeup of the alleged perpetrators:

Alleged Perpetrators Living in Household of Referral		
	Count	**Proportion**
Yes	89	55%
No or Missing Data	72	45%

For a majority, the alleged perpetrator resided in the same household as the alleged victim or victims. (This figure may be higher, but due to missing data, we cannot make stronger statements.)

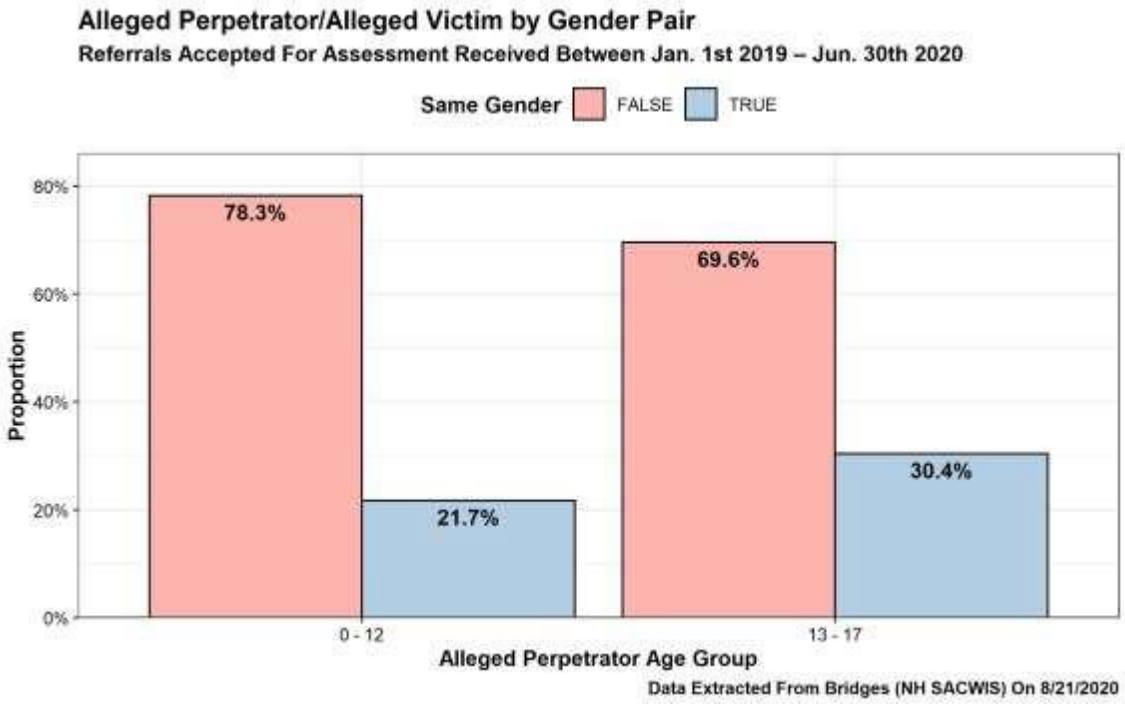
The chart below shows the proportion, split by the age 0 – 12 and 13 – 17 grouping for alleged perpetrators. A nearly similar distribution is observed and any differences do not appear to be statistically significant based on the data collected. (Fisher's Exact Test for count data was performed comparing the two alleged perpetrator age groups (p-value = 0.82) for the null hypothesis of no difference between groups.)



The table below provides data around gender pairs between the alleged perpetrators andalleged victims.

Count of Alleged Perpetrator/Alleged Victim by Gender Pair	
Same Gender	**Different Gender**
57	137

The chart below looks at the gender pair relation between the 0 – 12 and 13 – 17 alleged perpetrator age groups. Despite some variation between the groups, given the data collected,the differences are not statistically significant.(Fisher's Exact Test for count data was performed comparing the two alleged perpetrator age groups (p-value = 0.47) for the null hypothesis of no difference between groups.)



Reports Founded Jan. 1st 2019 – Jun. 30th 2020

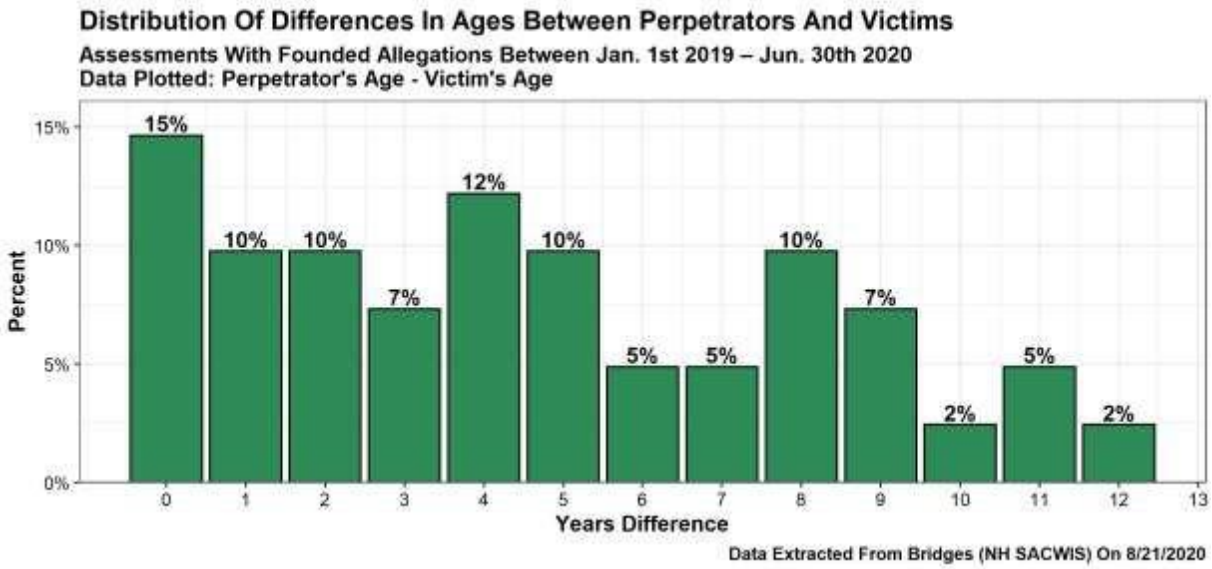
Below is a table summarizing counts from assessments that have findings documented in NH Bridges during the period under review.[4] (These assessments may have been received prior to Jan. 1, 2019.) The table displays counts for assessments where the perpetrator was aged 17 or under on the date the referral was received at Central Intake and was a finding of sexual abuse:

Count Founded Assessments	Count Unique Founded Perpetrators	Count Unique Founded Victims
34	35	39

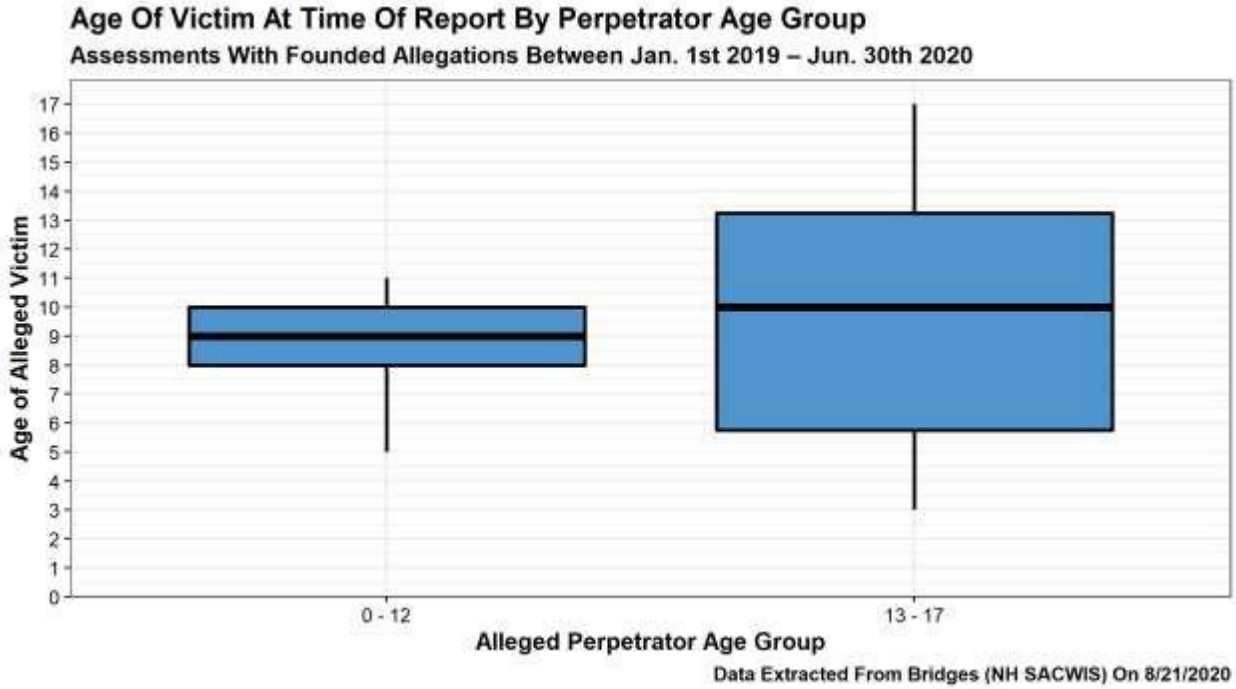
Of those assessments with findings, the victims can be categorized into the below age groupwith counts:

Founded Victims by Age	Count
0 - 12	8
13 - 17	31

The plot shown below expresses the difference in the ages of the perpetrators and their victims:



The boxplot below can be used to describe the distribution of alleged victim ages at the time the accepted report was received at Intake. The plot is split by the ages of the alleged perpetrator groups: 0 – 12 and 13 – 17. For the 0 – 12 age range for alleged perpetrators, the median age of the alleged victim was 9, while the interquartile range was between 8 and 10. For the 13 – 17age range for alleged perpetrators, the median age of the alleged victim was 10, while the interquartile range was between 6 and 13.25.



YPSB Prior History – Assessments as Alleged Victims or Victims

Tracking the histories of the 35 perpetrators reveals that a number of them (13 out of 35) have been alleged victims or victims in prior DCYF assessments before their finding as a perpetratorlisted above. A majority of these assessments were from alleged victims of sexual abuse. None of the allegations with a finding where they were alleged victims were specific to sexual abuse allegations.

YPSB Perpetrator With Prior Involvement in DCYF Assessments as Alleged Victim	Total Count of Assessments for YPSB Group as Alleged Victims	YPSB Perpetrator With Prior Involvement in DCYF Assessments as Alleged Victim With Sexual Abuse	Total Count of Assessments with at Least One Allegation of Sexual Abuse with the YPSB as Alleged Victim	Number of YPSB With Findings on Allegations Where They Were Alleged Victims
13	51	8	10	Less Than 5

For the 13 youth with prior involvement, the mean number of months from their last assessment as victims or alleged victims to the receival of the referral where they would subsequently be found to be a perpetrator of sexual abuse is 26 months. The median was 19 months.

YPSB Prior History – Case Involvement: CPS & JJS

Similar tracking can be done for these 35 perpetrators at the case level, both for Child Protection and Juvenile Justice Cases. The case type and bureau cannot be broken down further due to small numbers.

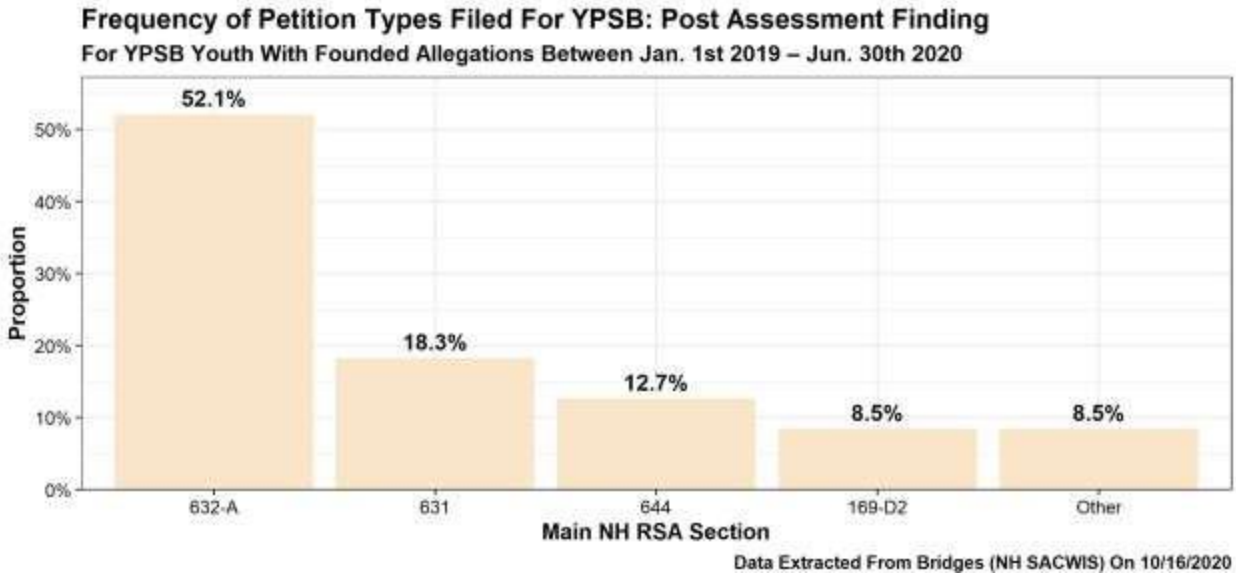
YPSB Perpetrator With Prior Involvement in DCYF Cases As Child (CPS or JJS)	Total Count of Cases for YPSB Group as Children Participating In Case (CPS or JJS)
8	14

Juvenile Justice Involvement Post Finding:

The table below summarizes Juvenile Justice (JJ) Involvement for the 35 perpetrators for casesstarted post finding. The majority were delinquency case types, but the breakdown cannot be provided due to small numbers.

YPSB Perpetrator With Involvement in JJ Cases Post Finding	Total Count of JJ Cases for YPSB Group Post Finding
20	25

The chart below looks at the frequency of petitions filed in court for all the YPSB youth applicable:



The majority of the petitions fall under the Sexual Assault and Related Offenses chapter (632-A)of NH RSA.

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Reports Received At Central Intake Jan. 1st 2020 – Jun. 30th 2021

The table below provides base information around accepted reports received at Central Intake where an alleged perpetrator was aged 17 or under on the date the referral was received and was linked with allegations of sexual abuse.

Count Accepted Referrals	Count Unique Alleged Perpetrators	Count Unique Alleged Victims
154	166	147

Of those accepted reports, the alleged victims can be categorized into the below age group withcounts:

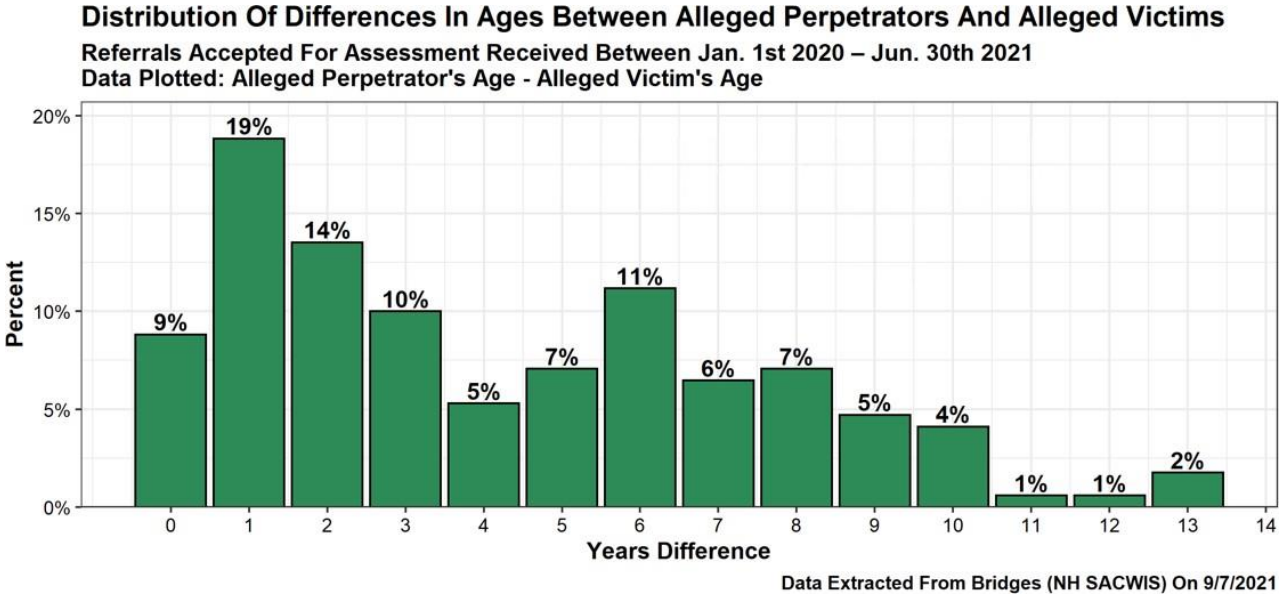
Alleged Victims By Age	Count
0	Less Than 5
1	Less Than 5
2	Less Than 5
3	8
4	7
5	14
6	11
7	9
8	9

Alleged Victims By Age	Count
9	Less Than 5
10	10
11	20
12	14
13	21
14	19
15	13
16	5
17	Less Than 5

Of those reports, the alleged perpetrators can be categorized into the below groupings:

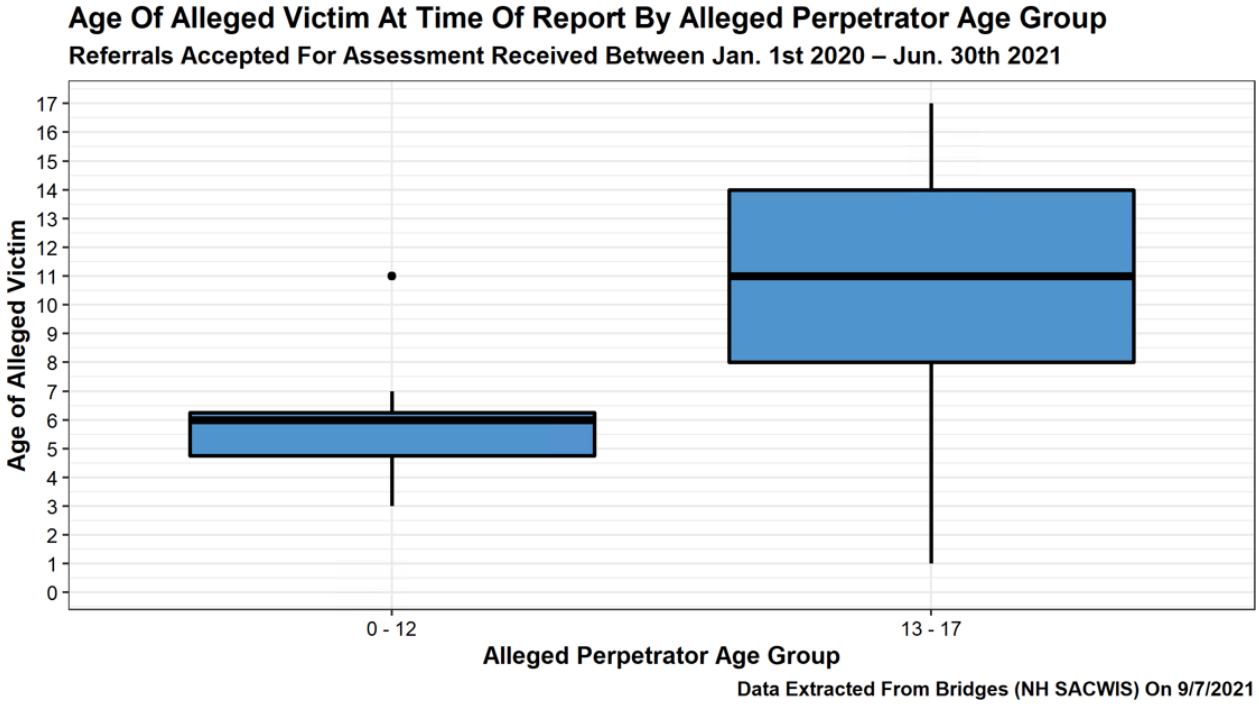
Alleged Perpetrators By Age	Count
Less Than 12	5
12	8
13	25
14	24
15	33
16	25
17	29

The plot shown below expresses the absolute value difference in the ages of the alleged perpetrators and their alleged victims across all age groups. Around 57% of the incidents have the difference in ages at 4 years or less apart, while 75% represents a difference of 6 years or less apart and 26% 7 years or more apart. Compared to the report from January 2019 to June 2020, where 52% had a difference in age of 4 years or less, 68% had a difference of 6 years or less apart and 35% had a difference of 7 years or more apart.



The boxplot below can be used to describe the distribution of alleged victim ages at the time the accepted report was received at Intake. The plot is split by the ages of the alleged perpetrator groups: 0 – 12 and 13 – 17. For the 0 – 12 age range for alleged perpetrators, the median age of the alleged victim was 6 (from 8 on the last report), while the interquartile range was between 4.75 and 6.25 (from 6 - 9.5 in the last report), considerable decrease on Victim's age from last report. For the 13 – 17 age range for

alleged perpetrators, the median age of the alleged victim was 11, while the interquartile range was between 8 and 14 (from 6-13 in the last report). This shows a significant reduction in age of victims for perpetrators on age group 0-12.

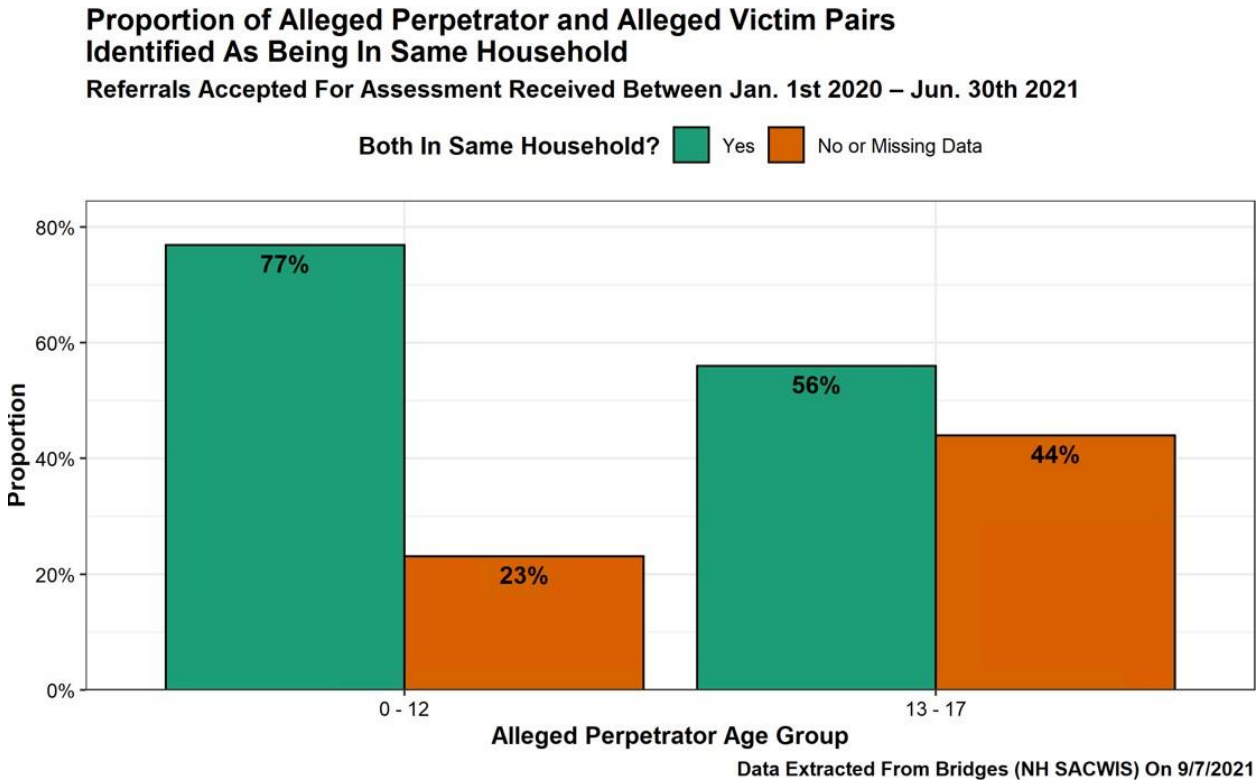


The table below provides information for household makeup of the alleged perpetrators:

Alleged Perpetrators Living in Household of Referral		
	Count	**Proportion**
Yes	89	58%
No or Missing Data	65	42%

For a majority, the alleged perpetrator resided in the same household as the alleged victim or victims. (This figure may be higher, but due to missing data, we cannot make stronger statements.)

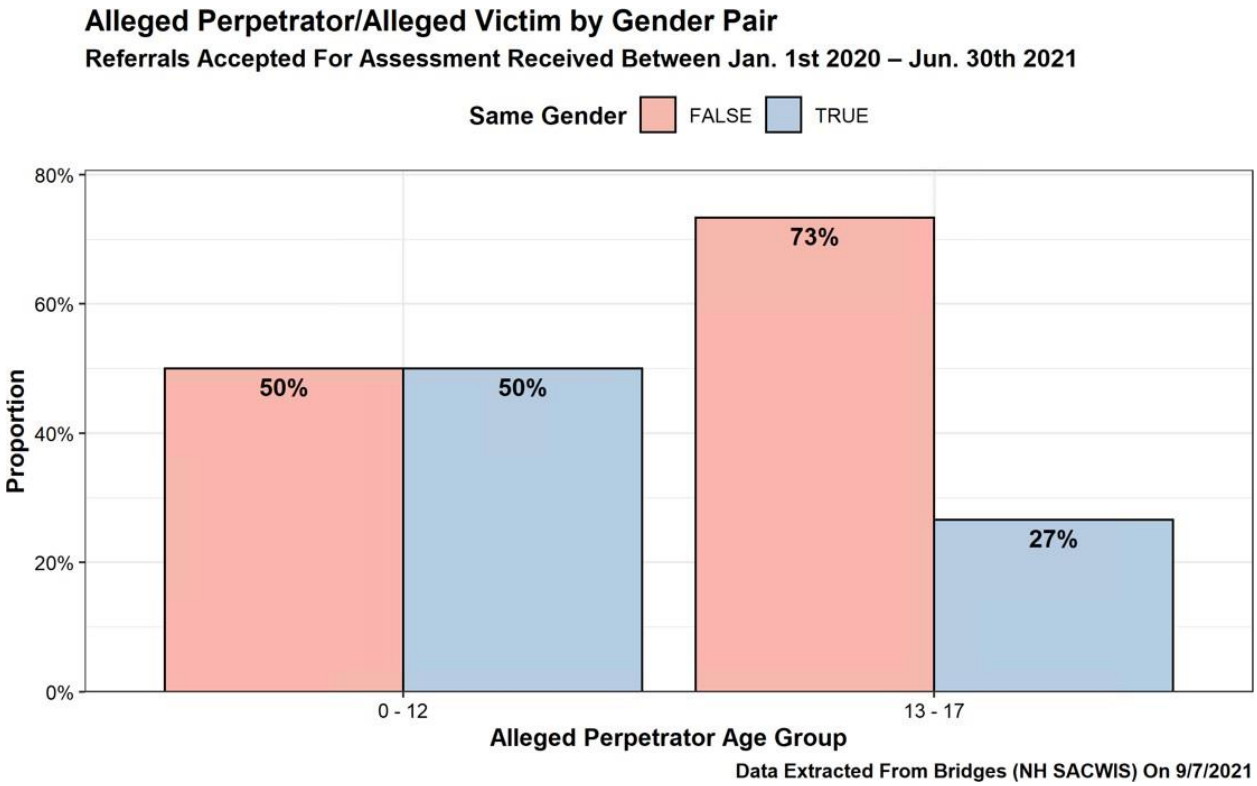
The chart below shows the proportion, split by the age 0 – 12 and 13 – 17 grouping for alleged perpetrators. For 0-12 group we can see a difference, with Perpetrators living in the same household representing a higher percentage in comparison to those who do not live in the samehousehold, or whose information is missing. A nearly similar distribution is observed for the group 13-17. Differences do not show to be statistically significant based on the data collected. (Fisher's Exact Test for count data was performed comparing the two alleged perpetrator age groups, p-value=0.95 for the null hypothesis of no difference between groups.)



The table below provides data around gender pairs between the alleged perpetrators and alleged victims.

Count of Alleged Perpetrator/Alleged Victim by Gender Pair	
Same Gender	**Different Gender**
49	121

The chart below looks at the gender pair relation between the 0 – 12 and 13 – 17 alleged perpetrator age groups. Despite some variation between the groups, given the data collected,the differences are not statistically significant. (Fisher's Exact Test for count data was performed comparing the two alleged perpetrator age groups, p-value=0.53 for the null hypothesis of no difference between groups.)



Reports Founded Jan. 1st 2020 – Jun. 30th 2021

Below is a table summarizing counts from assessments that have findings documented in NH Bridges during the period under review. (These assessments may have been received prior to Jan. 1, 2020.) The table displays counts for assessments where the perpetrator was aged 17 or under on the date the referral was received at Central Intake and was a finding of sexual abuse:

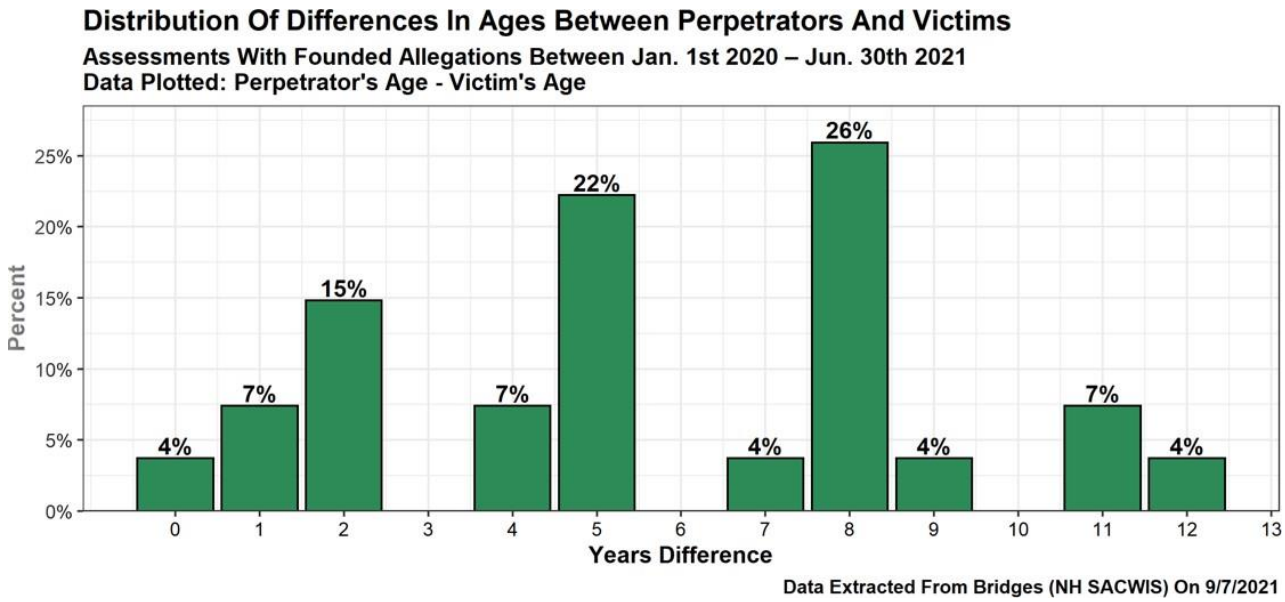
Count Founded Assessments	Count Unique Founded Perpetrators	Count Unique Founded Victims
26	24	26

Of those assessments with findings, the victims can be categorized into the below age groupwith counts:

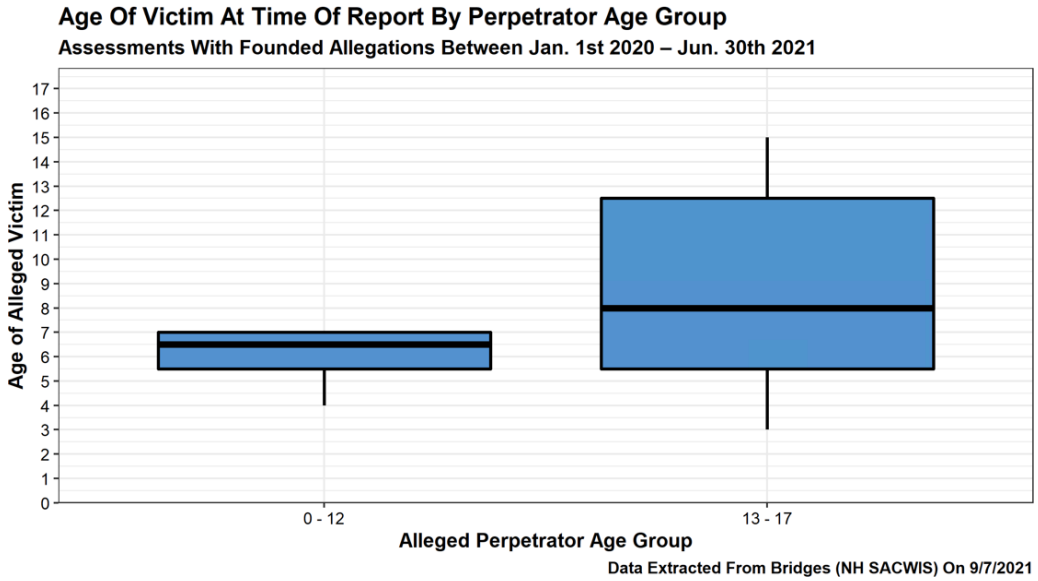
Founded Victims by Age	Count
0 – 12	21
13 - 17	6

There has been a considerable increase in substantiated allegations for the 0-12 years old group,from 8 (last report) to 21, while 13-17 has shown a considerable decrease, from 31 (last report) to 6. Together with the data above presented, this reinforces the fact that victims' ages have decreased considerably.

The plot shown below expresses the difference in the ages of the perpetrators and their victims:



The boxplot below can be used to describe the distribution of alleged victim ages at the time the accepted report was received at Intake. The plot is split by the ages of the alleged perpetrator groups; 0 – 12 and 13 – 17. For the 0 – 12 age range for alleged perpetrators, the median age of the alleged victim was 6.5, while the interquartile range was between 5.5 and 7 (prior report 8-10). For the 13 – 17 age range for alleged perpetrators, the median age of the alleged victim remained 8, while the interquartile range was between 5.5 and 12.5, not a considerable difference from the last report.



YPSB Prior History – Assessments As Alleged Victims or Victims

Tracking the histories of the 24 perpetrators reveals that a number of them (12 out of 24) have been alleged victims or victims in prior DCYF assessments before their finding as a perpetratorlisted above. A majority of these were alleged victims of sexual abuse.

YPSB Perpetrator With Prior Involvement in DCYF Assessments as Alleged Victim	Total Count of Assessments for YPSB Group as Alleged Victims	YPSB Perpetrator With Prior Involvement in DCYF Assessments as Alleged Victim With Sexual Abuse	Total Count of Assessments with at Least One Allegation of Sexual Abuse with the YPSB as Alleged Victim	Number of YPSB With Findings on Allegations Where They Were Alleged Victims
12	39	7	9	7

For the 12 youth with prior involvement, the mean number of months from their last assessment as a victim or alleged victim to receiving the referral where they would subsequently be found tobe a perpetrator of sexual abuse is 37 months. The median was 29 months.

YPSB Prior History – Case Involvement: CPS & JJS

Similar tracking can be done for these 24 perpetrators at the case level, both for Child Protection and Juvenile Justice Cases.[5]

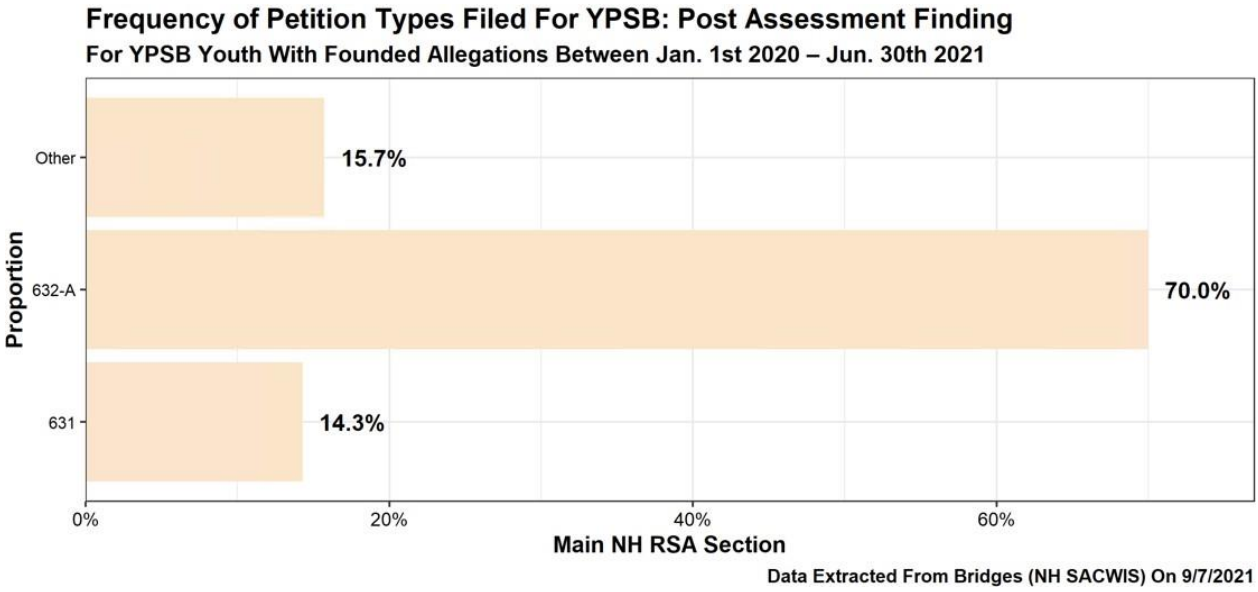
YPSB Perpetrator With Prior Involvement in DCYF Cases As Child (CPS or JJS)	Total Count of Cases for YPSB Group as Children Participating In Case (CPS or JJS)
7	17

Juvenile Justice Involvement Post Finding:

The table below summarizes Juvenile Justice Involvement for the 16 perpetrators for casesstarted post finding. (The majority were delinquency type cases.)

YPSB Perpetrator With Involvement in JJ Cases Post Finding	Total Count of JJ Cases for YPSB Group Post Finding
15	16

The chart below looks at the frequency of petitions filed in court for all the YPSB youth applicable:



The majority of the petitions fall under the Sexual Assault and Related Offenses chapter (632-A)of NH RSA.

Appendix C: Results of Online Survey

Purpose of Survey

The online survey is one part of a larger project exploring how to better serve child victims and Youth with Problematic Sexualized Behavior (YPSB) in NH. This project is funded through the Children's Justice Act Grant, which is administered by the New Hampshire Department of Justice. The purpose of the survey is to understand what is working, existing challenges, gaps, and suggestions for improvement.

Methodology

All professionals who registered for an online training on sibling abuse received an invitation to participate in an online survey about improving the response to youth with problematic sexualized behaviors in NH. Two follow-up email invitations were sent. Between June 2, 2020 and June 22, 2020, 116 people were invited to participate, 75 people started the survey and 64 people completed the survey (55% response rate). This response rate is considered fairly high for online surveys (Nulty, 2008[9]). A few of the people who did not complete the survey wrote that they were too new in their position to have any comments.

The University of New Hampshire Human Subjects Review Board approved all protocols. We used Qualtrics Research Suite, a secure web-based data collection system, to administer the online survey. The survey took about 5 to 10 minutes to complete. An introduction explained that the survey was anonymous and respondents could skip questions they did not want to answer.

Analysis

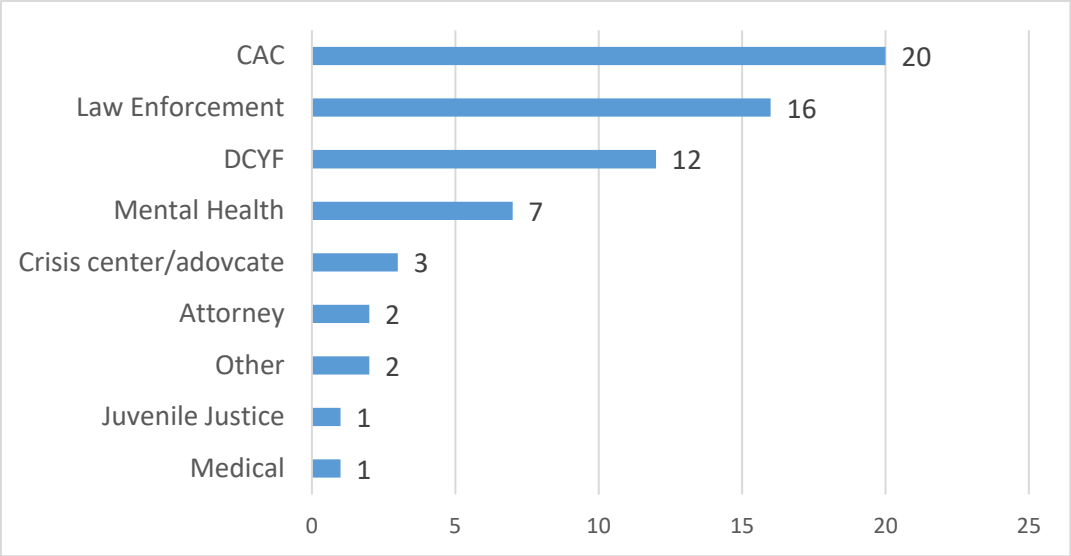
Most questions were open-ended and we coded all aspects of response so that one open-ended response could result in more than one code. The number of participants who answered each question varied, as indicated in the box on each graph. The question with the highest number of participants not answering (n = 16) was the question about what is working well for the response to YPSB. The question with the lowest number of participants not answering (n = 1) was about what the most serious gap is. When participants did not answer a question, often they wrote in "I don't know" or "too new."

[9] Nulty, D. (2008). The adequacy of response rates to online and paper surveys: What can be done? *Assessment & Evaluation in Higher Education, 33*(3), 301-314.

Who completed the survey?

Most of the participants were CAC professionals (n = 20, 31%), law enforcement (n =16, 25%), or DCYF (n =12, 19%). Other professionals included mental health (n = 7, 11%), crisis center advocates (n = 2, 3%) or other (n =2, 3%, which included CASA and a system advocate). One juvenile justice professional and one medical professional also completed the survey.

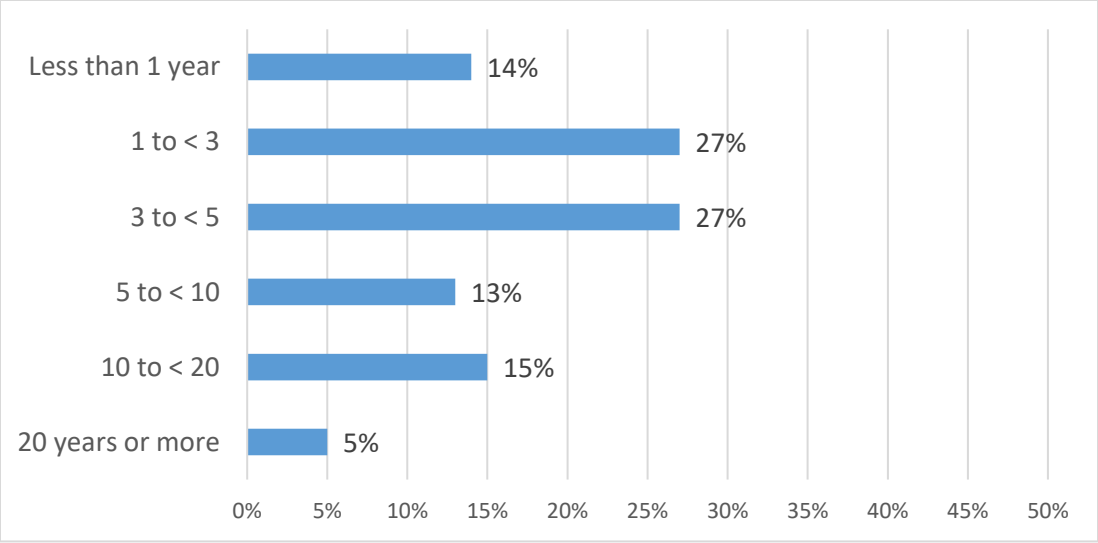
Figure 1. Number of participants



Length of Time in Current Role

Some participants were relatively new, with 41% having less than 3 years' experience, while others were more experienced, with 20% having 10 years or more in their current roles.

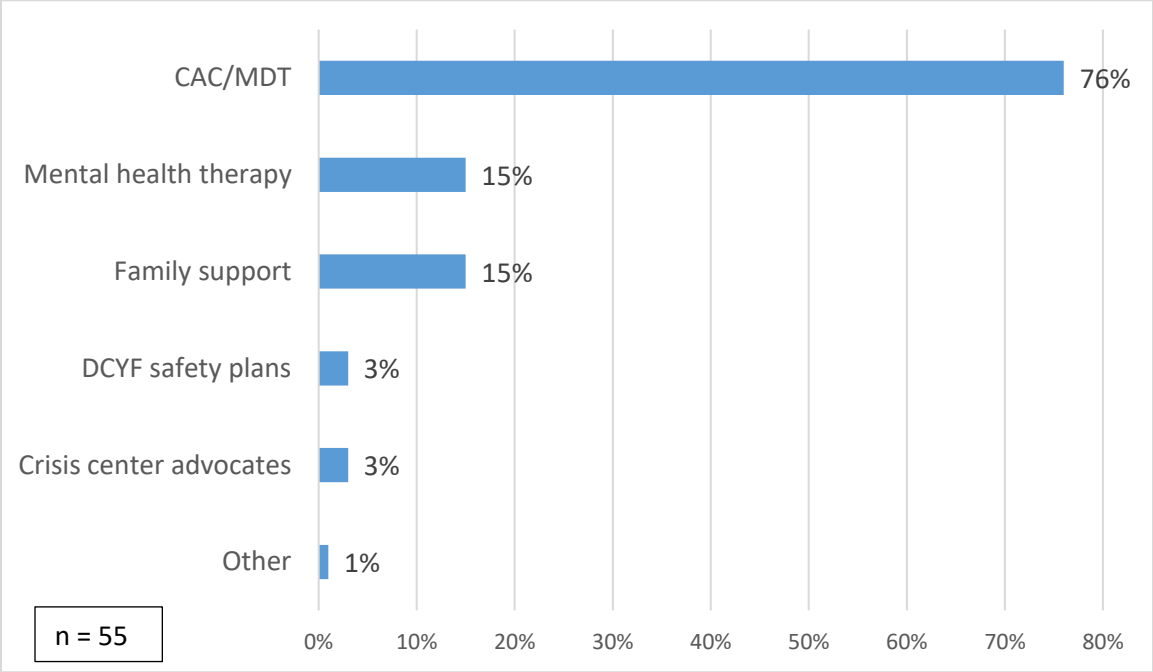
Figure 2. Length of time in current roles



What is working well now for the professional response <u>to victims</u> of youth with problematic sexualized behavior?

The majority of participants (76%) responded to this open-ended question that what was working well for victims of YPSB was the CAC/MDT response. Fifteen percent of participants mentioned mental health therapy or having open communication with the family and 3% mentioned DCYF safety plans or crisis center advocates as things that are working well. One participant mentioned starting from a medical stance as something that works well.

Figure 3. What is working well for professional response to victims of YPSB



<u>CAC/MDT working well to support victims (n = 42)</u>

Participants noted the overall CAC model, the team approach to victims and services, agency collaboration, and the timeliness of forensic interviews.

> *"I think our MDT works really well with connecting with families, expedites CAC interviews, medical exam appointments made, follow up for counseling, open communication between MDT members." (9)*

> *"All YPSB cases come through our CAC. All law enforcement agencies in our county know to refer them because victims need to be evaluated and have access to the services we provide." (19)*

> *"MDT response - all coming to the table MH services for victims Support and Advocacy for victims." (24)*

"I think the CAC process and the ability to wrap services around families - offering medical and mental health services - works well as it pertains to victims of youth with problematic sexualized behavior." (42)

Mental health therapy for victims (n = 8)

Participants noted referral to therapy, often in connection to the CAC.

"Providing resources to address the trauma of being a victim." (29)

"TF-CBT with a lot of parent involvement toward the end of the course of treatment, and sometimes both youth together, as well." (46)

"TF-CBT" (54)

Family Support (n = 8)

Participants thought what was working was open communication and supporting the child and family by connecting them to services.

"Right now we are able to offer support in getting therapy for the victim and can offer support services to the family." (30)

"Support the children and families if possible." (55)

DCYF safety plans (n = 2)

Two people mentioned the benefits of putting safety plans into place.

"Between DCYF and the CAC, we are usually successful in getting victims counseling services and DCYF is usually able to put a safety plan in place." (36)

"I think that from DCYF perspective, we are doing a good job making safety plans for supervision when this happens." (58)

Crisis center advocates (n = 2)

Two people noted what works well is having crisis center advocates connect families to counseling. One person mentioned the ability to fast track children into counseling as well as assisting families with compensation programs to pay for counseling.

"Crisis center advocates are connecting families with trauma-informed therapists who work with children, as quickly after they go through the CAC process as possible." (11)

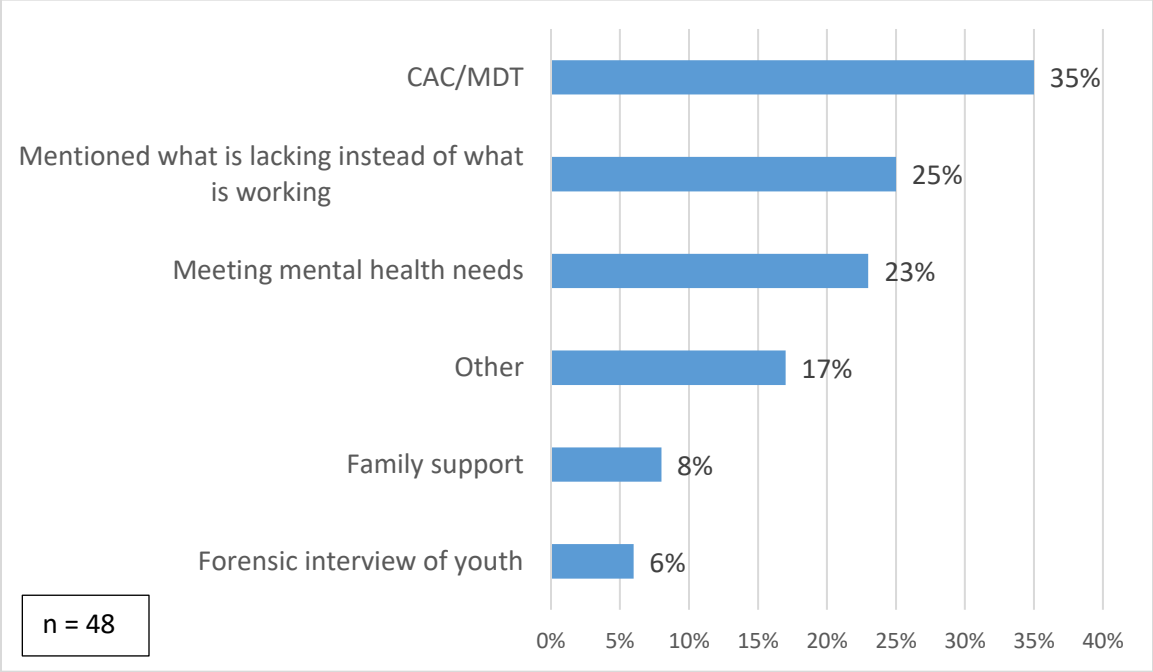
"Our crisis center developed a formal referral process with two counseling centers in our area. This allows us to fast-track children into counseling following their CAC interview. There is usually a few therapists who have experience in this area. We assist families with applying for the NH Victim's Compensation

programs so the family will not have any out of pocket expenses for counseling and they can receive financial compensation for missing time from work to bring their child to counseling (this often removes a barrier to making sure the child continues with counseling).” (63)

What is working well now for the professional response <u>to youth with problematic sexualized behavior</u>?

The most frequent response to this open-ended question on what works well for YPSB mirrored open ended responses to what works well for victims, with 35% of participants mentioning the CAC/MDT response. Interestingly, 25% of participants mentioned what is lacking instead of what is working well. Nearly one-quarter (23%) mentioned meeting the mental health needs of YPSB as something that is working well. Some participants (17%) mentioned other comments which are described below. A few people mentioned family support (8%) and the forensic interview of youth (6%) as working well.

Figure 4. What is working well for professional response to youth with problematic sexualized behavior



<u>CAC/MDT working well to support youth with problematic sexualized behavior (n = 17)</u>

Some participants simply noted collaboration, the team response, or coordination with CAC for interviews. Other participants commented that although the CAC/MDT is working the response also varies by location, by age of the YPSB, or by the age difference of youth.

Depends on the county in NH some MDT's are working together with JJ, prosecution, the courts etc and others are passing the "buck" to others. It is difficult to say because it is different everywhere. (22)

Depending on age, we will sometimes see the "perpetrators" at the CAC to evaluate for exposure to sexual abuse AFTER we've seen the victim to understand what occurred. (19)

Mentioned what is lacking instead of what is working (n = 12)

Some participants mentioned the lack of evidence-based services for youth, one participant said that when youth are labeled as offenders, it makes collaboration difficult, one participant noted that the response is case dependent and DCYF or law enforcement may work well in one situation but not in another. The overall consensus in responses to this question on what is working well was that there is a need to do better.

Again the team collectively understanding that there is a great gap in services for these children that are offending (especially with siblings). … wrap around approach by the team is key to ensure safety and overall well being for all. (62)

If the youth is the one who initiated the sexualized behavior, I don't feel that anything is working well - so I am so thankful for this research study. (63)

Meeting mental health needs of YPSB (n = 11)

Participants mentioned the need to meet their mental health needs and get them into services quickly.

We are able to intervene at an early age and get them into counseling and other necessary services. (30)

We do have a local MH provider who works with this population which is helpful. (45)

Other (n = 8)

Participants mentioned a variety of things that are working well, including professional development, that identification is done quickly, communication, handling by prosecutor's office instead of police, and not just punishing the youth.

..all of our juvenile sex offense cases that go to prosecution are assigned a prosecutor at our county attorney's office; they are not handled by police departments. (19)

What is working well is that we are looking more into the "perpetrator" and victim when things like this happen to provide everyone the help they need, and not just punishing the youth with problematic sexualized behaviors. (58)

Family support (n = 4)

Four participants mentioned offering the families services and support as something that works well.

Listening, compassion teaching/review of body safety as appropriate for age talking to parents about concerns with sexualized behavior (12)

Forensic interview of YPSB (n = 3)

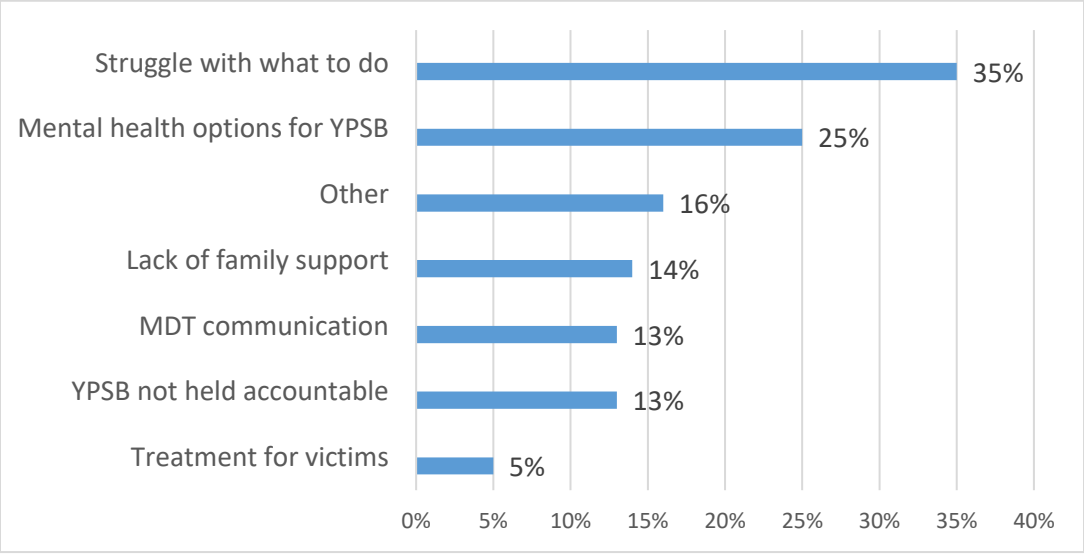
Three participants mentioned the forensic interviewing process.

I think forensic interviews are essential in determining if there is an incident that has happened to these youth with the sexualized behaviors. They may be victims themselves.(13)

What is the most serious gap in the professional response to these cases? (i.e., weakest link in the system)

The most frequent response (35%) to this open-ended question was that agencies struggle with understanding what to do with youth that perpetrate on other youth. A quarter of participants mentioned the lack of mental health options. Some participants (17%) mentioned other comments. About one in ten mentioned lack of supports for family/family support, MDT communication, or YPSB not being held accountable. Five percent mentioned the lack of treatment for victims.

Figure 5. Most serious gap in the professional response to YPSB



n = 63

Agencies struggle with what to do (n = 22)

Participants mentioned the lack of consistency, that each case seems to be treated differently, and lack of accountability. Many participants noted that because of agency criteria, youth often do not have appropriate follow up and "*don't fold into local services*." A few participants specifically mentioned that police do not take these cases seriously and are reluctant to get involved.

> *Because the youth with problematic sexualized behavior often fall in an age range that falls below what would constitute any legal action being taken (i.e. juvenile petition being filed, or even criminal charges) then there is often no definite action that is taken by any agency. (11)*
>
> *The most serious gap in the professional response to these cases lies with law enforcement. Response from law enforcement is varied, across the board. There does not seem to be any standardized response or best practice in place in terms of dealing with youth with problematic sexualized behaviors. (42)*
>
> *Our weakest link are the cases where the youth display problematic behaviors don't meet the criteria for services of any kind-too young/not appropriate for CHINS/Prosecution but also don't fold into local services. These are the kids that worry me, especially when they have parents that are in denial/not accessing resources. (45)*
>
> *I feel like the most serious gap (specifically sibling speaking) is When each MDT member feels as though their hands are tied by law or protocol and the offense does not reach to the level of them being able to implement something enough to rectify the situation… (62)*

Mental health options for YPSB (n = 16)

Participants mentioned the lack of qualified, experienced treatment options with many further noting the cost of services and the location of services as additional barriers.

> *The cost of such specialized services can be quite high and there are not many locations throughout the state that offer such services, therefore transportation or access to these types of counselors may not be possible for some families. (11)*
>
> *The supports available to youth with sexualized behaviors is limited, especially in the northern part of the state where it is more rural and resources are limited to begin with. Sometimes I feel like the family is left hanging after the CAC interview as aside from general counseling there are no resources available where the intent is to work with youth with sexualized behaviors. (43)*

Other (n = 10)

Participants mentioned a variety of other gaps, including *"lack of resources," "mindset," "law enforcement and DCYF case-loads too heavy," "continued follow up with victims," and "no clear definition of what is normal or problematic."* Others mentioned communicating with the school system and lack of knowledge on this topic.

> *Being able to communicate with the school systems to help best support the kids at school or relating to school when they are going through something like this. (60)*

> *The most serious gap in the professional response to these cases is the lack of knowledge about youth with problematic sexualized behavior. (36)*

Lack of supports for family and family support (n =9)

Participants mentioned the need for community supports for families and not wanting to talk about it.

> *There are a lot of barriers for families to provide supervision and get them connected to services especially right when the situation occurs. (27)*

> *Parental allegiance and capacity to for protection, particularly in cases of sibling abuse. (37)*

MDT communication (n = 8)

Participants mentioned gaps such as lack of information relay/communication between agencies and lack of one-stop shopping. The overall theme was the lack of information sharing, with two participants specifically mentioning the *"disconnect between DCYF and Police"* and *"healthcare cooperating with law enforcement"* as the most significant gaps.

> *Communication with other disciplines and the way information is stored and handled. Too many people with their hands in the pot Other disciplines not understanding what each entity can and can't do. Families being pushed around from agency (8)*

> *At times, after the initial forensic interview is conducted, each agency tends to conduct its own investigation, but do not continue to communicate during that process. (47)*

YPSB not held accountable (n = 8)

Participants mentioned law enforcement not prosecuting perps and that victims of child offenders do not see justice. Two people simply said *"criminal justice."* The overall theme was the need for accountability and justice.

Punishment for the offenders that would deter them from doing these acts again. (57)

Lack of accountability for the youth offender (ie., many youth offenders comment that they know nothing will happen to them because of their age) (21)

Perhaps having the youth with sexualized behaviors being interviewed by a detective instead of in a forensic interview, so they feel they are being punished. (58)

Treatment for victims (n = 3)

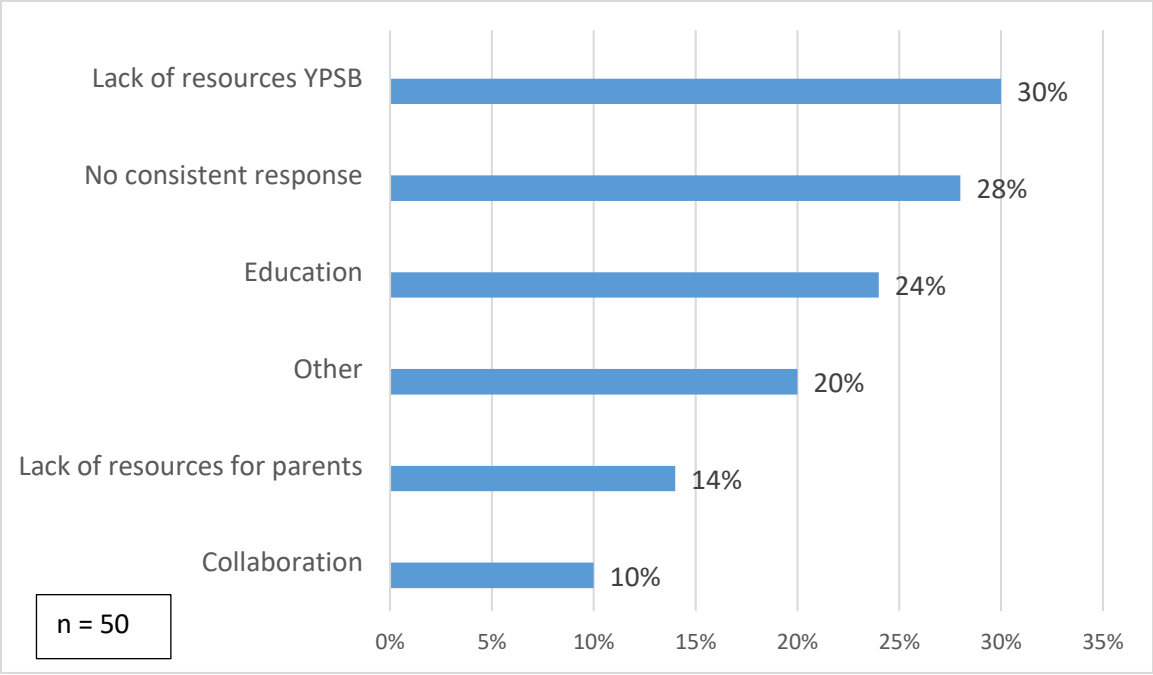
Three participants mentioned the need for treatment for victims.

Lack of qualified, experienced treatment for both the offenders and the victims. (5)

What are some *other* challenges?

In addition to the most serious gap in the professional response to YPSB, we asked an open-ended question about what some other challenges are. Nearly one-third (30%) of participants mentioned the lack of resources for YPSB, 28% mentioned the lack of a consistent response, and 24% mentioned the need for education on this topic. One in five participants mentioned other challenges which are described below, 14% mentioned the lack of resources for parents, and 10% mentioned collaboration.

Figure 6. Other challenges in the professional response to YPSB



Lack of resources for YPSB (n = 15)

Participants mentioned the challenge of finding necessary services to meet the needs of sexualized youth and the overall lack of resources to provide counseling.

> *Access to services such as mental health counseling and/or outreach services are a big challenge. At times there is a months-long waiting list for children to get a scheduled appointment with a mental health counselor which often results in a family not following through. (17)*

> *Availability of professional resources for youth offenders. (36)*

No consistent response (n = 14)

Participants mentioned the system itself and there is no consistent response in the state. Many mentioned that each case is handled differently depending on the location of the crime, the MDT involved, and whether or not Juvenile Justice is involved. Two participants' comments summarize the theme of many responses: *"Just the generalized feeling of helplessness; specifically when each MDT partner feels they are unable to assist, but feel that the other partner should be able to*" and *"without any agency being able to make this a mandate, it is highly unlikely the family will seek these specialized services."*

> *They do not receive the same level of support from the court system as victims of an adult perpetrator. (32)*

> *I also think there is an inconsistency within DCYF on their involvement in these cases and I believe that starts within central intake on whether they are screening them in or not and if they are, what exactly is the assessment worker investigating and what is their goal... if there is not a concern for lack of supervision between siblings, I think it is unclear to them at times of where they go from there other than recommending counseling.(38)*

> *Most importantly I think a lack of a statewide standard to use as a guide for these cases has led to a lot of confusion and a lot of communities who use a "hodgepodge" approach. (50)*

Education (n =12)

Participants mentioned the need for an educational system for professionals and that there is a lack of knowledge and training across all agencies. One participant mentioned education for students regarding reference to internet safety.

> *I don't think there is enough education on this topic and education on what services are available to this population. (30)*

> *The educational piece seems to play a role with regard to the response from LE. I think more education/formal training about the juvenile justice system and expectations from each agency's governing court might be helpful. (42)*

Other (n =10)

Other responses varied including the need to get releases done and the size of each party's case load.

> *From this morning's training, and thinking about my own cases, we do not give victims enough actual physical safety, and certainly not enough emotional safety. It was interesting to hear that best practice is to remove the child with the sexual behavior problem from the home to allow the victim to fully engage in treatment. (53)*
>
> *Many of the offenders are not only juveniles, but also developmentally delayed and incompetent to stand trial. (61)*

Lack of resources for parents (n = 7)

Participants mentioned the lack of parental resources and that many of parents are not equipped to appropriately respond to the issue.

> *Parents of YSPB have a difficult time accepting that their child may be crossing boundaries and must be approached delicately about the topic. If it is a sibling-on-sibling case, a lot of parents seem to be in denial or seem to be unable to separate their children effectively. (18)*

Collaboration (n =5)

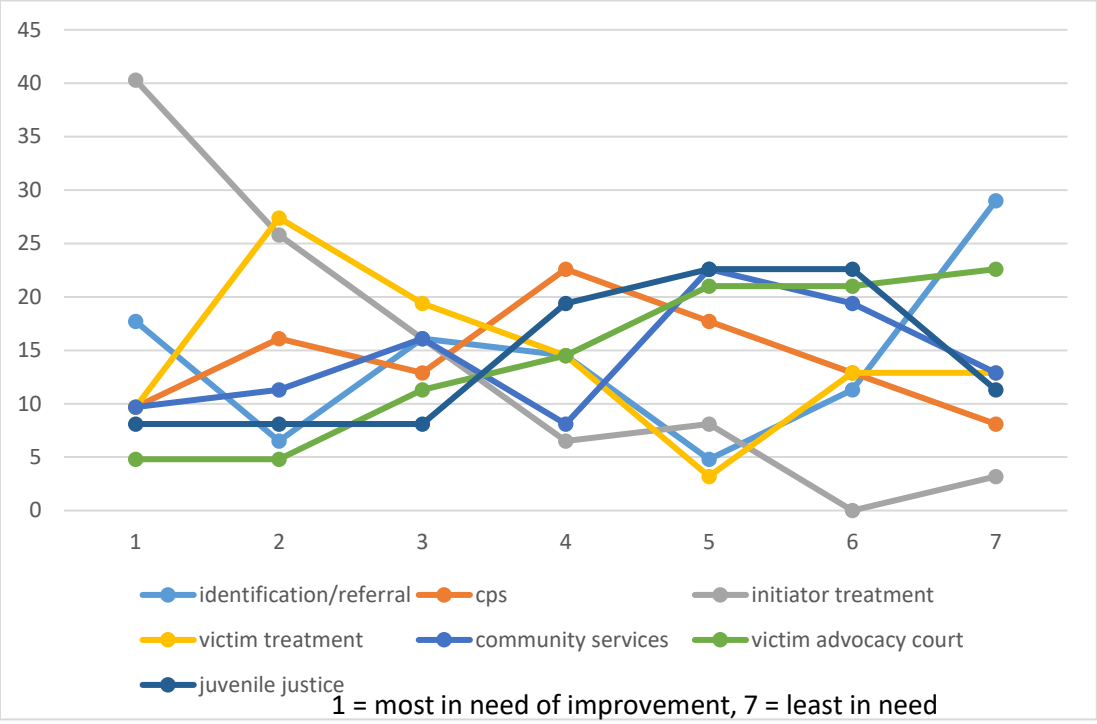
Participants mentioned challenges regarding communication between all stakeholders and with the MDT response.

> *I think the collaboration between the educational and juvenile justice system needs to work better together to provide continued services. (36)*
>
> *Participation and communication by Law Enforcement at case review and multidisciplinary team meetings to talk about child-on-child cases. (38)*

What area most needs to be improved?

Participants ordered what area most needs to be improved, with #1 most in need of improvement to #7 least in need of improvement. By far the area most in need of improvement was treatment for YPSB. Treatment for victims also received high to moderate ratings. Identification and referral received both ratings for most and least in need of improvement. CPS also received ratings suggesting need of improvement.

Figure 7. Rank order of area most in need of improvement

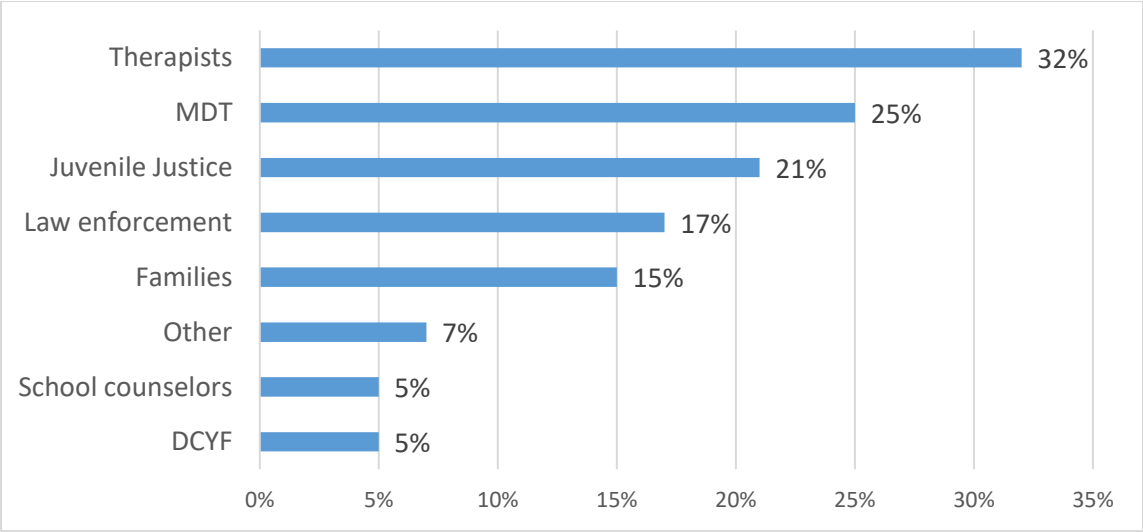


1 = most in need of improvement, 7 = least in need

Who needs to be more involved with these cases?

In response to an open-ended question asking who needs to be more involved with these cases, nearly one-third of participants answered therapists. About one-quarter of participants responded MDT (25%) and juvenile justice (21%). Others mentioned law enforcement (17%), families (15%), other (7%), school counselors (5%), and DCYF (5%).

Figure 8. Who needs to be more involved with these cases



n = 53

Therapists (n = 17)

I think counselors need to be more involved. Sometimes these counselors have so much information that can be useful in determining what is needed. Sometimes it is difficult to get adequate information from counselors even with a release of information. (13)

There needs to be options for treatment for YPSB so that it is not necessary to charge them and get them into JJ in order for them to be mandated to the very few treatment options that exist, so mental health. (22)

Experts who can provide opinions on behaviors that are being seen. (59)

MDT (n = 13)

Law Enforcement, Juvenile Justice and mental health trained in treating youth with sexualized behavior and the families of these children themselves. Often, there are other issues going on in these families that caregiver's need support and help with (ie. DV, substance abuse, finances etc) (36)

I think there needs to be a more long term checks and balances in place and that all members of the MDT should be involved throughout. (42)

The team as a whole team (54)

Juvenile Justice (n = 11)

Juvenile Justice should be involved earlier in the process. (19)

It felt like a ping pong game when you had a YPSB case because both child protection and JJ were just trying to pass it to the other. In my opinion, it was more important for JJ to get involved as it was a juvenile issue … I felt I often had cases where I had a child with sexualized behaviors acting on other children and JJ would say it was not their problem. Parents would want JJ involvement for the support and treatment but would be denied. (38)

Law enforcement (n = 9)

We need more frequent check ins with law enforcement as we need their approval before moving forward with our investigation. (1)

LE needs to take a more active role and be consistent in the response, especially with our 12-15 year olds (24)

The police. I feel these cases are often dismissed or minimized when the offender is a juvenile. Petitions can be filed, prompting the requirement of treatment for youthful offenders. (26)

Families (n = 8)

Families struggle to cope with it, it is difficult to ask for help. (5)

Parents or legal guardianship. (29)

Other (n = 4)

Participants mentioned *"system based advocates", "social service aspects*", and "*there are too many people involved now".*

School counselors (n = 3)

School guidance counselors/student services (60)

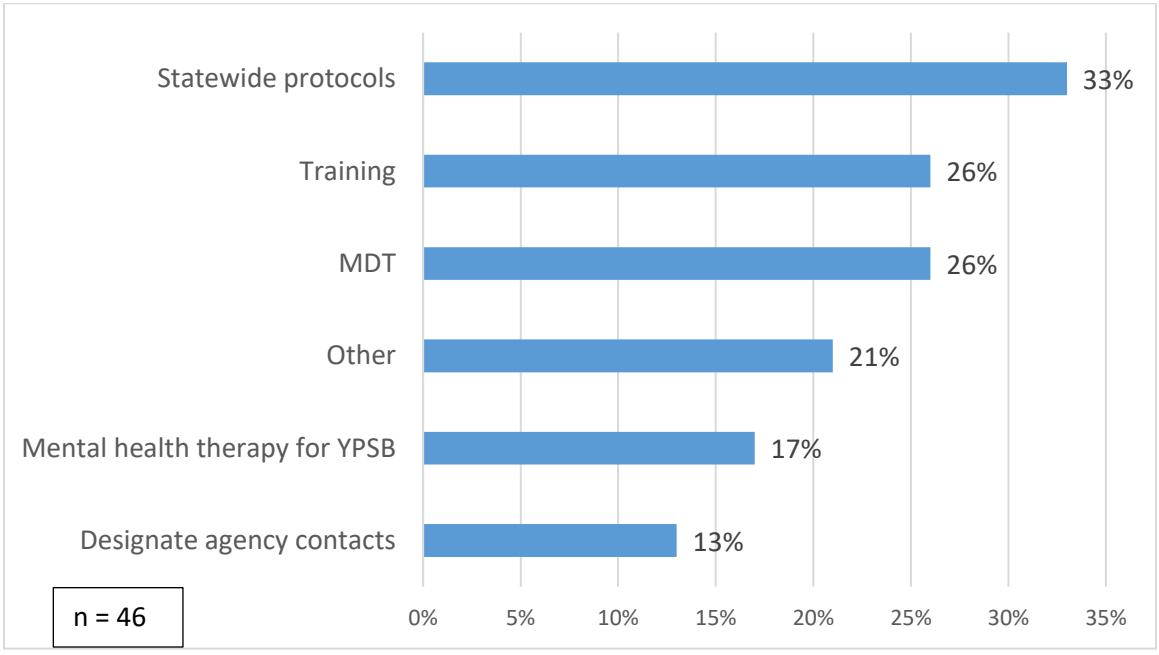
DCYF (n = 3)

DCYF seeing these allegations of youth on youth abuse as serious (31)

What recommendations do you have to ensure there is a consistent and coordinated response for these cases in NH?

In response to this open-ended questions on recommendations, one-third of participants mentioned the need for statewide protocols. One-quarter of participants mentioned training and multidisciplinary teams. One in five participants mentioned other recommendations, which are described below, 15% mentioned mental health therapy for YPSB, and 13% recommended designating agency contacts to work on these cases.

Figure 9. Recommendations



Statewide protocols (n = 15)

Participants mentioned that consistency is the key to be successful and there is a need to develop protocols or a unified response to these cases.

> *State wide protocols would be super helpful. It feels like there is an inconsistent response across all counties, and having a document or a manual or set of protocols to refer all disciplines to would be helpful. (19)*

> *Leadership from the NH Department of Justice and via NH police standards and training council. Adjust the curriculum to prepare every police Officer to deal with these cases and to understand the MDT model. (41)*

Training (n = 12)

Participants mentioned the need for training of all professionals involved in these cases.

> *Training on the issue so that all MDT members understand the dynamics and how to best serve victims and YPSB. (22)*

> *Educating other professionals like teachers and daycare staff to recognize sexualized behavior versus normal sexual development. (43)*

MDT (n = 12)

Participants mentioned the need for constant and consistent communication of the MDT, sometimes mentioning the increased involvement of particular agencies as illustrated below.

> *County Attorney's participation during the CAC interviews. (48)*

> *A shared, private protected way to share information and reach other professionals in the state. (49)*

> *The interdisciplinary team meetings with the CAC are very helpful. Ensuring participation by DCYF at those meetings would increase communication and coordinated response. (53)*

Other (n = 10)

Participants mentioned a range of recommendations, including "*money,*" "*support for families,*" and "*encouragement for victims to come forward*".

> *A special track in the juvenile justice system for youth offenders that focuses on services for both the child and family. (36)*

> *Timely referrals to police and/or child protection. (43)*

> *A release packet in place to help with ease of coordination. (55)*

Mental health therapy for YPSB (n = 8)

Participants mentioned the need for better access to mental health.

> *It would be nice if DCYF was able to mandate counseling and not just recommend it as a part of their safety plans. If families were required to enroll their child in specialized treatment before a case was closed, this might help. Some type of assistance from DCYF in funding the counseling would be helpful as well, as it is often very expensive treatment and insurance may not cover such costs. (11)*
>
> *Need for specific PSB treatments provided by trained clinicians. (20)*
>
> *Mental health and community providers that are trained in addressing child-on-child sexualized behaviors that work closely with DCYF and LE to address any other problems going on with caregivers/child/family. (36)*

Designate agency contacts (n = 6)

Participants mentioned the need to create dedicated workers across agencies to work on these cases.

> *Have designated workers assigned to these very specific cases with very specific needs. (28)*
>
> *I think that there should be specialized workers for these cases so that it is taken seriously and a protocol in place for these cases for workers to follow. (30)*

If you have any other comments about these cases, please let us know

Only a few participants had additional comments about these cases. One person said that there are few victim advocates that are specifically trained to assist families with delinquent children especially who have fallen victim to crimes and that there is too much time in between court appearances and adjudication that at times the families and the children feel forgotten about and continue to do what they do.

Others had specific suggestions such as: a) support groups for the youth victims, b) a comfort dog (CAC or otherwise) to help decrease the discomfort of the CAC process, c) more information about healthy modeling, what is normal for children sexually at different developmental stages, and how to set boundaries, d) increasing access to training in both assessment and treatment, and e) needing a capacity to enforce any type of counseling/treatment plan without a juvenile petition.

One participant noted:

Annually the NH public defender program commits considerable time and energy to train and prepare their attorneys to handle these types of cases. The prosecution network, with leadership from the NH DOJ and association of county attorneys, needs to expend more time and resources towards same. Equally the victim/ witness resources in these juvenile cases should match that provided in similar adult cases.

Summary

Responses to the open-ended online questions paint a clear picture of a response system to YPSB in NH in need of improvement. The one area that appears to be working well is the CAC/MDT response to victims of YPSB, with 76% of participants noting the team approach to victims and services, agency collaboration, timeliness of forensic interviews, and access to mental health services for victims as working well. In contrast, the CAC/MDT response to youth engaging in problematic sexualized behavior appears to work well in some locations but it also varies by age of the YPSB or by the age difference of youth. Interesting, 25% of participants mentioned what is lacking instead of what is working well for the response to YPSB. Nearly one-quarter of participants mentioned meeting the mental health needs of YPSB as something that is working well.

Because the goal of this study was to understand what needs to be improved, a number of questions focused on gaps, challenges, and who should be more involved. The most frequently (35%) mentioned serious gap in the professional response was that there is no consistent response and agencies struggle with understanding what to do with youth that perpetrate on other youth. Participants mentioned the lack of consistency, that each case seems to be treated differently, and lack of accountability. A few participants specifically mentioned that police do not take these cases seriously and are reluctant to get involved. When asked about other challenges, the lack of a consistent response was the second most frequently (28%) mentioned other challenge, suggesting that the lack of consistency is a struggle for professionals.

In addition to a lack of a consistent response as the most serious gap or other challenge, the lack of mental health options for youth engaging in problematic sexualized behaviors was rated as the most serious gap by 25% of participants and 30% of participants mentioned it when asked about other challenges. Participants mentioned the lack of qualified, experienced treatment options with many noting the cost of services and the location of services as additional barriers. Not surprisingly out of a list of seven service areas (identification/referral, CPS, treatment for YPSB, treatment for victims, victim advocacy in courts, juvenile justice, and community service), the area rated as most in need of improvement was treatment for YPSB. Treatment for victims also received high to moderate ratings as needing improvement.

When asked who needs to be more involved, the top three responses to this open-ended question were therapists (32%), the MDT (25%), and Juvenile Justice (21%). Participants felt

there should be more treatment options and that counselors should be more involved and share their insight with the team. Participants thought the whole MDT needs to have more checks and balances and work as a team. Participants felt Juvenile Justice needs to be involved earlier.

In response to an open-ended question on recommendations, one-third of participants (33%) mentioned the need for statewide protocols and a need for a more unified response to these cases. One-quarter of participants mentioned training for all professionals (26%) and better communication among multidisciplinary teams (26%). One in five participants mentioned other recommendations, such as a special track in Juvenile Justice for these cases, timely referrals to police/CPS, and a release packet to ease coordination. Better access to mental health therapy for YPSB, such as more providers or mandating counseling, was mentioned by 17% of participants. Some participants (13%) recommending designating agency contacts to work on these cases.

Appendix D: Results of Telephone Interviews

Purpose of interview

The telephone survey is one part of a larger project exploring how to better serve child victims and Youth with Problematic Sexualized Behavior (YPSB) in NH. This project is funded through the Children's Justice Act Grant, which is administered by the New Hampshire Department of Justice. The purpose of the interview is to understand what areas in need of improvement.

Methodology

CAC directors in NH provided names of the top three professionals in their area with expertise handling these cases. Directors were asked to include a diverse mix of professionals including law enforcement, prosecutors, clinicians, DCYF, and advocates. An initial email invitation was sent to 32 professionals on August 10, 2020. Between August 11, 2020 and September 15, 2020; 21 people completed the interview. The response rate was 66%. Three people declined and 8 people did not respond to 3 invitations.

The University of New Hampshire Human Subjects Review Board approved all protocols. Qualtrics Research Suite was used, a secure web-based data collection system, to administer the telephone interview. The survey took about 30 minutes to complete.

Who completed the interview?

Participants included law enforcement (n=6, 29%), DCYF (n=3, 14%), mental health (n=3, 14%), juvenile justice (n=2, 9%), crisis center advocates (n=2, 9%), CAC (n=2, 9%), prosecutors (n=2, 9%), and one medical professional completed the interview.

Participants had a range of experience, 23% (n=5) had less than 5 years' experience, 23% (n=5) had between 5 and 9 years' experience, 19% (n=4) had between 10 and less than 20 years, and 33% had 20 or more years' experience.

What is the hardest thing about these cases?

Three themes emerged as the hardest thing about these cases - the resistance and emotional aspect for families, team challenges working with these cases because no one agency is in charge, and the lack of services.

Family resistance and emotions. We heard that navigating the family system is often the biggest barrier because some families are just not open to doing what they need to (9). Many families are in crisis and it is especially emotional for families when there are two victims (18). We heard that families are often too embarrassed and do not want their child to be involved with a criminal investigation (6). A parent still has to admit that their child has a problem. We see a revolving door with these kids. Who should oversee these? (21)

Really any case with a juvenile, the biggest barrier is the parents, either they don't believe it or they are in denial. This makes it hard because parents have to comply with the conditions. (20)

If a sibling, parents are afraid they will take one of the kids away. We want to make sure we are here to help. Many times the kid has no idea what they were doing. Hard to get parents to trust police. (1)

We try to get parents to buy in to counseling and safety with bathing. They need to have some control as to when they will see the other family member. (17)

Team challenges. We heard difficulties around the fact that no one agency owns these cases (21) and that there is a lack of initiative by the team and that many do not know what to do and need to be held to standards (2). We heard that agencies have different timelines which make it challenging, especially because treatment cannot be put on a timeline. (7)

There always seems to be a breakdown in communication, (team members) don't come back together. I wish there was a debriefing, need communication for these cases. With youth with problematic sexualized behavior, no one really knows what is going on. (12)

Lack of services. We heard that it is challenging to get the help both victims and offenders need. In order to get the offender help, needing to go to the court system is problematic (14). We heard that it is a challenge to find treatment quickly (18) and that there is a lack of training for working with youth who engage with problematic sexualized behaviors, which results in limited access to services. (16)

But what do we do with these kids? What do we have in place in society that we have worrisome behaviors at such young age (17)

The lack of any sort of genuine services - just offer general counseling, not specific sexual reactive behavior. It feels inadequate (9)

How to improve identification and referral process?

The main theme was that additional training was needed, with training for teachers most commonly mentioned, with some participants mentioning training for DCYF and law enforcement. Other themes were that the referral and investigation process needs to be streamlined and that intervention should occur early in the process.

Training for teachers.

Guidance will try to talk to a child without calling us. But this is not their role and there is a strict protocol. They need to stay in their lane. (14)

Need to better understand what is age appropriate versus not. (1)

Need to get Know and Tell out there more. Folks are uncomfortable and need to realize don't need all the details to refer. (18)

Streamline process.

Process varies too much. Should be here is the case and then who needs to be notified. (3)

Need a card with what to do, call detective, call CAC. (4)

Police should not be able to choose, should be automatic referral to CAC. (2)

DCYF has screen out age - think it is over 12 they won't do a safety check. They will refer to le and then it goes through the cracks. (2)

So important to get kid into counseling even without disclosure. (2)

Need to intervene early.

Hesitant for people to get involved because these are kids. CHINS is not a great way for these juveniles to enter the system and there is no good system to get them involved. (5)

Need DCYF to be involved early and have more options for out-of-home situations. (6)

Get families involved with services sooner –have families sign release to send to mental health and then mental health will call to see if family wants services. Many do not want to work with DCYF and have lots of shame. Calling for services is a barrier for families. (7)

How to improve DCYF?

By far the most consistent theme is that access to services is too limited and often there is not a clear path for families to get services. Another theme was that better communication is needed between DCYF and other agencies. A handful of participants also noted that DCYF's goal is reunification but that this is not always appropriate. One participant thought that if probation were brought in earlier then there would be no wait for delinquency petition.

Access to services too limited. Many participants noted that many children do not get any services because of age restrictions at DCYF and that DCYF has "no teeth." We heard concern that there is a lack of follow up especially for OOH cases. One detective noted:

We can't get a criminal charge and don't know what the hang up is to getting services, but without a charge we can't get services. (8)

If DCYF screens out for OOH, should create a new assessment with OOH victim so victim can get services - split it so both victim and older youth get services. (14)

Hate to see CPS close investigation and family goes back to ole ways. (20)

Improve cross agency communication.

Need to share information. Can't share what services exist, can't brainstorm about what is needed. (4)

They should call police to make sure each has correct information before talk with families. (1)

How to improve treatment for youth with problematic sexualized behaviors?

The two main themes were to improve awareness of providers and the need for services. Awareness had to do with professionals needing a list of approved providers with expertise in this area. Need for services had to do with the cost of evaluations making it difficult to obtain services and that there are limited options for treatment.

Need awareness of providers with expertise.

One was tried as juvenile at 16 but he was like an adult and response needed to be adult like. What kind of therapist would be best - adult or child informed - how to determine that? (4)

Need a list of approved providers who have undergone training in this area (5)

Lack of services.

First step is need psychosexual evaluations and these can be costly. Victim compensation does not cover these - need to have a fund to cover the cost of these. Need funding and accessibility of services, some in Manchester but even less in rural areas. (1)

No options for services in the North Country. (9)

Wish there were enough counselors who specialized in this area. (17)

How to improve treatment for victims?

The two main themes for improving treatment for victims were the lack of services and difficulty with access to services.

Lack of services. A number of participants mentioned that services are not immediately available and that there is often a wait list for services.

System is overwhelmed. Making progress but there are wait lists (12)

Access to services. Barriers included transportation and insurance. Some participants noted that there needs to be more education for families about therapy and that no one is overseeing this connection with families, making access to services challenging.

> *If counseling could be in schools families would not have to figure out how to get to treatment. (5)*
>
> *Many families don't have health insurance and this can be a nightmare. (11)*
>
> *Community mental health centers need to identify who would be good to work with this population. (18)*
>
> *Is it possible for a therapist to check in like a chiropractic checks in in 6 months. (4)*

How to improve the CAC response?

Some participants mentioned that CACs help with referrals, with some noting that CACs are limited to treating victims, but that a team approach is needed for YPSB.

> *Gap is if we find out an offender we do not refer to CAC, unless been victimized themselves but hesitant to do this if over 12 because we don't want jj involved. CAC would have to change protocols, so not sure how to answer but this (team approach) is missing for this group. (5)*
>
> *A team approach is best for these cases. CACs are so knowledgeable and the more people involved the better. (10)*
>
> *If had someone at CAC that has a dual role to work with victims and offenders, could help link these to right facility. These cases are just so complex. (16)*

How to improve community services?

The main theme was that there needed to be better access for services. One participant said that schools, sports programs, and camp counselors should be educated and confident to speak up when they think something is wrong. Another participant said that not having a pediatric Sexual Assault Nurse Examiner (SANE) program is criminal and some families say they are done with the process because of difficulty getting medical services.

More services. Comments varied as far as what types of services are needed. Suggestions included that these kids need more oversight to ensure their home life is safe and stable. Another participant echoed this suggestion:

> *Need a person who gives families good advice, like a big brother/big sister, to help support the parents when life is so chaotic. (4)*

Other comments had to do with expanding the types of services such as group work and in-home services for families, as well as how services are coordinated.

For this type of population, group work is critical but some don't do it because of billing insurance. (7)

Community health centers are heavily relied and sorely understaffed, underpaid and overworked. Need to better integrate with these centers. (9).

Need education for parents that this is different. Parents have an awful shame around this. Need to help families through this. (17).

How can advocacy services for victims in court be improved?

Generally, participants felt that the juvenile system should allow prosecution-based advocates in court and that advocates could be one of the biggest supports for youth. One person wondered whether the AG could loan their advocates, and another wondered whether an advocate role could be combined with a guardian ad litem for victims. Another person said that parents are frustrated during the investigation because they say nothing is being done and that we need to help families understand the process in a more black and white way, such as providing a step-by-step handout for families.

These kids do not have anyone speaking up for them. (7)

Their brains are not hearing because traumatized. Need a handout for families to refer to. Need to help families understand the process in a more black and white way. (16)

Having advocates with police departments is super helpful. (5)

How to improve the juvenile justice response?

The most consistent theme was that the bar needs to be lower so youth can get services earlier and that a justice system response is not always helpful. The other theme was that there needs to be a better multidisciplinary response that includes JJPO. One participant mentioned there is no training on this issue for JJPOs.

<u>Need a way to get youth into treatment</u>. Many participants expressed frustration that the justice system is not always helpful and that a less strict process is needed before engaging the juvenile justice response. A few participants mentioned they would like to see diversion instead of a juvenile justice response.

Justice system is short sighted. These kids need intervention. We are doing a disservice for these kids, then they turn up in the adult system. (5)

Biggest grip is the competency hearing. Kids can sandbag this and can't be charged with sexual charges. Instead should do psychosexual evaluations and make sure won't happen again, and get them into treatment. (1)

Need more information sharing with JJPO and what the best outcome is for child beyond non-adjudication. (15)

If parent could have someone backing them and saying this is what you need to do. (7)

Multidisciplinary response is critical.

Would love to see JJ have relationship with CAC, like advocacy and DCYF relationship with CAC. (13)

(Police) have so little communication with JJPO. JJPO needs adequate resources. They are overwhelmed. (12).

How to improve the law enforcement response?

The two main themes were lack of knowledge among police officers, especially in rural or smaller departments, and the lack of collaboration, especially with DCYF. Some of the participants expressed frustration that there is no agency for police to refer to, like a justice center or CAC, so that services are received. This gap often results in a lack of a consistent response, as described by one participant, *"one 13 boy went through whole process, another nothing. How does this get decided? A mystery. Need a more uniform response." (21)*

One detective summarized, *"law enforcement has the biggest area to be improved. Our guys have to get more sensitive and stop asking the questions we want - sometimes they over step. It would be nice if we had some people to refer these too - to get them services, like a family justice center, CAC, and community based support and say to families not DCYF and voluntary services." (14)*

Lack of knowledge

State police who has handled this should be there rather or with local PD who has no experience. Family becomes jaded with lack of experience. (11)

Working in rural NH, law enforcement doesn't have a ton of experience with these cases so a lack of knowledge about these and there is room for improvement. It seems like a conflict of interest when there is a police prosecutor. (13)

Need more education. What is normal and what is not normal. (17)

What other areas need to be improved?

Responses to this open-ended question were wide ranging. Participants mentioned that additional training is needed, especially for prosecutors, and that family dysfunction plays such a big part of these cases that it complicates the process.

A few participants noted that it should be easier to get services for families who need them. This included difficulties regarding not meeting criteria for voluntary chins and competency to difficulties offering and receiving services when there is no disclosure. The need for additional resources for both in home and out of home situations and for additional treatment options was also mentioned. One participant noted the "*hardest thing is the shortage of resources to properly assess risk and then to have programs to refer kids to."*

Some comments reiterated earlier themes that "*we need a consistent and coordinated response. These are very sensitive cases and need a single unit for these cases, we start off that way, but then new cases come in and move on and there is no follow up."* Another participant shared, *"I worry these are the kids that are lost."*

Summary

Responses to the telephone interviews echo results of the online survey and paint a clear picture of a response system to YPSB in NH in need of improvement. When asked what the hardest thing about these cases is, participants mentioned the resistance and emotional aspect for families, team challenges working with these cases because no one agency is in charge, and the lack of services. These three themes also surfaced in response to questions on how individual aspects of the response could be improved, such as how to improve DCYF, law enforcement, and services in general.

Navigating the family system is often the biggest barrier for professionals because many families are in crisis and it is especially emotional for families when there are two children in the same family in need of support. Difficulties also had to do with the fact that no one agency owns these cases and that many professionals do not know what to do. We heard it was challenging to get the help that both children need and that in order for the child exhibiting sexual behaviors to get help needing to go to the court system is problematic and not efficient. We heard it is a challenge to find treatment quickly and that because there is a lack of training for working with youth who engage in problematic sexualized behaviors there is limited access to services.

Suggestions for improving the identification and referral process include needing additional training, especially for teachers, streamlining the referral process so it is clear what the process is, and that intervention should occur early in the process so youth do not have to wait for services.

Suggestions for improving DCYF were that access to services is too limited and often there is not a clear path for families to get services. Participants noted that many children do not get

any services because of age restrictions at DCYF and that DCYF has “no teeth.” We heard concern that there is a lack of follow up especially for OOH cases. Another theme was that better communication is needed between DCYF and other agencies.

Suggestions for improving treatment for YPSB and victims include increasing the number of providers who specialize in this and increasing awareness of providers with expertise in this area. Other suggestions were to increase access to psychosexual evaluations and decreasing barriers such as transportation and insurance.

As far as improving the CAC response, some participants mentioned that many CACs are limited to treating victims, but that a team approach is beneficial but lacking for YPSB. Suggestions for improving other community services had to do with expanding the types of services such as group work and in-home services for families, as well as how services are coordinated. Generally, participants felt that the juvenile system should allow prosecution-based advocates in court and that advocates could be one of the biggest supports for youth. The most consistent theme for improving the juvenile justice response was that the bar needs to be lower so youth can get services earlier and that a justice system response is not always helpful.

The two main themes for improving the law enforcement response were lack of knowledge among police officers, especially in rural or smaller departments, and the lack of collaboration, especially with DCYF. Some of the participants expressed frustration that there is no agency for police to refer to, like a justice center or CAC, so that services are received. This gap often results in a lack of a consistent response.

Appendix E: List of Contacts for National Scan

Agency	Contact
Baltimore County CAC, Towson, MD	Krista Trahan Amanda Podbielski
CAC of Bristol County, Fall River, MA	Cathy Rutkowski Lara Stone
Center for Hope, Baltimore, MD	Kerry Hannan
Center for Child and Family Services, Duke University, Durham, NC	Nicole Croteau Johnson Talia Wahl
Child Advocacy Center of Sedgwick County, Wichita, KS	Diana Schunn Erika Purcell Tabitha Winter
Continuum Care Institute, University of Alabama	Mandi Fowler
Dakota Children's Advocacy Center, Bismarck, ND*	Paula Condol
Dee Norton CAC, Charleston, SC	Carrie Jenkins
Juvenile Probation Treatment Program, Montclair, NJ	Marty Krupnick
Massachusetts Children's Alliance	Tom King
Metropolitan Organization to Counter Sexual Assault, Kansas City, MO	Julie Donelon
Mission Kids CAC, Montgomery, PA	Abbey Newman
Missouri Kids First CAC, Jefferson City, MO	Jessica Seitz
Mountain CAC, Asheville, NC	Geoff Sidol
NAFI CT*	Diane Thompson
National Center on the Sexual Behavior of Youth, University of Oklahoma Health Sciences, Oklahoma City, OK	Jan Silvosky Erin Taylor
National Children's Alliance	Michelle Miller Kaitlin Lounsbury
National Children's Advocacy Center, Huntsville, AL	Erica Hochberger
NJ Children's Alliance, Montclair University, Montclair, NJ	Nydia Monagas
Northeast Regional CAC, Philadelphia, PA	Teresa Smith Sue Ascione
Russell County CAC, Phoenix City, AL	Lynn Hammock Wanda Shaffer
Southwest Regional CAC, NCAC, Huntsville, AL	Karen Hangartner
Springboard Community Services, Baltimore, Bel Air, MD	Olivia Smith
West Virginia Child Advocacy Network, Charleston, WV	Caitlin Smith
Western Regional CAC, San Diego, CA*	Vicky Gwiasda

*Email only

Appendix F: Innovative CAC Models

We talked with a number of CACs doing innovative and comprehensive work in this area. Below some of the work at four CACs is summarized.

Baltimore County CAC. This CAC has had an internal program focused on YPSB since the 1980s. Referrals come from diversion and CPS. Adjudicated cases are mandated to attend treatment. Over time, there has been a shift to more diversion. This includes a formal contract to admit guilt on some level and to agree to treatment. We heard that the "option of charging is hanging over their heads somewhat" so that if a youth does not complete treatment, they could be charged. The CAC offers treatment for 10 to 21 year-olds. Offering services to this wide an age range is one of the unique aspects and strengths of this program. The CAC has four therapists and two part-time therapists (8 hour/week) all focused just on PSB. Treatment is a one-year program. They offer a variety of mediums, including EMDR, ITR, CBT plus, IFS. The program is funded by DJS – Juvenile justice and Baltimore County, which are 3-year grants they have to reapply for. Younger children, aged 7 to 9, are referred to providers in the community. These community providers are often full and then they refer to private providers who work with PSB. In 2012, they had MDT trainings that helped to change people's perspective and increase diversion. Other strengths of this program are that they have two specialized probation officers who understand this population and have a relationship with the CAC, and have specialized prosecutors.

Mountain CAC, Asheville NC. This CAC has a well-developed program for this population, with many treatment options available. They offer family, group, and individual treatment. The director developed one of the treatment models. They also use TFCBT PSB for children 12 and older, PCIT (Parent Child Interaction Therapy) for more aggressive children, and MST (Multi Systemic Therapy. They have two therapists for this population, one works with older kids and one with younger kids. Most are not court ordered to attend treatment. There is some diversion and this is becoming more common. If they do not start treatment, in rare cases CPS will file medical neglect and then substantiate this to get kids into treatment. They find that if they do not get treatment, they will see the youth 2-3 months later.

Treatment is funded by VOCA. They do not bill insurance because they find it is more problematic. Treatment focuses on trauma, attachment, and neuroscience because PSB is a symptom of a larger issue. Their re-offense rate is 3% for a sexual offense. They anticipate denial by the family and have a clinical supervisor to work on engagement. They use motivational interviewing to work through resistance to treatment. They have found that a successful strategy is to say to parents you did not cause it, but now you know about it and if it happens again, you could be legally responsible. They also show parents that treatment works and explain that when there are other behavioral issues, treatment can help with that as well.

Dee Norton CAC, Charleston, SC This CAC developed a treatment program 11 years ago for younger children and 3 years ago, they received buy in to expand services for adolescents. One of their lessons was that they learned that it took a lot of time to educate all professionals involved with these cases. They really underestimated the amount of outreach necessary, especially with the high turnover of staff. In particular, it took quite a bit of time to educate prosecutors because they had the mindset that residential treatment was needed for this group. To help with this, they shared research with prosecutors that residential treatment is not necessary, regardless of the offense. They also invested a lot of work to train law enforcement. A successful strategy was to invest in the development of two champions from the group of detectives. This has been very useful because they have found that officers will listen to another officer. They also had to educate juvenile justice psychosexual evaluators for the court who were recommending inpatient treatment so they could see that there are other viable options. A successful strategy was to use the PSB training series from NCA for MDT partners. They have found these especially helpful because the videos reinforce what they have been saying. It has also been helpful to bring in experts to talk about this issue to reinforce what they have been saying.

There is an informal diversion program where they encourage treatment and check in with the family every three months. Law enforcement has the file on their desk and tells the family they will shred it when treatment is completed. They use the Oklahoma PSB-CBT model for all ages. They looked at MST PSB for adolescents but had resistance to MST in the past and did not go this route. They had two grants to pay for Oklahoma PSB-CBT training. They also received a SAMSA 3-year training grant 11 years ago. There was 2-3 years of pre-work before the learning collaborative. This pre-work was described as critical because finding therapists to work with this population is challenging and it takes a while to build the buy in. They trained teams from 5-6 agencies. The training included consultation calls for 1 year. One agency dropped out and the only two that stuck with it were the two CACs. A couple of private practice therapists were also trained. In addition to attrition, with agencies dropping out of collaborative, there was also therapist turnover, and a lesson learned was to have a sustainability plan at the beginning. Overall, they described the learning collaboration as not so successful.

Five years after the SAMSA grant, they had an OJJDP grant on sustainability of the initiative. They found that it was too much for therapists to manage kids and families and hired a program coordinator for PSB. This person runs the program and provides ongoing outreach and case management. They estimate about ¼ of families are in the treatment programs. In a year, 12-15 kids graduate in the school age program. The program lasts 5 months with 5-8 kids in one group. The adolescent program is one year and needs better teeth/leverage to keep kids there then program for younger kids. In a year, 8-10 kids graduate. The program coordinator is now paid with unallocated CAC funds in addition to another grant that lasts for 2-3 years. VOCA is not interested in funding this. A successful strategy was to do a cost analysis to show the cost for one week of inpatient (about $800 a day for Medicaid) versus the cost of outpatient therapy.

National Children's Advocacy Center, Huntsville, AL. Like other successful programs, this CAC utilizes multiple therapeutic models. They use the Oklahoma PSB-CBT learning collaborative, have just started using TFCBT PSB with a preschool focus, have two therapists in private practice, and collaborate with the Continuum Care Institute at the University of Alabama. The Institute has a comprehensive program to serve this population that was developed more than 20 years ago. It serves: 1) Diversion - Adolescents involved with juvenile court and works with teens in the community, 2) Aftercare services – those leaving residential programs as they transition to the community, and 3) Younger kids - those not involved with court, 5-year-olds to adolescents.

The program serves 20 counties out of 63 and they are working to establish a statewide response. In 2016, there was a program evaluation of the diversion and aftercare population. Including non-contact offenses, the re-offense rate was 3% 4 years after program and 15% for general offenses (non-sexual).

With OJJDP funding, the Institute is expanding to serve school age children and to include a family model. They are also starting the PSB CBT adolescent model. They have learned that with manualized therapeutic models, it is easier to measure outcomes and it is easier to teach than with homegrown models. They do not bill for services – paid for by DYS, Department Youth Services.

They learned that processing these cases required a close relationship with the court system. They have a bifurcated juvenile justice system and each county interprets the state playbook very differently. They do have a true diversion program that includes two systems. One is the Department of Youth Services (DYS) that diverts from residential treatment. However, often there are no options for treatment available so youth would have to go to residential. Because this is not in the best interest of the youth, they created other options instead of placement. The second is that cases are diverted from the juvenile justice system. Most cases fall under the first scenario.

Before 2016, the Continuum Care Institute was not involved with the CAC. In 2016, the Institute received a OJJDP grant in Tulscaloosa County and the Institute slowly has infiltrated the CAC and now someone from the Institute attends the monthly MDT. As they have increased outreach, referrals have doubled. Few CACs see both victims and initiators. They are working with private providers through the CACs to serve this population and working to train more therapists.

One of the things they have learned is the power of outreach – as they did more of this work, referrals dramatically increased. The created a statewide "workgroup" which includes key decision makers – child welfare, juvenile justice, court, children's policy council, CAC. The first meeting is soon with the goal to understand how to have a consistent process and response for these cases.

The current CAC process is to interview both PSB victim and initiator (because it is welcoming and non-threatening and only ask about possible victimization). The advocate meets with the caregiver and if it has happened more than once or if coercion was involved the advocate describes group therapy. They are working to streamline the assessment process because it takes a long time. They have found that it is important for therapists to take a break when needed if they do not want to work with this population for a bit.

They have found that parents do not want to acknowledge how serious it is. They tell parents that they can help them avoid this behavior in the future and that it is a behavior change that needs to be addressed. They reassure them that the goal is not to arrest anyone but to change behavior. If parents think of children as victims, they seem to be more confident with treatment process.

They find that attendance at therapy can be difficult, even when there is a requirement to attend therapy. One lesson they have learned is that it is key to educate all professionals who work with caregivers about the value of therapy. It is important to help parents and law enforcement with what they think they know about this and to offer “hope” to parents.

Appendix G: Suggestions by Professionals to Help Achieve an A for Each Recommendation

Based on conversations with professionals in NH and across the country working in this area, we have identified five recommendations to improve the response to YPSB in NH. To better understand how NH is responding to this population, multidisciplinary professionals were invited to participate in an online survey and were asked to grade how NH is doing for each recommendation and to identify what would help achieve the recommendation. Participants (N=37) included CAC professionals, law enforcement, DCYF, mental health, and other professionals such as juvenile probation officers.

Recommendation #1: Educate everyone involved with youth with problematic sexualized behaviors.

Grade: C

What NH professionals working in the field believe would help achieve an A in reference to educating everyone involved with youth with problematic sexualized behaviors

There is a shortage of therapists in the area. Many want help and do not get it.

Everyone needs training.

Action plans would be training at the core level: In the police academy for Law Enforcement, on-boarding training for DCYF employees and, in particular, judges, certifications for mental health counselors working in the field.

Have trainings available via Pezi, Realias, and eventbrite and market them. These organizations reach different types of professions.

Required statewide training for all MDT members of sexual offenses and youth with problematic sexual behaviors.

There are not enough professionals in our community that specialize in this area and therefore not enough folks to tap into in terms of getting the proper education out to the MDT. We need more agencies that offer therapeutic services to YPSB and that can partner with us.

I think that more outreach and education is needed. Professionals who seek out information may be able to obtain needed education; however, not everyone seeks it out and/or is aware that it is out there.

More training readily available to community partners such as teachers, therapists, etc.

Continuing to work with MDT through case review, trainings and regular conversation. More materials/online resources for the MDT would be helpful.

Training more therapists to work with children to address the signs and symptoms of YPSB.

More education for law enforcement: encourage them to take these cases as seriously as adult sexual offenses. Victims of juvenile offenders are often left without justice, and juvenile offenders do not get the treatment they need.

While I think we are trying to do a decent job in terms of educating all involved, I think we still fall short. Certainly KNOW & TELL has been so helpful in terms of educating teachers in public school settings, there are many private schools/institutions who still fail to report and handle incidents of YPSB on their own.

School staff need more training or support

I am not sure, maybe more outreach.

NH would benefit from a "juvenile academy" - a training course required of police/prosecutors working with juveniles, guidance counselors with schools as well as DCYF and Juvenile justice professionals. This topic should be included.

To the best of my knowledge, there is currently no education being provided in this area. Roughly one year ago, Bridges organized a training by Kris Geno, of RTT Associates, to come to a case review to provide a training on this topic. This was helpful, but the audience was limited to those who attended case review that day. I believe outreach and education is being done on child sexual abuse and reporting laws, but not on the topic of YPSB.

More standardized training across the MDT-it seems most folks learn about YPSB issues "on the job" (many from their CAC's) and this really isn't discussed a lot outside those issues. Many do not understand that this is something that can be treated/can be an on-going issue and sweep it under the rug or do not know how to provide the appropriate interventions.

Continued platforms to provide to team members – i.e. webinar to share with new MDT members regarding this that can be incorporated into CAC orientation or MDT meetings.

Ongoing training and development of professionals within the state who then can remain in state as foundational supports to state stakeholders. Necessary changes may also need to include key state figures in developing response protocols to address YPSB rather than "just send them to therapy" practices or "the parents are protective enough so we aren't going to file". These protocols could then lead to the ability to create contract procurement opportunities with service agencies that can provide appropriate treatment and case management. With those opportunities come opportunities to provide education and development opportunities in order to maintain standards established within the contracts.

Continued outreach and education on the topic that is supported by the AG's office as well as County Attorneys and DHHS.

We would need more training for those who are working with these children.

We need more well trained experts, treatment providers, and increased accessibility to trainings (people don't attend trainings if they will loose income to make time/space to attend).

I believe mandatory training for judges and professional witnesses is necessary. In my experience, judges limit this information from a jury and when it is allowed, it is difficult to find a law enforcement member who can articulate the differences.

On-going annual trainings for partners. This could include large trainings such as the AG's conference and smaller, more concentrated trainings such as Case Review or teacher workshop presentations.

More training opportunities.

More training sessions in the office of DCYF

Start with recommending teaching and updated literature back up with UNH and state schools training therapists and social workers and police in NH

Why are we not doing better?

Only select attend training

I am a licensed clinician and I don't think that outside of this training, I have seen trainings specific to youth showing sexualized behaviors.

I think there's maybe an understanding of what PROCESS to use when these cases come up (in our county, at least), but I don't think there's an understanding of WHY we do it the way we do and why it's important to intervene ASAP. It's like a surface level understanding. Much more education is needed.

Lack of access to qualified trainers/professionals.

It seems that NH has limited resources available and those limited resources become non-existent in the large area of the state that is more remote.

Lack of education & resources.

Not enough resources, educational materials or trainings.

YPSB is a difficult subject and socially unacceptable and society does not talk openly about it to the point of almost being a secret subject.

We have no resources, and no money to implement them.

Some populations are much easier to reach and educate than others. Overall, I think that most law enforcement agencies have some understanding of the differences between sexually reactive behavior and sexual initiation. I know that anytime a LE agency reaches out to our CAC about a case, specifically involving an incident of YPSB, we use it as an educational opportunity.

I think educating judges and administration/staff/teachers at private institutions proves more difficult.

It would be helpful if NH adopted the MST approach to sexualized behaviors for youths and began to treat it as a behavior rather than a delinquent act or criminal act. NH is behind in its understanding of the whys and has absolutely no appropriate treatment options for our youth with sexualized behaviors

The poor schools....how could they possibly take on more right now?

I am not seeing any outreach by CAC to anyone other than Law enforcement.

Variation of services in parts of the state - the ability to navigate and utilize the supports and services that can be accessed through appropriate JJ referrals varies depending on region, frequency of use/exposure. This leaves large parts of the state with gaps.

We are not coordinated - many years ago when Maria Gagnon was the ED of the CAC, she developed a task force to examine and respond to this issue. We met regularly and all the key players were there - JPPO, County Attorney's office, CAC, law enforcement, DCYF, Bridges, Boys & Girls Club, some therapists etc. We were gaining momentum but then when Maria left, the work did not continue. We need someone who can devote the time to organizing a working group to address this issue.

Lack of awareness/funding

This past year has been difficult with so much turnover in partner agencies. Need to provide different platforms and avenues to provide this education.

Resistance to engaging with this population and the complexities that come with it, and a lack of specific uniform protocols for MDT members to follow in response to the identification of a youth exhibiting PSB.

No one wants to take the lead on this issue

The demand for services is so high, our helpers are burning out and are having trouble accessing the energy to learn more especially about difficult subjects like this.

I believe NH struggles in this area because of lack of judicial/ law enforcement training.

I think people are overwhelmed and feel there are not enough treatment options for juveniles. Understanding is the first step in working with YPSB populations.

CAC's are not talked about unless someone has to attend one.

Recommendation #2: Designate a lead agency and have community response protocol in place.

Grade: C-

What NH professionals working in the field believe would help achieve an A for designating a lead agency and having a community response protocol in place

Provide trainings/protocols at MDT meetings.

This all has to come from the top - AG's office - implementing the above, establishing the lead agency, protocols etc.

One release that lists all agencies needed to create the MDT. One signature gives ability to exchange basic information like demographics and need/treatment goals/progress.

A standardized protocol and the actual designation of a lead agency.

Create this system and provide our MDT with access to the education/protocol.

Having a lead agency designated along with a clearly outlined consistent response would be beneficial.

More resources. More involvement of a larger/different MDT than usually at the CAC to include the professionals listed above.

The Department of Health and Human Services provided workshops for the professional that were interested but until learning becomes part of an initial and updated mandatory training, this subject continues to be uncomfortable.

Training and protocol to establish consistency

I think designating a lead agency and having community response protocol would lead to best practice in these cases. I think having a lead agency would lend to more collaboration and cooperation as well as defined roles, follow through and accountability. When there is a dedicated response team, there is less of a chance for victims' and families to fall through the cracks.

Designating an entity as the lead organization and establishing MOUs for coordination of these cases, of course none of this matters without strengthening the MH response and services for these individuals.

If more than law enforcement and the CAC made the decisions

In our area, at least, collaboration is fabulous between CAC, probation, DCYF, mental health, and DV supports. The schools are not represented in the MDT and therefore often less informed.

Consistency across counties and offices.

Having one lead agency take the lead. The National Children's Alliance has a Best Practice document on YPSB and it suggests that the CAC's are in the best position to identify children and help prevent them from falling through the cracks.

We need an AG's protocol/addendum that addresses this issue. This is HUGE. Often these kids turn into a case of hot potato between DCYF, Law Enforcement and various JJ folks. We need a system that fits.

Need to have a strategy in place to establish lead agency and protocols. Maybe incorporating this into a statewide team summit.

Enlisting support of state stakeholders to create protocols that uniformly lay out appropriate/mandated response to identified youth exhibiting PSBs.

AG protocols that require this kind of response

The lead agency needs to inform all law enforcement they are the lead agency. Furthermore, they need to train other agencies on the beginning or originating steps of a case.

Statewide Protocols that address YPSB from the AG's office.

Who would talk the lead on this? JPPO?

Designate a lead agency in the state to help move this, also need training and accountability going forward.

Why are we not doing better?

Huge gap from report of incident to charge

Currently hit or miss within LE and DCYF, dependent on investigator. Judges are not educated. No avenues to pursue appropriate interventions and counseling.

No one person in charge of referral process to the different people on the MDT.

Everyone is so hands off about these cases - our MDT agencies are involved, but no singular agency is the agency to "take the lead" on YPSB cases. Perhaps that agency should be juvenile probation, and perhaps they should have a more significant seat at the table when it comes to these cases.

We do not have this to offer our teams at this time.

To my knowledge, NH does not have a designated lead agency for these cases, nor are there clear protocols.

Need for a protocol/policies in place. More collaborative work to include JPPOs at the table.

The connection between sexual abuse and children is not accepted as the major causation of mental illness.

We at the CAC try to educate our MDT on how best to handle these cases, but the response across agencies is so inconsistent

Counties in NH are large and diverse. Larger LE agencies have the benefit of having detectives and/or juvenile officers. Smaller agencies do not have this luxury. For this reason, patrol officers are often "covering" cases and have not had much, if any, formal training around CACs and the purpose and benefits of the multi-disciplinary team and the importance of each respective team members' role.

NH agencies do not work collaboratively – i.e. probation does not work with DCYF. Law enforcement is the only one who can call for a CAC. Schools are not involved in anything. Family court orders are ignored and not enforced by law enforcement- no centralized system.

The above is not happening.

We do not have a lead agency so addressing this need is not being done in any coordinated way. I get the sense that agencies that make up the MDT feel that taking the lead on this type of work is not under their mandate. This may be true, but we all have a stake in helping these children, so it is imperative that create a model to address this issue.

I just think each community has handled this stuff their own way and there has never been any specific guidance.

Lack of resources to address this. Team members needing the training and education and being allowed to attend training and be a part of response team.

Not sure. We have response protocols to child abuse that ensures timely and strategic responses to disclosures of child abuse that ensures victims are treated fairly and receive necessary supports to support their overall well-being. It is hard to answer the question as to why we do not have the same things in place for a demographic of children that without treatment can become offenders.

No guidance on what is best practice has been provided by any lead agency (AG, DHHS-DCYF, County Attorneys)

Not to repeat previous response, but believe there is a sense of an overwhelming task ahead, instead of breaking up goals into smaller more tangible tasks.

I think NH may not be doing terrible at this. JPPO in my area is pretty strong and trauma informed.

I do not know, but it may be because there is no clear agency or one that is not overburdened already with other aspects of child maltreatment.

Recommendation #3: Create a committee focused on this issue.

Grade: C-

What NH professionals working in the field believe would help achieve an A in creating a committee focused on this issue

There is not enough people maintaining these areas right now and it shows

Creating a committee

It takes time, keep advocating and reminding the committees/cheerleaders to keep going.

Creating a committee. This research study and the efforts going into this YPSB project are the most "committee"-like efforts I've known of thus far.

Put this type of service into practice.

Protocols/policies, more resources, more clinicians to work with these children and the MDT as a whole for education and training.

Training all mental health therapists in reactive sexualized behaviors and offering free continuing education courses as a way for them to add this in to their specialization offerings.

Actually establish people within the specialized roles described in the question

To my knowledge, nothing like this occurs in our state.

I may well not understand the question.....our MDT is fabulous, but is not focused on creating systems for YPSB

Additional services offered at the CAC.

I think a mix of both could work. Having specialized JPPO's, therapists, prosecutors etc. that meet as a group regularly like a wrap-around service for the child to make sure all the issues are being addressed. I was reading about the Sexual Incident Response Committee (SIRC) in Salem, Oregon, which enables schools to be the lead agency in identifying and addressing sexual misconduct. They work with their probation, DA, treatment providers, etc. They have a screening to assess the child's needs then mobilize resources to address the needs. It sounded very interesting and an effective approach to address the issue.

I think designating a lead agency who would then put together a committee would be the way to go-sort of need to do both to get things going

An initiative from the state might help with this (i.e. how CACs formed) or more like SART and ACERT initiatives

Creating a statewide committee that creates a set protocol of response pulling from all disciplines.

Any of the listed issues above. The only agency that is currently looking at the issues around YPSB is the GSCA

The CAC's I have interacted with do a tremendous job. They could of course use more training and resources. We could use dedicated probation officers but nothing will change unless the judiciary provides support.

Creating a statewide committee-starting small with a few representatives from law enforcement, DCYF, CAC's, juvenile probation/parole, prosecutors and therapists and building from this.

I certainly support specialized therapists working with children with problematic sexualized behavior and I think our judges need more education. But the reality is the laws need to be modernized to achieve all of this.

Develop a statewide committee, including mental health therapists, police, DCYF medical and trauma specialists or others who deal with children/teens in this specific area

Why are we not doing better?

It takes time to shift focus.

Everyone is talking about the issue amongst themselves/within their discipline/in their jurisdiction, but we are not expanding beyond that. To standardize the response across the state, I believe it would need to be a statewide committee.

We do not have this in our community (to my knowledge).

Need more consistency on how the cases are handled and more collaboration.

The subject is not discussed openly and parents are often blamed instead of addressing the reactive behaviors.

NH Is woefully lacking in mental health and treatment related resources for all ages, and there does not seem to be a lot of motivation to change these attitudes outside of the people who work in this field

NH has no availability for specialized trauma specialists. Our children are waiting up to 9 months to a year for a therapist. We have drug court without any follow up and probation officers who do not arrest for violations.

CACs are not consistent across services.

We have not met to discuss the issue as a group, so we have no plan to address this issue. The former child advocate at Bridges (now the family support worker at the Nashua CAC), worked with RTT to work out an informal MOU where Bridges could call her to see if she could provide some services to children/youth. We would explain the situation, and Kris Geno (RTT) could do

an assessment and provide condensed services to families who did not have insurance. If services were not mandated, however, families would not go to RTT or Clearview as there is often a great deal of denial around the issue.

Again, I think this has been done on a community by community basis but not statewide and there has been no formal protocol or universal best practice.

Lack of resources, funding to support.

Lack of education, lack of therapeutic supports specifically trained to address PSB (therapists and psychologists that conduct risk evaluations). Lack of desire to address a huge gap in service that ultimately reduces victimization in the future. I would also go as far as saying a lack of clear leadership at this time. Someone has to take ownership first to then pull in the rest of the disciplines.

No one wants to take the lead

Lack of judicial continuity.

I believe trying to decide you should start or facilitate this initiative.

Our laws need modernization.

Very little for PSB initiators.

In our area, we have only a few qualified mental health counselors. I don't think this has to be a sub field specialty though but better training at the core level.

Referral packets at local CAC's that biological parents need to complete for the local CMHC's to obtain the referral, get information from CAC interview and start services. This way, if the person is in foster/relative care or placement, the biological signatures can be obtained and services can be streamlined.

Trauma-informed therapists with specialized training in this area that are will be able to commit to working with these youth for a long term period of time.

Finding out if our local universities could provide something like this and could participate.

Having access to an adequate number of quality providers so that individuals are not placed on long waiting lists for services.

More clinicians who work specifically with initiators and victims of PSB. There are so few clinicians available. It would be great to have clinicians at the CACs who specialize in working with initiators and victims of PSB and their families.

Providing the link to resources is a good thing but it's an uncomfortable subject matter and there are multiple barriers to why a parent or trained professional would want to open the link and study it.

Actually implement the program(s) described in the question

The availability of more mental health resources and clinicians. Shorter wait lists/times for children and families to receive mental health services. While tele-therapy has certainly opened up more availability/opportunities to get children services faster, it is not a good fit for many.

We can certainly make referrals to services in our area, but we don't have the capacity to assess those needs in house, nor do we have the capacity to hire for that role.

Our local MDT is strong and connected...sometimes it is DCYF or CAC folks who work through resistance before MH ever meets them....

Perhaps money and time to develop such a committee.

Recommendation #4: Establish and expand mental health services.

What NH professionals working in the field believe would help achieve an A in establishing and expanding mental health services

Sometimes this is not even offered. Young adults who I have been in contact with do not like this approach and would rather be in person to make the connection

Very little for PSB initiators.

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Our local MDT is strong and connected; sometimes it is DCYF or CAC folks who work through resistance before MH ever meets them.

We do not have a case manager, but we do have a family support worker at the CAC. She works with parents who are resistant and does her best to help the family understand the importance of therapy. Bridges advocates do the same and we have training material on how to respond to common reasons parents don't want to pursue therapy for their child (he's so young, he won't remember anyways; by talking about it, it will just make it worse; I didn't have therapy when I was abused as a child, and I am fine etc.). I have spoken to some CAC models that have an in-house therapist and it is much easier to get the family connected this way.

Any step forward would help achieve this-this is abysmal in this state.

Free training/support to community mental health services to help them achieve this.

Education to treatment providers in appropriate response protocols for treatment and case management. Getting training in at the ground level with pre-licensed therapists may be most beneficial as this group needs experience and hours in order to get licensed. Other states run off this model to create increased access to service by having pre-licensed therapists get trained and developed in treatments that address high-risk children and families while under the supervision of more experienced professionals.

Incentives for therapist to be specifically trained in this area.

Clinicians who specialize in this area being available for this type of referral

Raise Medicaid reimbursement rates

Decrease barriers for professionals to work in NH (our licensing board is too rigid)

We need more providers.

More incentives for therapists to work with this population.

We need many more therapists so wait lists aren't so long. Often so much time goes by the initial crisis has passed and families could be more resistant to supports.

Having an expert and mental health services within each CAC throughout the state

Why are we not doing better?

Too few mental health counselors educated in the field or feeling like it needs to be a specialty field.

Not jumping on getting signatures of biological parents when we have them around. With children often not being in their care, we can't miss these opportunities when they are there to get signatures that may be needed in the future.

Significant lack of MH services, significant unwillingness (or lack of knowledge) on how to work with/treat this population, significant therapist turnover.

To my knowledge, we do not have anything like this in NH.

NH does not have nearly enough providers to offer services to all those who need it. This is especially true in the more remote locations throughout the state.

More clinicians and resources for the youth and their families/caregivers.

It is not an openly discussed subject matter and numerous bias concepts to overcome.

Again, NH is woefully lacking in any kid of resources like this

There is an overwhelming shortage of mental health resources and clinicians for kids in this state.

To my knowledge, this is not occurring and telehelath is not best practice especially for a PSB youth.

Perhaps if we developed a strong, consistent message from the MDT about how therapy can benefit their child. Sometimes the information the team gives to the parent in the post interview is very limited for a variety of reasons usually involving the police or DCYF. In addition, there are a lot of kids who don't disclose during their interview. Therefore, when the parents go into the post meeting, they may get the message that their child did a great job and there were no disclosures. The parents often stop listening after that as they are so relieved as they equate no disclosure with no abuse which is not the case. Perhaps a category of 'unable to determine' instead of 'no disclosures'. I know our CAC interviewer usually always recommends therapy but I have had some parents question the need for therapy if nothing happened.

Lack of funding

Lack of resources - this past year many community mental health centers are finding it difficult to fill open positions.

I don't believe many, if any agencies offer a specific treatment program to address PSB.

Lack of a clinical work force

Our Medicaid reimbursements rates are dramatically lower than surrounding states for outpatient mental health services forcing many private providers simply refuse to accept it. The demand for services is high and our capacity/work force is too low. Many are not getting access to care.

There is such a shortage of mental health clinicians in the state and this such a specialty with limited supports.

I don't know how to hire more therapists.

Need to develop CAC's that speak not just to forensic interview and related coordination, but also to medical and mental health needs of child and family.

Recommendation#5: Establish and expand diversion programs.

Grade: D+

What NH professionals working in the field believe would help achieve an A in establishing and expanding diversion programs

More programs for these youth are needed

Again, this goes back to education and training at the core level.

Teaching of this resource to other professionals.

Creating or educating about diversion programs throughout the state.

Providing more that one specialist in the subject matter and expect them to cover multiple counties and have parents travel to help their children have access to treatments.

Training and implantation of the programs described in the question

I am not overly familiar with the diversion program(s) in our area and how often it is used. That being said, with a 3% recidivism rate, it sounds as though it is something we need to explore/evaluate more. It would likely be beneficial to focus on the rehabilitative focus, especially in YPSB cases.

We have had diversion programs in my county historically (I use to work for one), but they have not had longevity in our area.

The Association for the Treatment of Sexual Offenders (ATSA) has a report from the task force on children with sexual behavior problems and they cite two randomized trials that

demonstrated the effectiveness of CBT for children with sexual behavior problems. The National Children's Alliance also recognizes CBT as an effective treatment model. NH would need to work with providers who specialize with YPSB to discuss how to deliver this service in an accessible way for all families (cost of therapy, transportation, childcare issues for siblings). Any treatment though has to include the parent/caregiver. The NCSBY also discusses the need for CBT and TF-CBT to address children's trauma but safety should be the dominant focus.

More knowledge of best practices in this area/more formalized programming

funding/programs

Response protocols

Have diversion programs in all counties and have them all be active and communicate with each other. They need to be uniform.

Lack of established diversion programs in many counties and even the ones that have diversion do not have the clinical work force to refer these kids to.

More programs and a better understanding of what resources are currently available.

We have local diversion that are effective

I do not know, but agree that diversion and expansion of its use in rehab of children/teens would be ideal.

Why are we not doing better?

Diversion is not appropriate in these cases

As a licensed clinical mental heath counselor, I can't name a program in my area for helping youth offenders.

Not sure. Admittedly, I don't know much about the juvenile diversion programs in the state.

More resources/referral sources.

Therapists and Behaviorists are uncomfortable providing advice and treatments in New Hampshire.

NH is woefully lacking in both resources and professionals needed to implement any kind of treatment related programs, and law enforcement gets inconsistent training

I do not think NH has a diversion program for PSB

We do not have a coordinated response - whether it be rehabilitative or punitive. Some police departments have had to put a juvenile petition on a child as a way for them to get the appropriate services. DCYF can't mandate counseling unless it becomes an open case, and often these cases are closed during assessment phase, so no counseling can be enforced.

Again, lack of funding and lack of providers equipped to work with this population

Lack of consistency across the state. Resources of diversion programs.

Not sure where New Hampshire is at in this process. However, if I'm reading it correctly it could be very beneficial in addressing PSB.

No one wants to take the lead, lack of clinical work force to address YPSB, no protocols or guidance to help steer the response

An assessment of what is currently being offered in the state (name of therapists, facilities and programs) is critical. From here have a centralized list of these resources for every discipline. As a committee is formed, there could be a statewide "case review," for the committee members who choose a couple of cases to review specific to YPSB.

Do you have suggestions for short-term changes to address YPSB?

Mandated training in all disciplines

JPPOs should be involved from detection of problematic behaviors and on; not just after a CHINS or other adjudicatory hearing.

Educational materials for families and teams. Education for clinicians to increase their knowledge/ability to work with initiators and victims of PSB.

Additional research, more education and accessibility to treatments.

Easy access to training for schools...web based, and in short intervals....

Perhaps we could start by having one person identify all cases involving YPSB. Bridges noticed this pattern in the spring and summer of 2018 (roughly 20 cases). We brought it to the attention of the CAC and met to discuss it. Bridges then met with a JPPO, a DCYF supervisor and the Office of the Child Advocate. We did not make much progress in addressing this but everyone agreed it is an important issue that needs to be addressed. In the short term, perhaps every case involving YPSB could be on case review so it can be discussed thoroughly. Perhaps a staff member of RTT Associates or a therapist connected to ATSA could attend the case review to give their expertise.

Getting a committee together ASAP of committed professionals throughout the state. It does not need to be large to begin with and can be expanded as it develops.

1- Helping family to understand YPBS and the importance of intervention for the child and others, short term and long term. 2 Find out models utilized in other states to actualize interventions. 3. Look into funding and legislative measures to sponsor bills/funding

Do you have suggestions for YPSB protocols?

Time frames on when cases should be brought in by. Not just based on statute of limitations- have to consider youth with PSB and victims needs.

Exactly everything already stated: All child-on-child goes to lead agency and evaluated on allegations and age of offenders. Cases deemed serious allegations are investigated and set up for both MH and pyscho-sexual and diversion intervention/probation/school/family court. Cases deemed minor child-on-child are investigated and set up for family intervention and MH counseling.

Consent forms for other area agencies available at CAC's to help ease referral process.

Set age limits, CPSWs doing interviews when appropriate, police departments and DCYF working collaboratively to make the decisions about how the case moves forward.

Make the training mandatory for the subject matter. The more it is addressed and discussed the more opportunities there will be for accessible treatments.

I would recommend following the best practice protocols laid out by the National Children's Alliance. In addition to their best practices document, they also have documents and videos on: where to begin, what we can do, what happens now etc. Thank you for doing this work!

Just that something needs to come out of the AG's office so it is statewide. I also think if we are rolling out a new addendum or protocol it would be helpful to provide training along with it that reaches many members of the MDT, not just investigative partners.

It would be nice to form a committee of professionals across the state to really delve into forming realistic protocols for both the investigation process and more importantly the treatment process.

Mandated completion of treatment protocols from providers specific trained/certified in PSB intervention and treatment to ensure decreased risk of continued PSB.

Utilizing the protocols from other states and adapting to NH so not reinvent the wheel.

1- What adults need to do if a child is seen with complaint of YPSB, by educators, by medical personnel 2. Steps to take after initial history taking