

Children with Problematic Sexualized Behaviour



Environmental Scan & Service Needs Review

October 2022



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on behalf of Association of Alberta Sexual Assault
Centres



Acknowledgements

We would like to gratefully acknowledge the following organizations and individuals for sharing their expertise and experience:

Alberta Health Services Child Abuse Service (Calgary, AB)
Association of Communities Against Abuse (Stettler, AB)
Calgary Communities Against Sexual Abuse (Calgary, AB)
Caribou Child and Youth Centre (Grand Prairie, AB)
Central Alberta Child Advocacy Centre (Red Deer, AB)
Central Alberta Sexual Assault Support Centre (Red Deer, AB)
Child and Youth Sexual Abuse Team (ON)
Chinook Sexual Assault Centre/ Child and Youth Advocacy Centre (Lethbridge, AB)
Dragonfly Counselling and Support Centre (Bonnyville, AB)
Lethbridge Family Services (Lethbridge, AB)
Little Bear Child and Youth Advocacy Centre (Lloydminster, AB/SK)
Lloydminster Sexual Assault Services (Lloydminster, AB/SK)
Lumenus Community Services (North York, ON)
Luna Child and Youth Advocacy Centre (Calgary, AB)
PACE Centre (Grand Prairie, AB)
Radius Child and Youth Services (Oakville, ON)
Saffron Centre (Sherwood Park, AB)
Sanare Centre (Medicine Hat, AB)
Sexual Assault Centre of Edmonton (Edmonton, AB)
Waypoints Community Services Association (Fort McMurray, AB)
Wood's Homes Phoenix Program (Calgary, AB)
Zebra Child and Youth Advocacy Centre (Edmonton, AB)

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Executive Summary

The Association of Alberta Sexual Assault Services (AASAS) is a provincial umbrella organization, representing 15 member agencies, whose mission is to provide a unified voice on sexual abuse and sexual assault issues, increase access to sexual assault and abuse services, and work with government and other stakeholders to develop effective policies and sustainable program funding. In February of 2022, AASAS received funding from the Ministry of Health to conduct an annotated bibliography, literature review and environmental scan/service review for children/youth with problematic sexual behaviour. This process included conducting 28 interviews with members from Alberta sexual assault services/child advocacy centres/community-based organizations, Alberta-based problematic sexual behaviour experts and other notable Canadian programs.

Literature Review – In Brief

The literature review aimed to shed light on the issue of problematic sexual behaviour amongst children and youth by summarizing current scholarship and critically examining it in relation to survivor-centric theory and practice. It revealed problematic sexual behaviour is a highly complex social issue with a heterogeneous population ranging in age, development, behaviours, motivations, pathways, risks, and protective factors. Contrary to common belief, the evidence indicates most young people with problematic sexual behaviours will not grow into adults who commit sexual crimes. Scholars and advocates therefore caution against language that is stigmatizing and harmful, as many of these young people have faced trauma and adversity and are undergoing important developmental changes (Silvosky et al., 2020). Furthermore, the behaviour is unlikely to persist (Lussier, 2017). Indeed, problematic sexual behaviour is the result of a complex interplay between individual, family and environmental factors (Silvosky et al., 2020) and must be viewed from a trauma-informed and developmental lens (Lussier et al., 2019).

Yet, despite the reasons for the behaviour and the low risk of persisting or reoffending, sexual abuse victimization remains unacceptably high and can result in significant harm. Sexual assault centers have long witnessed the harm from sexual abuse, even amongst children, and have worked tirelessly to support those impacted. This is further complicated by the high rate of under-reporting and the limited success of the criminal justice system in prosecuting sexual abuse cases, which likely results in underestimating recidivism (Beek et al., 2018). For these reasons and given the high proportion of child sexual abuse that occurs from other young people, scholars have advocated for prevention and early intervention efforts for problematic sexual behaviour (McKibbin & Humphreys, 2020; Shawler et al., 2020; Silvosky et al., 2020).

Furthermore, in contrast to what the low recidivism rates suggest, sexual violence continues to be a pervasive social issue. To illustrate, over a six-year period (2009-2014), there were 117,238 police-reported sexual assaults in Canada, mostly among young women and girls (Rotenburg, 2017). Self-report studies show substantially higher rates. Using data from the General Social Survey, 636,000 sexual assaults were found in 2014 alone (Conroy & Cotter, 2017). Therefore,

further work is needed to understand the low recidivism rates for adolescents with sexual behaviour problems, the desistance of the behaviour between adolescence and adulthood, and the continually high rates of sexual violence against women and girls.

This work presents an opportunity to deepen our understanding of young people with problematic sexual behaviour and consider what role sexual assault services have, if at all, in working with this group. More work is needed to understand the possible implications to victim-based services and how this sector can collaborate and consult with those who work in the offender-based field in a shared effort towards prevention and early intervention.

Service Mapping – In Brief

In Alberta, most services are available only after a youth is engaged with the criminal justice system (i.e., forensic-based services). Some forensic services are specialized to sexualized behaviour, while others address youth criminal behaviour in general. Typically, these services are not easy to find (or to find information about) since they are only accessible through referral or court order. Outside of these services, the following was found:

- Four specialized community-based services (Dragonfly Counselling & Support Centre – Bonnyville; Lloydminster Sexual Assault Services; Central Alberta Sexual Assault Support Centre - Red Deer; Child Abuse Service (AHS) - Calgary)
- Seven specialized forensic psychologists and clinicians who may be contracted to provide private services to children/youth with problematic sexual behaviour
- Three agencies who will see this population within their regular programming (Grand Prairie Sexual Assault and Trauma Centre; Sexual Assault Centre of Edmonton; Lethbridge Family Services)

Themes from Qualitative Interviews – In Brief

Service Need: In interviews with sexual assault services and child advocacy centres, the majority indicated they receive requests for services regularly, with some noting increasing frequency over the last few years. Some of these young people are identified at intake or triage.

Who are these Children? They are highly varied, and there is no one typology. There are some common individual, family and environmental factors/characteristics. These young people are not the same as adults who sexually harm others and must be treated differently.

Key Issues:

Stigma/Fear: These children/youth and their families face pervasive and harmful stigma. Society largely responds out of fear, assuming these children are the same as adult sexual offenders.

Caregiver Response: Parents/caregivers have a range of reactions and lack information and support. Many situations involve sexualized problematic behaviour with siblings and other family members, leading to extensive family disruption and breakdown.

Children's Services Response: Challenges accessing timely and appropriate supports through Children's Services. As a result, many families sought assistance from community-based organizations, where they also encountered limited availability of specialized services for children and youth with problematic sexual behaviour.

School Response: Variability in school responses. Uncertainty regarding problematic sexual behaviour sometimes resulted in approaches perceived as punitive or inconsistent with trauma-informed and treatment-oriented approaches.

Access to pornography: Access to sexually explicit material is highly prevalent amongst this population.

Treatment Best Practices: Children/youth with problematic sexual behaviour have a range of treatment needs. Skilled clinicians with specialized training are required to work with this population. Expert clinical supervision is also needed. Proper assessment is critical for determining the best course of action and level of treatment for these children/youth. Holistic assessments that include protective factors, needs and understanding of the environment (including family/home life) rather than focusing solely on problematic or offending behaviour, are best practice. Parents/caregivers are, in essence, *the most* important part of treatment, as treatment success can hinge on parental engagement.

Service Gaps/Challenges: Accessible, specialized services are needed for all ages and genders. Most services available are for male youth over the age of 12 who have been charged, although this too is limited, with demand outpacing available services. There is also a shortage of skilled/trained clinicians in the province. Community-based organizations do not have the resources to send their clinicians to training or provide expert clinical supervision. Other gaps include limited available family support, system engagement/accountability, and general knowledge and awareness about children/youth with problematic sexual behaviour.

Collectively, these findings highlight opportunities to strengthen Alberta's response to children and youth with problematic sexual behaviour and their families. The recommendations that follow are intended to support ongoing collaboration among government, sexual assault services, child advocacy centres, community organizations, and other partners to improve access to coordinated, specialized, and evidence-informed supports.

Recommendations

1. Identify clinicians/agencies willing to work with children/youth with problematic sexual behaviour in Alberta and seek funding to provide specialized training.

2. Formalize access to regular expert clinical supervision and consultation for service providers across the province.
3. Establish a community of practice amongst clinical service providers to establish standards of practice, review evidence-based interventions and create new knowledge in the Alberta context.
4. Examine efficacy of virtual services for families in rural/remote communities.
5. Provide general education about children/youth with problematic sexual behaviour to organizations and individuals supporting children impacted by sexual abuse, including but not limited to: sexual assault services, child advocacy centres and other clinicians.
6. Develop an education program for schools and other community partners.
7. Develop an information source for parents/caregivers.
8. Collaborate with Children's Services to strengthen the service response for children and youth with problematic sexual behaviour and their families.
9. Develop a province-wide safe internet usage and anti-pornography campaign for both parents and young people.
10. Collaborate with child advocacy centres to strengthen service pathways for child and youth with problematic sexual behaviour and their families.
11. Establish a prevention-focused committee in the province.

Introduction & Background

The Association of Alberta Sexual Assault Services (AASAS) is a provincial umbrella organization, representing 15 member agencies, whose mission is to provide a unified voice on sexual abuse and sexual assault issues, increase access to sexual assault and abuse services, and work with government and other stakeholders to develop effective policies and sustainable program funding. An intermediary focused on improving the effectiveness of services related to sexual violence, AASAS' goals are to serve as an umbrella organization for the collaborative and coordinated efforts of Alberta community sexual violence service providers and to provide comprehensive, streamlined, multidisciplinary sexual violence services to all Alberta residents, regardless of language, culture, race, ethnicity, religion, class, sexual expression, gender, age, or ability.

As part of this work, AASAS facilitates a Clinical Directors Network comprising clinical directors from member organizations. In 2021, the Clinical Network began discussing a growing trend many members were seeing in their agencies. Families of children and youth with problematic sexualized behaviour were contacting agencies and requesting support/services. The network expressed an interest to AASAS in further exploring and increasing understanding of the service needs of this population and the services available in the province.

In February of 2022, AASAS received funding from the Ministry of Health to conduct an annotated bibliography, literature review and environmental scan/service review for children/youth with problematic sexual behaviour. This report presents the literature review and findings from the environmental scan/service review.

Project Objectives:

The project had 4 objectives:

1. To increase understanding of the issues surrounding children with sexual behaviour problems (or, what is the nature of the problem?)
2. To understand what we need to do to address it well
3. To describe the current service landscape in Alberta for this population/issue
4. To develop recommendations for next steps in improving the service response in Alberta

This report is intended to inform ongoing dialogue and collaboration among government, child advocacy centres, community organizations, and other partners. Its findings and recommendations are designed to identify opportunities to strengthen Alberta's response to children and youth with problematic sexual behaviour and their families through enhanced coordination, shared learning, and improved access to specialized supports.

Methods:

In addition to the annotated bibliography and literature review, there were two additional methods employed:

1. Interviews

- Members from Alberta sexual assault services/child advocacy centres/community-based organizations (N=19)
- Alberta-based problematic sexual behaviour experts (N=6)
- Other notable Canadian programs (N=3)

In total, 28 interviews were conducted and thematically analyzed. Interview questions can be found in Appendix A.

2. Online environmental scan/analysis

- Guiding question: What services are available for children/youth with problematic sexual behaviour in Alberta? Canada?
- Services in Alberta and Canada were identified through a Google search using combinations of the following keywords: (children OR youth OR adolescent) AND (sexual harmful behaviours OR problematic sexual behaviours OR intrusive sexual behaviours OR sexual offences OR sexual perpetration) AND (Alberta OR Calgary OR Edmonton OR Canada).
- Services were summarized across various themes such as target population, setting and treatment approach

Full results from the environmental scan can be found in Appendix B.

Literature Review

The literature review that follows aims to shed light on the issue of problematic sexual behaviour amongst children and youth by summarizing current scholarship and critically examining it in relation to survivor-centric theory and practice. Some topics such as risk assessment and clinical treatment are not reviewed in depth. Given the primary audience for this review is people engaged in survivor-based work (e.g., sexual assault centres), the review set out to provide a foundational evidence-based understanding. It also aims to explore how offender-based work is, or could be, situated within survivor-centric work, and where there are gaps, remaining questions and tensions in both research and practice.

Terminology & Definitions

The scholarship uses many terms for children and youth with these behaviours, making this a challenging topic to navigate. Some phrases used are “sexual behaviour problems,” “problematic sexual behaviour,” “sexually harmful behaviour,” “sexual offending,” and “juvenile sexual offending.” Since terminology differs between those under 12 and those over 12, each will be discussed separately below.

Children under 12

When speaking about those 12 and under, the literature appears to be generally consistent in using child-first language such as “children with sexual behaviour problems,” “children with problematic sexual behaviour” or “children exhibiting sexualized behaviour problems.” Doing so avoids stigmatizing language and emphasizes the behaviour as the problem, not the child themselves (Silovsky et al., 2020). The Association for the Treatment of Sexual Abusers (ATSA), a highly reputable international and multidisciplinary organization promoting evidence-based practice, uses the term “sexual behaviour problems” for children ages 12 and younger (Chaffin et al., 2008).

For these children, there is no widely agreed definition in the literature about what constitutes problematic sexualized behaviour (Lussier et al., 2019; MNCASA, 2017). In 2006, ATSA established a task force that defined sexualized behaviours in children as:

Children ages 12 and younger who initiate behaviors involving sexual body parts (i.e., genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others (Chaffin et al., 2008, p. 198).

These behaviours exist along a continuum from inappropriate to problematic to abusive and can involve behaviours that are entirely self-focused (e.g., excessive masturbation) or involve other children. They also range from showing/looking at private parts to fondling and penetration (MCASA, 2017). The main considerations when determining if sexual behaviour is problematic include behaviour frequency, developmental factors, and level of harm (Mesman et al., 2019). In a review of the literature, the Minnesota Coalition Against Sexual Assault (MNCASA, 2017) offered:

Sexual behaviors are viewed as developmentally inappropriate when they (1) occur at a greater frequency or at a much earlier age than would be developmentally or culturally expected, (2) become a preoccupation for the child, and/or (3) reoccur after adult intervention/corrective efforts (p. 21).

When determining potential for harm amongst children under 12, other scholars consider the following: whether the situation involved age/developmental differences between the young persons; if coercion, force, or intimidation was used; whether the sexual behaviours caused emotional distress and/or physical injury; and whether the sexual behaviours interfere with the child's social development (Lussier et al., 2019).

The developmental emphasis on these descriptions is evident and consistent with much of the literature. Scholars underscore the developmental difference between children under 12 and adolescence, thus refraining from referring to it as "sexually abusive behaviour" for children under 12 (DeLago et al., 2020). ATSA (n.d.a) explains: "Children under age 12 are identified as having atypical sexual behavior, not sexually abusive behavior, due to their young age, developmental level, and the continual changes that occur throughout childhood" (Fact 4). What's more, children under 12 differ in their motivations. These behaviours may be due to curiosity, anxiety, imitation, attention-seeking, or soothing (Chaffin et al., 2008), and they are more likely to act impulsively, rather than with planned, rationalized acts (ATSA, n.d.a).

Children over 12

For children over the age of 12, terminology is less straightforward. Some continue with problematic sexual behaviour language described above up until the age of 18, citing accordance with the United Nations Convention on the Rights of the Child (Silovsky et al., 2020). Others refer to youth differently using language such as "juvenile sexual offender" or "adolescents who offend sexually" to reflect the criminal nature of the behaviour. This language aligns with Canada's Youth Criminal Justice Act, where children over the age of 12 can be charged with a criminal offence. Leamon (2016) rationalizes that this is because 12 is recognized as the age of moral maturity; when a child is developmentally able to process complex moral issues and understand actions and consequences. However, not all children over the age of 12 are the same, nor are their sexually problematic behaviours. The California Evidence-Based Clearing House for Child Welfare (2022) explains:

Many labels have been used to capture some youth in this population, including "adolescent sex offenders," "sexually aggressive youth," and "juvenile sex offenders" to name a few of the most common labels. These labels were considered too narrow for this topic area. For example, not all youth who engage in sexually aggressive behaviors are "offenders" in the legal sense and not all juvenile sexual offenders have engaged in aggressive or nonconsensual sexual behaviors (e.g., many are so-called status offenders who engaged in consensual sexual activities with peers). Moreover, these labels have the unfortunate and unnecessary effect of labeling the youth, rather than the behavior.

Adolescents with sexual behavior problems comprise a heterogeneous group of youth, none of whom should be characterized primarily by his or her sexual acts (para. 1).

While the above quote reflects the United States legal context, it demonstrates the variation and complexity of the issue amongst adolescents. For example, adolescents with problematic sexual behaviour may also have intellectual or cognitive disabilities, rendering their functioning at a younger developmental age (Blasingame, 2018). In one study, adolescents with a learning or cognitive disability accounted for over one third in a 700-person sample from problematic sexual behaviour treatment programs in the United Kingdom (Hackett et al., 2013). Problematic sexual behaviours for youth range as well and can include voyeurism, exhibitionism, fetishism, frottage, sexualized comments, public masturbation, and sexual assault/abuse (Blasingame, 2018).

Given the complexities of language and definitions, this literature review will consistently use the term “problematic sexual behaviour” for both children and youth, in line with the bulk of the literature. For adolescents who have been charged and/or convicted of a sexual offence, this review will refer to them as “adolescents who have committed sexual offences” in an effort to use person first, non-stigmatizing language (Malvaso et al., 2020). Since much of the research on youth has been with those who have been adjudicated for a sexual offence, using this language will reflect this reality. When the word “child” is used in this report, it refers to children under the age of 12. When “youth” or “adolescent” is used, it refers to those over 12 years old.

Prevalence & Characteristics

There are no national population-based statistics on the incidence rate of problematic sexual behaviour in children and youth, largely due to inconsistencies in identification and reporting (Mesman et al., 2019). Current police-reported data, however, indicate youth make up a large portion of those who commit sexual offences against other children/youth in Canada. National police-reported statistics indicate 30% of those accused of sexual crimes against children and youth were under the age of 18 (Cotter & Beaupré, 2014). More specifically, when the victim was under the age of 12, the most common age range of the accused was between 12 and 17 years old (39%). When the victim was between 4 and 6 years old, 46% of those accused were between the ages of 12 and 15 years. When the victim was between 0-3 years old, the most common age range of the accused was 12 to 15 years old (25%).

These rates, however, likely underestimate the extent of adolescent-committed sexual offences, as sexual abuse in general is a highly underreported crime where non-disclosure or delayed disclosure are widespread amongst children (Azzopardi et al., 2018). For example, in a representative sample from Quebec, Canada, three-quarters of adults either never disclosed their childhood sexual abuse or delayed disclosing by more than five years (Hébert et al., 2009). Studies involving self-reported instances of sexual abuse by other young people show much higher rates than official statistics. In a nationally representative study of children and adolescents in the United States who had been abused, 76.7% of sexual offences against males

and 70.1% against females were committed by another adolescent (Gewirtz-Meydan & Finkelhor, 2020). Comparing this to the Canadian police-reported rate of 30% illustrates the possible extent of the reporting gap.

Determining prevalence rates of children under 12 with problematic sexual behaviour is more difficult since they are typically not found through policing statistics and no one system is responsible for responding to reports (MNCASA, 2017). Data from the U.S. Department of Justice on 13,471 adolescents who had committed a sexual offence against a minor found that 16% were under 12 at the time of the offence (Finkelhor et al., 2009).

Sex of Child/Youth with Problematic Sexual Behaviour

As far as males versus females, females with problematic sexual behaviour are typically younger than males (DeLago et al., 2020; Finkelhor et al., 2009; Silovsky & Niec, 2002). In some research samples, they also have higher rates of child sexual abuse victimization (DeLago et al., 2020), mental health problems and PTSD (Malvaso et al., 2020). There is also some evidence that females engage in less invasive behaviours and are less coercive than males with problematic sexual behaviour (DeLago et al., 2020; Miccio-Fonseca & Rasmussen, 2014).

Police-reported statistics show male adolescents are responsible for the vast majority of sexual offences in the United States (Finkelhor et al., 2009) and Canada (Cotter & Beaupré, 2014). Likewise, research based in treatment settings has also shown the majority of these young people are overwhelmingly male (DeLago et al., 2020; Hackett et al., 2013). Data from child welfare agencies, however, show almost similar rates of males versus females with sexual behaviour problems. A study based in Quebec, Canada, found that of those aged 5-18 who had been involved in a child protection investigation for problematic sexual behaviour (N=957), 56.4% were male, and 43.6% were female (Lussier et al., 2019). This study did not include a data breakdown of age by sex; however, whether females comprised the younger age group, consistent with previous research, is unknown.

Relationship

When children/youth with sexual behaviour problems involve others, they are most likely to do so with a family member. In police-reported Canadian data, 59% of adolescents who had been accused of committing a sexual offence against those under 12 years of age did so against a sibling, cousin or an extended family member (Cotter & Beaupré, 2014). Other samples of children and youth with problematic sexual behaviour have made similar conclusions. In DeLago et al. (2020), three-quarters of their sample (N=218), or 70% of children under 13 years and 87% over 13, were related to the child with whom they engaged in the behaviour.

Pathways to Problematic Sexual Behaviour

Child Sexual Abuse

Research has repeatedly shown that the majority of survivors of child sexual abuse do not go on to sexually harm others or develop problematic sexual behaviours (Allen, 2017; Leach et al., 2016; Ogloff et al., 2012). Yet, those who commit sexual offences are more likely to have histories of sexual abuse, indicating there is an association between the two. For example, two large meta-analyses found a much higher rate of sexual abuse histories in both adolescents (Seto & Lalumière, 2010) and adults (Jepersen et al., 2009) who had committed sexual offences compared to non-sexual offending counterparts. In another study using a nationally representative sample of 6,628 grade 9 students in Switzerland, Aebi et al. (2015) found boys who had been sexually abused were significantly more likely to self-report using sexually harmful behaviours. Females were also found to be at increased risk in this study.

There is also an association between child sexual abuse and children under 12 displaying problematic sexual behaviour. In a sample of 1,112 children, Allen (2017) found children with sexual behaviour problems were significantly more likely to have histories of sexual abuse. Finkelhor and Browne (1985) theorize this is due to “traumatic sexualization,” where children who have experienced sexual abuse learn that sexual behaviour is a means to achieving a need or goal. Traumatic sexualization can also manifest as PTSD where a child “experiences child sexual abuse-related intrusive thoughts and hyperarousal that then prompts the commission of sexual acts” (Allen, 2017, p. 190). Although child sexual abuse is associated with problematic sexual behaviour for both children and youth, there are many young people who exhibit these behaviours and do not have a sexual abuse history, suggesting there are other causal factors involved (Allen, 2017).

Child Adversity & Trauma

More recently, several studies have focused on examining whether other forms of child adversity are associated with problematic sexual behaviour. For example, emergent evidence suggests a link between problematic sexual behaviour and exposure to domestic violence. Ybarra and Thompson (2018) analyzed six waves of data from 1,586 youth (ages 10-21 years) between 2006 and 2012. They found exposure to parental intimate partner violence was strongly associated with the development of sexually aggressive behaviours. Likewise, in a study on younger children, Canadian-based research found a significant association between children aged 3 to 5 years with problematic sexual behaviours and sexual coercion between their parents (Cale & Lussier, 2017). From these findings, the authors theorize that sexually abusive behaviour between parents may disrupt normal sexual development of young children, leading them to model harmful sexualized behaviour with others.

Research is also finding that multiple forms of childhood trauma and adversity, including sexual abuse, physical abuse, parental neglect and exposure to domestic violence, are associated with problematic sexual behaviour (Allen, 2017; De Lago et al., 2020; Gross et al., 2017; Hackett et al., 2013; Lussier et al., 2019; Malvaso et al., 2020; Seto & Lalumière, 2010). In

a sample of 957 Canadian children/youth with child protection files on problematic sexual behaviour, Lussier et al. (2019) found that many of the Children/youth experienced significant life adversities such as physical abuse, sexual abuse, parental neglect and other serious nonsexual behaviour problems. Just over half of the sample (52.3%) had experienced at least two types of victimization, and 11.3% had experienced at least four. Lussier and colleagues conclude problematic sexual behaviour “is best understood from a trauma perspective where [problematic sexual behaviour] is part of a developmental history characterized by the accumulation of early life adversities including polyvictimization which impact[s] the child’s functioning in multifaceted ways” (p. 47). Allen (2017) refers to this as “developmental psychopathology”, where emotional and behavioural dysregulation result from child adversity and manifest as problematic sexualized behaviours.

Exposure to Pornography & Sexual Content

Problematic sexual behaviour is also associated with pornography usage. In a meta-analysis of 22 studies across seven countries, Wright et al. (2016) found pornography use positively and significantly correlated with sexual aggression for both adults and young people, male and female. Likewise, Ybarra and Thompson (2018) showed the use of violent pornographic content was associated with sexual aggression amongst adolescents even after controlling for other risk factors. Several other studies have found a significant association between pornography exposure and sexual aggression in young people (Dawson et al., 2019; Vera-Gray et al., 2021; Vega & Malamuth, 2007; Ybarra et al., 2014).

What’s more, in samples of children/youth (4-17 years old) with problematic sexual behaviour, high rates of exposure to sexually explicit material have been reported. DeLago et. al. (2020) found over half (58%) of their sample of 218 mostly male youth had been exposed to sexually explicit material. Furthermore, those who viewed sexually explicit material engaged in a greater number of invasive sexually harmful behaviours in this study. Likewise, in a clinical sample of young children ages two to six with problematic sexual behaviours, Smith et al. (2019) found a significant and positive association between children with intrusive problematic sexual behaviour (defined as invasive or aggressive) and exposure to sexual content (at home and in the media).

Associated Factors

Children with problematic sexual behaviour are also more likely to have additional challenges or diagnoses such as depression, anxiety, withdrawal, aggression and hyperactivity (Allen 2017). In a clinical sample of children 6–12-year-olds with problematic sexual behaviour, Kellogg (2010) found 76% had Conduct Disorder, 40% had Attention-Deficit/Hyperactivity Disorder, and 27% had Oppositional Defiant Disorder. Studies also show these children and youth are more likely to struggle in school, have poor boundaries, struggle with peer relationships and have emotional and behaviour problems (Elkovitch et al., 2009).

The Impact of Problematic Sexual Behaviour

Problematic sexual behaviour can range widely and involve only the child themselves, such as in the case of excessive masturbation, or it can involve other children and vary from less intrusive to intrusive-type behaviours. For instance, in a sample of 218 young people (ages 4-17 years) receiving treatment for problematic sexual behaviour against others, DeLago et al. (2020) found the following non-invasive behaviours occurred: sexual kissing (19%), exposed genitals (27%), and sexual touching over clothes (23%). Intrusive behaviours documented were digital/object-genital contact (46%), oral-genital contact (43%), penile-anal contact (21%), and penile-vaginal contact (15%). This range in behaviour can result in little to no harm to others all the way up to serious and aggressive sexual offences, resulting in significant harm (Chaffin et al., 2008).

While recognizing there may be some behaviours that result in little or no harm to others, there are many complex and interrelated factors that affect if, how and to what extent a person may be impacted. These include victim age, the victim's relationship to the person who harmed them, frequency of harmful behaviour, degree of force/coercion, the child's own interpretation of the experience, reactions to disclosure, level of parental support, and degree of self-blame (Briere & Scott, 2015; Godbout et al., 2014; Olafson, 2011). Meta-analytic research indicates childhood sexual abuse can have substantial negative long-term psychological and physical outcomes (Hailes et al., 2019). Evidence has repeatedly demonstrated significantly higher rates of depression, anxiety, PTSD (Amado et al., 2015; Hailes et al., 2019; Lindert et al., 2014; Maniglio, 2012) and addiction (Halpern et al., 2018) in survivors of childhood sexual abuse. Adult survivors of childhood sexual abuse also often struggle with interpersonal relationships, parenting, and attachment (Sanjeevi et al., 2018).

Importantly, research indicates that sexual abuse of a child can have a similar impact as that from an adult (Allen et al., 2014), and studies focusing on outcomes from sibling sexual abuse have found high rates of depression, anxiety, and low self-esteem (Bertele & Talmon, 2021). Moreover, a growing body of neuroscience indicates that trauma, including child sexual abuse, during key developmental periods can fundamentally change the architecture of a child's developing brain, leading to long-term health and social consequences (Perry, 2009).

Recidivism

McCann and Lussier (2008) explain the current challenges in determining recidivism rates amongst youth with problematic sexual behaviour; the first of which is the definition of reoffending. According to these scholars, most studies look to the criminal justice system to determine if a reoffence has occurred through charge or conviction. As sexual abuse is highly underreported (Azzopardi et al., 2018), and faces serious challenges in successfully moving towards conviction through the criminal justice system (Rotenberg, 2017), this focus has limitations. Further, whether a study utilizes charge data or conviction data will also influence recidivism rates found. For example, Worling and Långström (2006) found a sexual offending rate of 15% amongst youth when using a new charge as the criterion and a lower rate of 14% when using conviction as the data point for recidivism.

McCann and Lussier (2008) also identify the length of follow-up in a research study as another important factor in recidivism rates, as longitudinal studies tend to report higher recidivism. Another consideration put forth by these researchers is treatment versus non-treatment samples, since those in treatment tend to have lower recidivism rates (McCann & Lussier, 2008). In general, McCann and Lussier (2008) assert that studies involving nontreatment samples over longer periods of time based on charges rather than convictions demonstrate higher recidivism rates.

With this in mind, meta-analytic research from these same scholars involving 18 longitudinal studies found sexual recidivism amongst young people (age 6-20) ranged widely from 1.6% to 29.9% with an average of 12.2%. The authors explain the range in recidivism is likely due to variation in study design and follow-up periods. By comparison, the recidivism rate for non-sexual crimes amongst this same sample was 53%, indicating these young people are much more likely to recidivate via non-sexual crimes (McCann & Lussier, 2008).

In a more recent review involving 106 research studies with 33,783 youth who have been adjudicated (official arrest or conviction) for sexual offences, Caldwell (2016) found a recidivism rate of between 3 and 10%, with a weighted average of 5%, over an average of 5 years. What's more, this same study revealed a significant decline in sexual recidivism rates over a 34-year period. In other words, there appears to be significantly less sexual reoffending since 2000 (Caldwell, 2016). In fact, when the date of the study was examined, average sexual recidivism rates were even lower. More recent studies that had been conducted over the last 15 years found an average of 2.75% recidivism (Caldwell, 2016). This is in line with reduced violent offending (Caldwell, 2016) and reduced sexual abuse (Finkelhor & Jones, 2012) over the last few decades. While this study did not include treatment as a factor in its analysis, access to treatment programs and community supervision are provided as possible explanations for the declining trend (Caldwell, 2016).

While these recidivism rates represent the best-known data, the focus on legally based definitions of sexual offending and re-offending likely underestimates both prevalence and recidivism due to low reporting, arrest and conviction in this area (ATSA, n.d.b; Beek et al., 2018; Grossi et al., 2017; Malvaso et al., 2020; Rotenberg, 2017). Furthermore, recidivism rates for subpopulations such as females, children under 12 and youth with low intellectual abilities are unknown (Miccio-Fonseca & Rasmussen, 2018). There is also some indication that samples of children and youth involved in the child welfare system and in residential treatment may have higher rates of recidivism. In a sample of 609 boys ages 2-17 who had previously engaged in serious problematic sexual behaviour and had child welfare involvement, Grossi et al. (2017) found 20% had re-engaged in the behaviour. "Sexual reoffence" was defined as any new hands-on problematic sexual behaviour, thereby excluding any sexual behaviours that did not involve physical contact. This study also found boys who began exhibiting problematic sexual behaviour in early childhood (ages 2-7) were significantly more likely to persist in the behaviour than those who started exhibiting at age 8-11 or 12-17. The persistence rate for the early childhood group was 31.2%, and interestingly, the vast majority (92.2%) were never

adjudicated despite most being 12-14 years old by study end. Likewise, studies involving males in residential treatment have found 17.4% recidivism (Rasmussen, 2018). Thus, it is possible that subpopulations of children and youth with sexual behaviour problems may have additional risk factors that put them at higher risk for recidivism.

In short, the literature appears to converge by agreeing that the majority of children with sexual behaviour problems do not continue with the behaviour into adolescence, and likewise, the majority of adolescents do not go on to become adult sexual offenders (Lussier, 2017; McCann & Lussier, 2008; McCuish et al., 2016). If young people are to reoffend, they are much more likely to engage in nonsexual crimes (McCann & Lussier, 2008). Some research shows there may be subpopulations, such as those involved in child welfare or residential programs, who may be at higher risk for sexual recidivism (Grossi et al., 2017).

Risk Assessment & Treatment

Worling and Långström (2005) succinctly summarize five possible outcomes for young people with problematic sexual behaviour: 1) some will stop the behaviour on their own, over time; 2) some will desist once caught and sanctioned, perhaps due to shame and embarrassment; 3) some stop only after being caught and receiving treatment; 4) some who commit sexual offences and are never detected by authorities will go on to offend into adulthood; and, 5) some young people will continue to sexually offend against others despite being caught, sanctioned and treated. This description illustrates the variation in outcomes for young people with sexual behaviour problems, showing first, not all young people will continue with the behaviour, and second, not all are “high-risk” or requiring specialized treatment. Worling and Långström (2005) go on to explain that assessing risk is critical so that those who are low risk are not mislabeled and subjected to harmful restrictions, family separation, and ineffective treatment, nor do they take up space in limited specialized treatment programs. For those deemed to be higher risk through assessment, appropriate restrictions and specialized treatment can be provided to reduce chances of further sexual harm (Worling & Långström, 2005).

While establishing risk and treatment need is critical, the challenge lies in the limited understanding of risk factors amongst children and adolescents with sexual behaviour problems due to the heterogeneity of the population (ATSA, 2017). Early work by Worling and Långström (2003) found evidence to support the following risk factors: deviant sexual behaviour (e.g. interest in prepubescent children or sexual violence), prior sexual assault sanctions, having two or more victims, having committed stranger sexual assault, lacking peer relationships/experiencing social isolation, and not completing treatment. Later, McCann and Lussier (2008) found previous sexual offences, previous nonsexual offences, juvenile’s age at intake (older equated with higher risk), use of threats/weapons, having a stranger victim, and whether there was ever a male victim were predictive of sexual recidivism, though this was based on small samples with low effect sizes. More recently, Christiansen and Vincent (2013) found prior non-sexual offending, offending against a child, early age of onset of behaviour, and poor school performance to be predictive of sexual recidivism amongst adolescents. These

studies demonstrate the variation in risk factors and lack of consistent empirical evidence. Further, what is mostly known about young people and risk is based on samples of male adolescents adjudicated for sexual offences, thereby limiting what is known for children, females, transgender youth, and those with limited intellectual functioning (Miccio-Fonseca & Rasmussen, 2018).

Hence, accurately determining risk is difficult. Research on risk assessments is developing with some empirical support for their effectiveness, but more research is needed (Gotch & Hanson, 2016). In a meta-analysis of research on the predictive validity of four common assessment tools (J-SAOP-II, J-SORRAT-II, ERASOR and Static-99), Viljoen et al. (2012) found these tools were better at predicting risk than chance, but with moderate effect sizes and heterogeneity across studies, concluded current assessment tools are insufficient to make precise predictions. To-date, common assessment tools include (Gotch & Hanson, 2016):

- Estimate of Risk of Adolescent Sexual Offence Recidivism (ERASOR; Worling & Curwen, 2001)
- Juvenile Sex Offender Assessment Protocol – II (J-SOAP-II; Prentky & Righthand, 2003)
- Juvenile Sexual Offense Recidivism Risk Assessment Tool – II (JSORRAT-II; Epperson et al., 2005)
- Structured Assessment of Violence Risk in Youth (SAVRY; Borum, 2006)

More recently, risk assessments have evolved to include protective factors (Miccio-Fonseca & Rasmussen, 2018) such as the PROFESOR (Worling, 2017) and MEGA³ (Miccio-Fonseca, 2010).

Treatment

Young people who have specific risk factors are best suited to specialized treatment; yet not all children and youth with problematic sexual behaviour share the same risk or protective factors and may not require specific treatment focused on sexually offending (Beek et al., 2017). When they do, meta-analytic research has shown cognitive behavioural therapy and multisystemic therapy are most effective in reducing recidivism (Schmucker & Lösel, 2015; Walker et al., 2004). ATSA (2017, p. 40) outlines the following aspects of effective interventions for adolescents:

- Focus on dynamic risk factors supported by current research;
- Promote safety while facilitating prosocial and developmentally appropriate skill development;
- Use evidence-based interventions that match presenting risk and needs;
- Include caregivers and other positive supports;
- Address risk and protective factors across the adolescent's natural ecologies (e.g., family, peers, school);
- Occur in the natural environment when possible to allow the adolescent and his/her caregivers to practice skills and use social supports in real-life situations;

- Tailor approaches to match individual characteristics and circumstances of the adolescent (e.g., developmental status, learning styles, gender, culture); and
- Address sexually abusive behaviour problems as well as other conduct problems

For adolescents, the central rehabilitation model cited in the literature is the Risk-Need-Responsibility (RNR) framework. Gotch and Hanson (2016) explain that the Risk principle determines the intensity of services; youth at higher risk of recidivism receive more intensive services. The Need principle states that treatment should focus on the criminogenic factors associated with the risk (factors likely to cause the behaviour), and Responsivity involves providing treatment that reflects a person's individual factors such as learning style and motivation (Gotch & Hanson, 2016). Research has found that for general offences, RNR interventions are associated with large reductions in recidivism and are most effective for adults who commit sexual offences (Gotch & Hanson, 2016), suggesting the RNR model may also be effective amongst younger populations.

For children under 12, trauma-focused cognitive behaviour therapy (TF-CBT) has shown evidence of effectiveness (Cohen et al., 2004). Other practice principles supported by research are (MNCASA, 207, p. 40):

- Treatments need to directly address problematic sexual behaviours and be developmentally sensitive, considering the cognitive, emotional, and behavioural capacities of young children;
- Behavioural, family-focused, cognitive-behavioural, and psychoeducational approaches appear better than unstructured supportive therapy or unstructured play therapy approaches;
- Many effective treatments teach impulse-control skills, coping strategies, boundary issues, and work to improve caregiver-child relationships;
- Effective treatments directly involve the parent/caregiver in treatment; and
- Effective treatments teach caregivers to use behaviour management skills

When children and youth go through specialized treatment using the above components, research indicates their rate of recidivism or persistence of behaviours is reduced (Carpentier et al., 2006; Caldwell, 2016; Silovsky et al., 2019; St. Amand et al., 2008). Children under 12 involved in cognitive behavioural therapy have found a 2% recidivism rate over a 10-year period (Carpentier et al., 2006). Notably, in a meta-analytic review of practice components for children under 12, Amand et al. (2008) established the parent or caregiver was critical in whether the child discontinued problematic sexual behaviour, finding parent behavioural management skills as most strongly associated with reductions in problematic sexual behaviours.

Literature Summary & Continuing Questions

The review of the literature revealed problematic sexual behaviour is a highly complex social issue with a heterogeneous population ranging in age, development, behaviours, motivations, pathways, risks, and protective factors. Contrary to common belief, the evidence indicates most young people with problematic sexual behaviours will not grow into adults who commit sexual crimes. Scholars and advocates therefore caution against language that is stigmatizing and harmful as many of these young people have faced trauma, adversity and are undergoing important developmental changes (Silvosky et al., 2020). Furthermore, the behaviour is unlikely to persist (Lussier, 2017). Indeed, problematic sexual behaviour is the result of a complex interplay between individual, family and environmental factors (Silvosky et al., 2020) and must be viewed from a trauma-informed and developmental lens (Lussier et al., 2019).

Yet, despite the reasons for the behaviour and the low risk to persist or reoffend, sexual abuse victimization remains unacceptably high and can result in significant harm. Sexual assault centers have long witnessed the harm from sexual abuse, even amongst children, and have worked tirelessly to support those impacted. This is further complicated by the high rate of under-reporting and the limited success of the criminal justice system in prosecuting sexual abuse cases, which likely results in underestimating recidivism (Beek et al., 2018). For these reasons and given the high proportion of child sexual abuse that occurs from other young people, scholars have advocated for prevention and early intervention efforts for problematic sexual behaviour (McKibbin & Humphreys, 2020; Shawler et al., 2020; Silvosky et al., 2020).

From a survivor-centric lens, the low risk of recidivism found in this research field confronts other known primary prevention research. Several risk factors have been empirically linked to male perpetration of sexual violence. These are: a history of experiencing childhood sexual abuse and other forms of childhood abuse, including exposure to domestic violence; delinquent behaviour; hyper-masculinity; rape myth acceptance; hostility towards women; belief in traditional gender norms; early sexual initiation/sexual risk-taking behaviour; sexually aggressive peer groups; male sexual entitlement; exposure to community crime and violence; macro-level issues such as social norms supportive of sexual violence; as well as weak laws and policies (CDC, 2016, UN Women, 2015, Tharp et al., 2012). When looking at this research base, children and youth exhibiting sexual behaviour problems appear to have several of these risk factors, raising the question of how this is implicated in understanding risk, recidivism and prevention in problematic sexual behaviour populations.

Furthermore, in contrast to what the low recidivism rates suggest, sexual violence continues to be a pervasive social issue. To illustrate, over a six-year period (2009-2014), there were 117,238 police-reported sexual assaults in Canada, mostly among young women and girls (Rotenburg, 2017). Self-report studies show substantially higher rates. Using data from the General Social Survey, 636,000 sexual assaults were found in 2014 alone (Conroy & Cotter, 2017). Therefore, further work is needed to understand the low recidivism rates for adolescents with sexual

behaviour problems, the desistance of the behaviour between adolescence and adulthood, and the continually high rates of sexual violence against women and girls.

Another area requiring further examination involves the pathways into problematic sexual behaviour. As revealed in previous sections, a proportion of young people with problematic sexual behaviour have histories of sexual abuse and may be acting out traumatic sexualization (Allen, 2017). What implications does this hold for sexual assault centres who historically were set up to help only survivors? The topic of problematic sexual behaviour challenges the victim/offender binary from which anti-violence services have long been established (Larance et al., 2022).

This work presents an opportunity to deepen our understanding of young people with problematic sexual behaviour and consider what role sexual assault services have, if at all, in working with this group. More work is needed to understand the possible implications for victim-based services and how this sector can collaborate and consult with those who work in the offender-based field in a shared effort towards prevention and early intervention.

Available Services in Alberta

This project focused on identifying available community-based services for children/youth with problematic sexual behaviour. Findings from the environmental scan are a combination of an online search process and interviews with service providers.

Forensic & Private Practitioners

Community-based services are those anyone can access. In Alberta, most services are available only after a youth is engaged with the criminal justice system (i.e., forensic-based services). Some forensic services are specialized to sexualized behaviour, while others address youth criminal behaviour in general. Typically, these services are not easy to find (nor find information on) since they are only accessible through referral or court order. The following forensic services were specified by interviewees, but likely do not represent all forensic-based services available in Alberta:

- Wood's Homes Phoenix program – Calgary
- Forensic Adolescent Program (AHS) - Calgary
- Youth Forensic Centrepont Program (AHS) – Edmonton
- Sifton Family & Youth Services - Lethbridge

Seven forensic psychologists and clinicians who may be contracted to provide private services to children/youth with problematic sexual behaviour were also identified:

Calgary-Based	Edmonton-Based
<ul style="list-style-type: none">•Dr. Gary Brayton in Calgary (Clinical Social Worker)•Sandie Forsythe (Clinical Social Worker)•Dr. Lawrence Deck (Psychologist)	<ul style="list-style-type: none">•Dr. Ann Marie Dewhurst (Psychologist)•Ian Mackenzie (Clinical Social Worker)•Carolyn Barker (Clinical Social Worker)•Ashley Barlow (Sexual Psychologist)

Outside of forensic services and private practitioners, there is little available in Alberta. Four community-based, specialized programs were identified.

Community-Based Services

Of the four specialized, community-based services identified, three are sexual assault services and member agencies of AASAS. They are as follows:¹

¹ For more information, please see environmental scan in the appendix

Dragonfly Counselling & Support Centre (Bonnyville)	Lloydminster Sexual Assault Services (Lloydminster)	Central Alberta Sexual Assault Support Centre (Red Deer)	Child Abuse Service (AHS) (Calgary)
<ul style="list-style-type: none"> • Personal Safety & Wellness Program: A psychoeducational-based program for children ages 4-16 with PSB • Individual PSB Clinical Counselling: Children 6-12 years • Individual/Group PSB Clinical treatment: Youth 12-17 who have forensics involvement 	<ul style="list-style-type: none"> • Sexual Behaviour Program: A psychoeducational based program for children under 12 yrs with PSB • Youth Connections Program: An educational-based program for youth 12-17 years with PSB. Can have forensics involvement 	<ul style="list-style-type: none"> • Sexual Behaviour Support Program: Provides clinical intervention for children/youth up to 18 years with PSB. Must have no forensics involvement 	<ul style="list-style-type: none"> • Problematic Sexual Behaviour - Cognitive Behaviour Therapy (PSB-CBT): Clinical group-based treatment for children 7-11 yrs with PSB

In addition to the above, three agencies will see this population within their other service programs, but do not have a specialized service for problematic sexual behaviour. These are generally trauma-focused or psychoeducational-based programs. Agencies conduct clinical assessments to determine suitability for services. Child/youth who present with more complex, serious sexualized behaviour issues are not suited for these programs. These agencies are:

Grand Prairie Sexual Assault & Trauma Centre (Grand Prairie)	Sexual Assault Centre of Edmonton (Edmonton)	Lethbridge Family Services (Lethbridge)
<ul style="list-style-type: none"> • Sexual Violence Treatment Program: Clinical treatment for children/youth 4-18yrs. Will see those with PSB. Must not be charged. 	<ul style="list-style-type: none"> • Child & Youth Counselling Program: Clinical treatment for children under 12. Will see those with PSB. Must have history of child sexual abuse. 	<ul style="list-style-type: none"> • Families Thriving Together/General Counselling Program: Clinical treatment for children/youth ages 3-17. Will see those with PSB.

In addition, other sexual assault services reported they provide informal supports to parents since there are no other services available in their respective communities. These agencies described providing parents with information and normalizing appropriate sexual behaviour. Some also spoke of supporting parents as they navigate various systems.

A few sexual assault services shared this work is outside their scope/area of expertise, and they screen out for any sexually harmful or offending behaviour during their assessment process. While recognizing this as a barrier to service access, one respondent emphasized how the agency is already stretched to capacity with long waitlists under its current scope.

Child Advocacy Centres

Child advocacy centres do not offer formalized, specialized service within their agency to children/youth with problematic sexual behaviour. Some child advocacy centres have referral pathways to community-based services or contracts with private clinicians, however. Several child advocacy centres pointed out the CAC-CYAC National Guidelines², which indicate the separation of victims and offenders. *Guideline 1: Child-focused setting* states:

The CAC/CYAC provides services to diverse populations of children, youth and their supporting family members in a welcoming, physically and psychologically safe, neutral, trauma-informed and comfortable child- and youth-friendly setting.

Key Component

- The CYAC must have policies and procedures that address the separation of victims and [alleged] offenders during the investigative process, and as necessary throughout delivery of the full array of CYAC services in order to provide a service that is physically and psychologically safe for children. If a CYAC shares a building location with an existing agency that provides services to [alleged] offenders, there should be a separation between children, non-offending caregivers, and [alleged] offenders, for example, arranging to meet with [alleged] offenders on different floors or at different times of day. **In addition, CYACs that serve children with problematic sexual behaviours should also make provisions to ensure the physical and psychological safety of all children and youth who visit the centre.**

For some, this has been interpreted as children with problematic sexual behaviour cannot access the same space. For others, it's a question of how to avoid "crossover" between children with problematic sexual behaviour and other children who may have been harmed in the family. One respondent explained, "[there is an] understanding that CACs across the province are not seeing children who 'offend;' this practice framework has not been developed." Several acknowledged the need and expressed wanting to improve child advocacy centres' service response to this population but felt the above guidelines limited these possibilities and may need to be revisited.

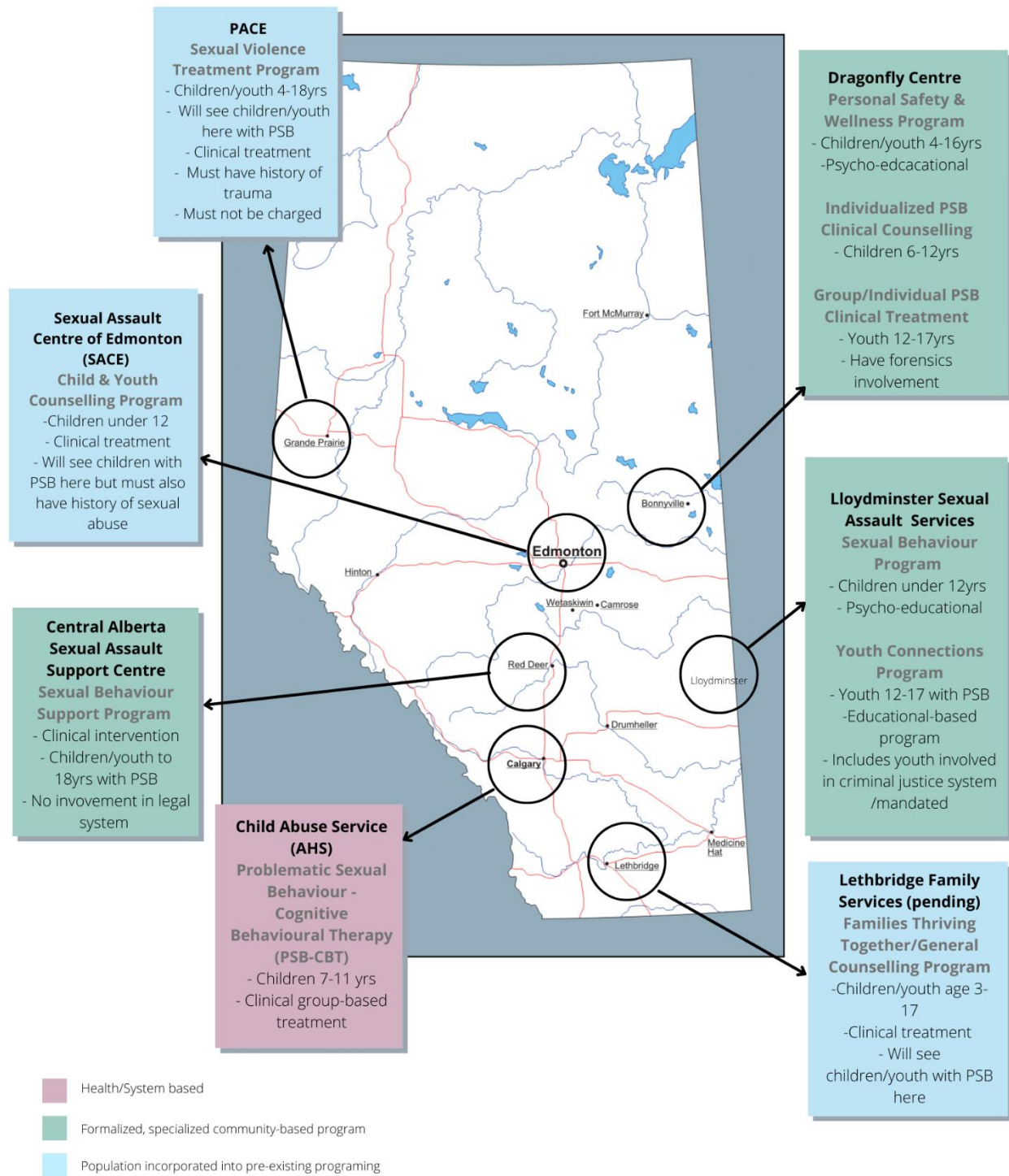
Some child advocacy centres do provide informal supports to families, such as information and system navigation. Because child advocacy centres are set up as multidisciplinary teams with key system partners, they have a unique advantage in supporting families navigating systems such as policing and Children's Services. Some child advocacy centres engage with schools as needed and provide information on normal/problematic sexuality, boundaries, and safety plans. In some cases, CAC staff engage with families through the school system and provide psychoeducation.

Available community-based services are summarized in the map below.

² <https://cac-cae.ca/best-practice-guidelines-for-canada/>

Map of Alberta

Community-Based Services for Children/Youth with PSB



Themes from Qualitative Interviews

28 interviews were conducted with members of sexual assault services and Child Advocacy Centres in Alberta, experts on problematic sexual behaviours, and representatives from several notable treatment programs in the country. The themes from the interviews are summarized below.

Service Need

Several Alberta sexual assault services reported an increase in requests for services related to children/youth with problematic sexual behaviour. In interviews with sexual assault services, the majority indicated they receive requests for services regularly, with some noting increasing frequency over the last few years. The most common service request is from parents. Schools and daycares were also identified as places contacting sexual assault services for help with this issue.

"We've noticed a major increase during the pandemic, and largely with the problematic sexualized behaviours in terms of siblings within the home."

"I was actually surprised with the amount of calls that we do get from parents and grandparents wanting help."

"Parents are scared...they are freaking out. They don't know what to do."

Other sexual assault services shared that children/youth with problematic sexual behaviour appear in their intake process. Since a portion of children/youth with problematic sexual behaviour have histories of child sexual abuse, they may access sexual assault services as victims. Through intake and assessment, problematic sexual behaviour may be identified. Respondents explained this is at times challenging to navigate, as some have policies and philosophies that deter supporting those who use or have used harmful/abusive behaviours. Unless a specific program is available, most sexual assault services will decide the treatment course on a case-by-case basis.

For sexual assault services that do not provide a specialized service for this population, interviewees indicated having no referral source for these families. Those in rural communities underscored a lack of services in general, explaining that for many families, their only option is to seek help in larger cities, which are often several hours away. While there may be private clinicians available, interviewees indicated costs for these services are prohibitive for most.

Several child advocacy centres also reported encountering children with problematic sexual behaviour, most often during triage.³ One large child advocacy centre stated they had 65 problematic sexual behaviour cases last year, with numbers this year on track to surpass this number. A few smaller child advocacy centres are in early phases of service delivery and

³ Some CACs are integrated with SASs in the province.

reported not yet seeing this population. They, however, anticipate that this will change, and numbers will increase as they expand their services.

"We are seeing sexual behaviour engaging with younger and less able children; asking or threatening coercion on other children to participate in sexual activities that are too sophisticated for their age."

"Yes, [we are] hearing about these children on a very regular basis in our interdisciplinary meetings; however, this is not the group that is focused on during these meetings; we are focused on providing supports to the other young person (the victim) in this situation."

Who are these Children/Youth?

One of the most prominent themes from experts and those who provide specialized programs is how we frame or talk about the issue of child/youth problematic sexual behaviour. Experts explained that historically, children and youth have been viewed and treated as "mini adult offenders." As the field has evolved, the conceptualization and understanding of children and youth has changed dramatically. Experts were adamant; adult sex offender assessment, diagnosis and treatment is incompatible with children and youth. As one interviewee explained: "The reason why this is separated [now] is [because] the reason children engage in these sexual behaviours is not at all the same as why adults do." However, despite this, society still largely views these children "through an adult sex offender lens."

As a result of brain science and an increased understanding of brain development, experts now recognize this problem as largely a developmental one. As one expert explained:

"It's really clear in the literature and in the work with experts that this is a part of developmental navigation that this youth is going through. We need to look at the sexual acting out behaviour in much the same way as any other out-of-step developmental process."

According to those interviewed, the vast majority of children and youth are not acting from a place of sexual deviance. Several explained that these are "acting out" behaviours rather than manipulative or coercive behaviours. A few discussed how many of these children use sexualized behaviours as an unhealthy way to meet unmet needs. Terms such as problematic sexualized behaviour are more appropriate and reflect the true nature of the behaviour.

Experts and those who provide specialized programs describe these children/youth as highly varied; there is no one typology, but there are some common characteristics. Some of the common descriptions provided are themed below:

Individual	Environmental
<ul style="list-style-type: none"> - Limited ability to self-regulate; sexual behaviours are used to soothe/regulate - Low self-esteem/self-worth - Limited healthy coping skills - Low attachment - Limited boundaries - Disability – ADHD, learning disabilities, spectrum disorder, FASD - Low intellectual ability - Problems with impulse control 	<ul style="list-style-type: none"> - Social isolation/poor peer relationships/experience bullying - Exposure to pornography/sexually explicit material/activity; sex is normalized - Trauma exposure – CSA, DV - Chaotic home environment – DV, high stress - Low parental supervision - Parents – mental health, addictions, trauma history

One expert described four common groupings of children with problematic sexual behaviour. One group, comprised of a “large number of children”, engage in these behaviours as sexualized play: “It is sexualized play. They are confused. They have been exposed to sexual practices and behaviours outside of their developmental frame.” Some may have a history of child sexual abuse, but many do not. Most have been exposed to pornography or other sexual material outside their comprehension/development. A second group are children who are exploring their own sexuality and genitalia as part of the normal developmental process. In these cases, the respondent explained, parents are often overreacting to this behaviour as children are not conceptualized as sexualized beings.

The third group are children and youth who act out sexually as a form of expressing anger. According to the same expert, these children are frequently viewed as “perpetrators”, but this is inaccurate. These are often children/youth on the spectrum, with lower intellectual abilities, and sometimes high ACES scores: “The literature would say these kids are very similar to other kids acting out. There really isn’t a distinction at this age. It is another form of acting out emotional distress or unmet needs.” These children have been exposed to pornography/sexually explicit materials and are repeating the behaviours: “It’s a form of acting out but not necessarily the intentional kind to cause sexual harm.”

The fourth group are those driven by sexual arousal. They often lack executive functioning control and have boundary problems. These children/youth are more reactive and impulsive and demonstrate more sexual perpetrator-type behaviours.

Environmental factors also have an important role in influencing behaviour. Among respondents, several explained that many of these children have “chaotic” homes. Addiction, parental mental illness and domestic violence were examples given. Of note, domestic violence was identified by one expert as more common amongst children with problematic sexual behaviour than a history of child sexual abuse, explaining that within the context of domestic violence, sexual violence and misogyny are commonplace. As such, children who witness domestic violence “are taught a whole lot of messages about the power of coercive sex.” This respondent explained:

"With that dynamic - when dad is really scary and sexualized in his behaviour and is sexually assaultive of mom during fights and misogynistic, and all of that really does have an impact on adolescent boys, and often you see that kind of macho attitude, entitlement, attitude coming through."

Another common contextual factor is low levels of parental supervision. A few respondents acknowledged some parents may be "disengaged" or "overwhelmed" and therefore unable to adequately supervise their children:

"And then we have family adversity. And so family adversity is things like parental mental health, separation, divorce, kind of a chronic, chaotic family environment, lack of boundaries, lack of modelling of healthy coping skills or emotional or self-regulation skills. We always like to say it doesn't mean these are bad parents it means that parenting is hard, and so we also have to factor in other histories that parents have [including] with their own trauma."

Lastly, many of these children face social isolation/exclusion. Respondents affirmed a combination of poor social skills; a lack of peer relationships and experiences of bullying add to heightened social isolation. Social isolation, in turn, leads to more time online and increased risk of ongoing exposure/engagement with pornography.

Overall, experts explained that multiple factors often lead to children/youth exhibiting this behaviour. A sole focus on sexualized behaviours is inadequate to understanding and treating children with problematic sexual behaviour.

"[People] always assume there's something wrong with them, you know 'he's just a sexual offender,' [but there is] much more going on here than his offending...[it's] the tip of an iceberg...there's a lot more going on beneath the surface."

Key Issues

Through the interviews, several key issues surrounding children with problematic sexual behaviour were identified. They are as follows: 1) stigma/fear, 2) caregiver response, 3) Children's Services response, 4) School response, and 5) access to pornography.

Stigma/Fear

The theme of stigma and fear was notable in the interview data. Many respondents shared that these children/youth face pervasive stigma. Society, and in turn parents, schools and professionals continue to view these children/youth as perpetrators and "mini sex offenders." As described by one interviewee, our societal view of adult sex offenders is a perception that they are "untreatable, unimaginable, and scarred for life." As such, this is how children/youth with problematic sexual behaviour are often viewed as well. From this standpoint, people react with "fear and panic," which often leads to harmful and counterproductive responses. One expert explained the common approach is to "isolate and separate them from everything

normal and then expect them to be good or fixed.” Examples given included schools that suspend children unnecessarily or isolate them in an administration office during recess. One respondent added:

“We can turn down the fear and increase the awareness that this is something that is...it has a beginning, a middle and an end, and kids recover from this, and they move on and live happy ever after lives, and they aren't pedophiles.”

“[This] requires a community analysis – otherwise it perpetuates the stigma and “creepy perpetrator” [view]. Families eventually reunify anyway with help or not...[these children] are not mini-pedophile adults – you are making them worse by ostracizing them. You are increasing risk by not allowing them to engage in the community and be part of the community.”

The impact of this ongoing stigma and fear appears in several subsequent themes.

Caregiver Response

Another key issue identified from the interviews is the reaction of parents and caregivers when they learn their child/youth is demonstrating problematic sexual behaviour. Several sexual assault services and child advocacy centres described numerous calls to their agencies from parents desperate for help for their child/youth with problematic sexual behaviour. Part of this reaction, and something that will be further described below, is the current response from Children’s Services. Presently, interviewees in several jurisdictions explained that Children’s Services no longer works with these families unless there is a clear protection issue. Interviewees elaborated that families are instead told by Children’s Services to “deal with it themselves”; in some cases, being told to contact the family of the victimized child directly. Understandably, this causes great distress to parents/caregivers and has been a common reason why they contact community-based services for help.

Interviewees explained that parents can have a range of reactions once they learn about their child’s behaviour. Reactions can range from minimization to maximization and include defensiveness, disbelief, guilt, shame and fear. Some parents may minimize and “not understand the seriousness of it...say[ing] ‘boys will be boys,’ or this is an age thing.” Others may become hypervigilant and want to over-monitor or interrogate their child.

Complicating the issue, many situations concerning children/youth with problematic sexual behaviour involve siblings or cousins who are harmed. As such, parents/families face extensive difficulty supporting both children. There is often a family “blow up” and widespread blame. Adding to this, parents/caregivers may also have their own history of trauma, contributing to what one respondent called a highly “multi-layered” situation.

Fear and stigma were often reflected in parental reactions, as described by those interviewed. Three respondents shared:

"A lot of these families...they're shocked, they had no idea this was happening, and then the fear of coming forward [for help], and I think that's wrong - like it really bothers me that there's so much fear."

"Families would rather sweep it under the rug than pick up the phone and say, 'hey this has happened in my home'."

"What I see quite often is parents being ashamed of these things, not knowing where to go, not knowing what to do, so trying to deal with it within the home and then it becomes worse, and the behaviour escalates, or else an incident occurs at school, and then it becomes more of a disciplinary situation versus a treatment piece."

For some, this involves not reaching out for services or not engaging when services are available.

Children's Service Response

The scope of the Child, Youth and Family Enhancement Act appears to have narrowed the threshold for intervention, resulting in reduced authority and involvement from Children's Services in cases involving children and youth with problematic sexual behaviour. Interviewees identified consistent challenges in how Children's Services responds to this population and their families, and several long-standing professionals described a marked shift in practice over the past five years. Specifically, they noted that Children's Services now appear to engage differently, with current practice emphasizing an initial assessment of whether the family can protect the child. According to multiple participants, if the family indicates that it can ensure the child's safety, Children's Services often does not proceed with further involvement. This shift has raised concerns about gaps in oversight, support, and early intervention, and underscores the need for a clear obligation on someone within the system to ensure that timely intervention for the child and family actually occurs.

"When the Enhancement Act came in, where no longer could Children's Services intervene based on the behaviour of the child, we started to see a change, and it's really escalated in the last 5 years, where there's this lack of involvement from Children's Services."

Interview participants identified several concerns regarding the implications of the current mandated requirements within the Act and this approach.

First, respondents questioned how ongoing child safety and implementation of safety plans could be assessed in situations where there was no ongoing involvement or follow-up. A few interviewees with experience with Children's Services described there being no assessment specific to HSBs, follow-up, or monitoring to ensure safety plans were being followed and that parents were protecting the child/other children. In some situations, Children's Services have

asked clinicians to assess protection risk, which is outside the therapeutic role. Respondents indicated there needs to be an authority to monitor parental capacity to protect.

"Our position is, how do you know the parent can protect unless you investigate?"

"It puts us in position to monitor safety – this is not a therapeutic role – they have offset protection onto us. Our mandate is not to investigate protection risk."

"Children's Services who have a file will say oh there's an effective safety plan in place and close the file but that doesn't mean the safety plan is effective or that it's even being executed so it continues to create risk."

Second, several interviewees reported that, in their experience, families who were not involved with Children's Services often faced challenges accessing publicly funded specialized assessment and treatment services. Several clinical experts indicated they no longer get referrals from Children's Services and worry about where these children are receiving treatment, since most families cannot afford a private clinician and most services are only accessible through Children's Services or with forensic involvement. Third, without the involvement of Children's Services, some worried that parents are unlikely to engage with treatment at all. Having an authority order treatment for children and then monitoring progress ensures children and families access services and get the needed treatment.

"This does need to be mandated; people need to have accountability to be able to get their child support and move through the process. These kids need help, and there's nobody making sure that they're going to help."

School Response

Schools represent another key issue for children with problematic sexual behaviour since problematic sexual behaviour can occur in the school context. Interviewees described how fear and stigma are prevalent within school systems as well and can influence the reaction from school administration. Some discussed how school responses that alienate and isolate children can create harm and "end up making things worse." These responses are often punitive-based and are incongruent with treatment.

"The struggle is the knee-jerk reaction: "we don't want the kid in the school." He can be in school as long as we manage safety. As long as [there is a] person in the school to manage the safety and knows the story."

Some schools are receptive to training, education and becoming part of a child's treatment team. A few service providers shared they have had some success in working with schools, while others indicated schools are "desperate for help."

"Schools don't know what to do, and they are begging for solutions because it's a constant problem for them, and they don't have that consultation piece; they don't have that someone that can say, like, here's how to proceed."

Access to Pornography

Access/exposure to pornography and sexually explicit materials or activities was highlighted above when describing common characteristics or behaviour patterns of children/youth with problematic sexual behaviour. It is revisited here as a key issue because it came up so frequently with interviewees. Almost all service providers/experts discussed exposure to pornography as a common experience for these children and youth. As one service provider said: "It's almost 100%."

Interviewees described how children and youth have much unsupervised access to the internet and sexually explicit material is easy to find. Parents were described as sometimes "naïve" about children's technology skills and the availability of this material online. In addition to finding materials on their own (either intentionally or unintentionally) or sharing it amongst their peers, respondents also discussed how some children are targeted by adults in chat rooms and sent links to explicit sexual material. Respondents emphasized how prevalent this exposure is and how it is harmful when it is far beyond a child/youth's developmental level or ability to comprehend it.

"I deal with this all the time – a lot of kids learn about sex from porn – when they have disabilities, this is hard to understand that people don't actually like to be treated this way. We have to teach them how to have healthy relationships and sexuality [in treatment]."

"When I was a kid, you had to actually go to the store to get Playboy, right? And...then videos came along, and then you had to have somebody go to the video store and get them. Well, now, a ten-year-old with computer skills – they're online and accessing all sorts of stuff, and they build arousal patterns [around it]."

Treatment Best Practices

Respondents also spoke of common treatment issues and through interviews, identified best practice themes: clinician skill, assessment and family engagement. As reviewed above, it is important to note there is much variation in these children and youth; therefore, level and type of treatment will vary.

Common Treatment Issues

Interviewees shared common treatment issues for children/youth with problematic sexual behaviour. Importantly, this description is not meant to be clinically comprehensive but provide readers with an increased understanding of who these children/youth are and what some of their treatment needs may be. They are:

- Limited ability to self-regulate; sexual behaviours are used to soothe/regulate
- Low self-esteem/self-worth
- Limited healthy coping skills
- Low attachment
- Lack of boundaries
- Lack of impulse control

Respondents described how many of these children/youth show up in clinical settings and some of their typical reactions or treatment needs:

- Some children show up in treatment not knowing what they did or are doing is wrong. They are confused and don't understand.
- Some have a sense of betrayal that someone reported them. For example, betrayal from a sibling with whom they may have initiated or engaged in the behaviour.
- Some are confused about love and care and have shown their love for their sibling through sexual activity. They do not know how to demonstrate appropriate feelings.
- Some have a lot of shame and embarrassment.
- Some are acting out trauma from child sexual abuse.
- Some have a sense of loss of power.
- Some use these behaviours as a form of self-soothing or self-harm. These behaviours release chemicals, so they feel better when they do them. For example, dealing with negative feelings through excessive masturbation.
- Some need to learn new ways of coping with feelings. If sexual acting out is a coping skill, it cannot just be taken away. It needs to be replaced with healthier coping skills.

Skilled Clinicians & Clinical Supervision

Respondents underscored that working with these children is "specialized work...not just anyone can do it. You need specialized training." While several recognized the skills/training level needed varied depending on the population (i.e. children with problematic sexual behaviour versus youth with sexual offence charges), all emphasized the need for specialized training in the respective area.

The following training resources were identified in the interviews:

Safer Societies Press

Safer Society Press provides a range of products including online training for professionals working in the field of ending violence and abuse.

<https://saferpress.org/safer-society-trainings/>

Association for the Treatment of Sexual Abusers (ATSA)

ATSA provides several educational resources for service providers including an annual conference and Master Class series.

<https://www.atsa.com/meet-atsa/education>

The University of Oklahoma Health Sciences Centre

The Centre provides training in Problematic Sexual Behaviour-Cognitive Behaviour Therapy (problematic sexual behaviour-CBT).

<https://psbcbt.ouhsc.edu>

Radius Child and Youth Services

Radius Training Institute is a multi-disciplinary team of experienced clinicians who are committed to delivering high quality, cost effective training for professionals working in children's mental health. They specialize in training related to the assessment and treatment of children and youth who have experienced trauma, abuse, neglect, or witness intimate partner violence, and with children and youth who have engaged in sexually harming behaviours.

<https://radiuscys.ca/training-institute/>

Several experts/service providers also underscored the importance of joining ATSA: Association for the Treatment of Sexual Abusers (soon to be renamed) to ensure providers are adhering to best practice and ethical standards. ATSA is:

An international, multi-disciplinary organization dedicated to making society safer by preventing sexual abuse. ATSA promotes sound research, effective evidence-based practice, informed public policy, and collaborative community strategies that lead to the effective assessment, treatment, and management of individuals who have sexually abused or are at risk to abuse.⁴

Respondents also emphasized how, in addition to proper training, regular clinical supervision with an expert is essential.

⁴ <https://www.atsa.com>, para. 1

Proper Assessment

Proper assessment is critical for determining the best course of action and level of treatment for these children/youth. Holistic assessments that include protective factors, needs and understanding of the environment (including family/home life) rather than focusing solely on problematic or offending behaviour are best practice. Several of those interviewed referred to the PROFESOR tool for holistic assessment and the work of Dr. James Worling in Toronto.

Several discussed how current risk assessment tools (i.e. tools that determine whether someone is low, medium, or high risk) are ineffective and that risk for sexual offending cannot be predicted amongst children and youth. Further, respondents cautioned anyone conducting safety or risk assessment should have appropriate training.

"We got lots of requests for safety assessments – can he go back to school – etc? We just don't have the training for this level of assessment. I would highly highly argue that nobody should be doing that without the proper training."

The following assessment tools were identified during interviews:

ERASER

The Estimate of Risk of Adolescent Sexual Offense Recidivism, Version 2.0 (ERASOR) is designed to assist evaluators to estimate the risk of a sexual re-offense for individuals aged 12-18 who have previously committed a sexual assault.

https://grahamwatson.ca/resources/erasor_2.0_10-page_coding_form.pdf

PROFESOR

Protective + Risk Observations For Eliminating Sexual Offense Recidivism (PROFESOR) is a structured checklist to assist professionals to identify and summarize protective and risk factors for adolescents and emerging adults (i.e., individuals aged 12 to 25) who have offended sexually.

PROFESOR is intended to assist with planning interventions that can help individuals to enhance their capacity for sexual and relationship health and, thus, eliminate sexual recidivism.

PROFESOR is *not* designed for the purpose of predicting the risk of future offending.

<https://www.profesor.ca/>

Child Sexual Behaviour Inventory

The 38-item Child Sexual Behavior Inventory (CSBI) was developed to assess children who have been sexually abused or are suspected of having been sexually abused. The measure is designed to be completed by a female caregiver.

<https://www.nctsn.org/measures/child-sexual-behavior-inventory>

Behaviour Assessment System for Children (BASC)

A comprehensive set of rating scales and forms, BASC-3 helps you understand the behaviors and emotions of children and adolescents. BASC-3 applies a triangulation method for gathering information. It analyzes a child's behavior from three perspectives: self, teacher, and parent.

<https://www.pearsonclinical.ca/store/caassessments/en/basc/Behavior-Assessment-System-for-Children-%7C-Third-Edition/p/P100008193.html?tab=product-details>

Trauma Symptom Checklist for Children

The TSCC allows you to measure posttraumatic stress and related psychological symptomatology in children ages 8-16 years who have experienced traumatic events, such as physical or sexual abuse, major loss, or natural disasters, or who have been a witness to violence.

<https://www.parinc.com/Products/Pkey/461>

The Sex Offender Need Assessment Rating (SONAR)

The SONAR includes five relatively stable factors (intimacy deficits, negative social influences, attitudes tolerant of sex offending, sexual self-regulation, general self-regulation) and four acute factors (substance abuse, negative mood, anger, victim access), used to evaluate change in risk levels among sexual offenders.

<https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/sx-ffndr-nd/index-en.aspx>

Family Engagement

Most experts and service providers emphasized the importance of having parents engaged in treatment with their child. For many, parents/caregivers are, in essence, *the most* important part of treatment, as treatment success can hinge on parental engagement. One explained how therapists are only with the child for a short period of time; parents/caregivers, on the other hand, are constantly with the child outside of treatment and can follow treatment practices at home. When parents are reluctant or resistant to be involved, the effectiveness of the treatment is diminished.

"If I had to choose between seeing the kids and seeing the parents, I would choose to see the parents. We only see these kids for a blip in time... It's like the rest of the week they're at home, and they're at school."

"Way more success when parents are involved – kids end their sessions faster; parents feel more equipped. Kids don't do well when parents aren't involved – hard to make progress."

Parents/caregivers may require their own counsellor, as does the child who was harmed. In some cases, this may involve up to 4 different counsellors working with one family. Some discussed the importance of working with all clinicians as a team. Sometimes the family and child who has been harmed may access treatment within the same program. Other times, the child who has been harmed may be provided services by another clinician in a different service agency. Respondents emphasized the need to collaborate amongst therapists and, when safe to do so, move towards family reunification. Including elements of family reunification in

treatment was identified as a best practice by several experts and service providers.⁵ As one shared:

"The family is always going to be a family. We need to find a way to manage the risk issues by doing repair stuff, or else you're condemning them to always live separately."

⁵ Family clarification, reconnection and reunification are different phases. For a full review and guide to this practice see Tabachnick, J., & Pollard, P. (2016). *Considering family reconnections and reunification after child sexual abuse: A road map for advocates and service providers*. Enola, PA: National Sexual Violence Resource Center. <https://www.nsvrc.org/publications/nsvrc-publications-guides/considering-family-reconnection-and-reunification-after-child>

Service Gaps & Challenges

One of the aims of this project was to describe the current service landscape in the province, including gaps in service. This section provides an overview of service gap themes according to those interviewed. Foremost, service providers characterized widespread service gaps for all children and youth with problematic sexual behaviour. In other words, “there’s not much for anyone.” The following quote illustrates this perception held by many:

“I wouldn't call it a [service] gap. I would call it like a canyon...that I can't see the bottom of.”

More specifically, accessible specialized services, skilled clinicians, family work and education/knowledge are gaps in the province. In addition to these, there are particular system-level challenges that contribute to a limited and detrimental service response. The section closes with a brief look at the impact when services are scarce.

Accessible Specialized Services

By and large, most services available are for male youth over the age of 12 who have been charged, although this too is limited, with demand outpacing available services. Respondents explained youth who have been charged often face waitlists and are unable to access specialized treatment in their communities. Further, while on waitlists, families do not have access to support services.

Seven private practitioners were identified in Edmonton and Calgary, with three nearing retirement. Yet, accessing private treatment is often unattainable for families without Children’s Services involvement, as they pay out of pocket.

Outside of forensic treatment and private care, there are only 4 community-based specialized services in the province: Bonnyville, Red Deer, Lloydminster and Calgary. Three of these offer clinical intervention and the fourth, psychoeducational programming and supports. Two have waitlists. With only 4 specialized programs in the province, families in rural and remote areas must drive many hours for treatment.

Three other agencies in the province accept children with problematic sexual behaviour into their general counselling programming: Grande Prairie, Edmonton and Lethbridge. While adding an important service option to families in these communities, there are other possible limitations such as program space and specialized content.

Many respondents declared more specialized and accessible services are needed in the province.

Skilled Clinicians

Skilled clinicians are an important part of having accessible, specialized services. Several identified the dearth of available clinicians specialized in this area in the province. Some discussed the challenge they face in attracting clinicians to this work, in part because of stigma and incorrect assumptions about sex offending and children/youth. As one respondent shared, “finding people who are interested in this work is the hard part.” A few cautioned that this work is not for just anyone; a particular type of person is needed:

“This work is not for just any clinician – you have to be unbiased, non-reactive – it may go against your value system; that’s important to know. It has to be someone who is passionate about it; otherwise, you can cause harm. You can’t be shocked or disgusted.”

Access to training is another challenge encountered by clinicians. For those who are interested in the work, the cost of training can be prohibitive, and many community-based services cannot afford to send their staff. Rural and remote communities face additional difficulties. Several rurally based organizations discussed how they struggle with a shortage of clinicians in general, so finding a specialized clinician is almost infeasible.

Ensuring trained staff have access to clinical supervision is another important aspect identified by those interviewed. For those who have received the necessary training, clinical supervision from an expert should also be provided. However, many agencies cannot afford to contract an expert for this reason. One clinician confirmed she wants to be able to consult with an expert in her work with children but does not have funds for this through her agency. Another reason for clinical supervision is to reduce risk of burnout. With so few specialized therapists, ensuring their sustainability is an important part of providing available, specialized services. One respondent shared:

“Never do it alone, never do [this work] in isolation...that clinician - he or she needs to have a team around them that understands the work they’re doing because otherwise, you’re gonna have individuals burn out – these folks need a network.”

Family Support & Reconciliation

In addition to treating children/youth with problematic sexual behaviour, families also require support. Several respondents identified limited family supports in the province in general. Many services shared that parents/caregivers, grandparents, and extended family members often contact their agencies looking for help. Without formalized programs, many agencies are doing the best they can by providing information and emotional support.

A related part of family support involves family reconciliation work. Noted as a best practice, some respondents shared this is commonly not addressed, or not addressed well, in most specialized services (including forensics) in Alberta. Because most problematic sexual behaviour occurs within families and the “family disruption is huge,” family support and

engagement are a crucial part of an effective intervention. When siblings are separated for safety reasons, but the child/family cannot access treatment or reconciliation work is not available, the family unit suffers:

"[The reunification work with adolescents] - there's no one doing that. When you have child and family services saying you cannot be around your brother, but our kids are like 'I miss my brother' and want a relationship...I've had so many cases with these poor kids, like families really do suffer because of that...you end up with these split families for like years, I'm talking years."

System Coordination Challenges

One of the key themes identified by interview participants was uncertainty regarding system roles, responsibilities, and service pathways for children and youth with problematic sexual behaviour and their families. Participants described situations in which legislative mandates and system responsibilities could result in no single system having a clearly defined lead role in supporting these families. As previously described, Children's Services are not typically involved with these families and policing/forensics is only engaged if the child is over 12 and charged with a criminal act. According to interview participants, this can create situations where families experience challenges accessing coordinated assessment, treatment, and ongoing support. Interviewees shared:

"Time and time and time again I see cases where the kid that's engaged in these behaviours is just falling through the cracks of systems."

"When we have like kids that are like 12 or 13 or 14, when the police aren't going to open up an investigation and Children's Service, isn't going to open up a file... so that way the family doesn't have any access to subsidized or free services and there's nobody following up to ensure that that child has access [to treatment]."

Interview participants described situations in which the ministry did not intervene because the circumstances did not meet the legislative threshold for a protection response. In these situations, families were often left to navigate the situation and seek appropriate supports on their own. Participants reported that many families subsequently encountered limited availability of specialized services for children and youth with problematic sexual behaviour.

"If our system is going to say this is the parent's responsibility, then it would be nice if our system would somehow also provide training for parents to manage these types of issues."

In child advocacy centres where multi-disciplinary teams exist, interview participants also identified opportunities to strengthen information sharing and referral pathways within multidisciplinary responses. Several described situations in which existing privacy practices and referral processes limited child advocacy centre staff's ability to proactively connect

families with information, supports, or resources. As one respondent explained, “the referral source must always remain anonymous.” In other words, if a family reports to police or Children’s Services that their child has problematic sexual behaviour or was a victim of another child, that source is protected. When this occurs in the context of Children’s Services not opening a file, and police not charging due to their mandates, child advocacy centre staff are unable to contact the family directly to offer information, support or resources. As a result, some participants reported that child advocacy centres were only able to provide support when families contacted them directly.

"It would be beneficial to have a consent to release information worked out within the CAC partner agencies so that CAC staff could connect with the families, but we don't have any consents to release that information given the fact that the referral source remains anonymous."

Education, Knowledge & Awareness

According to respondents, knowledge about children/youth with problematic sexual behaviour remains low. Professionals such as teachers, school administrators, Children’s Service workers, victim advocates and other clinicians have insufficient knowledge about problematic sexual behaviour. Views instead tend to be in line with those of the general community who inaccurately perceive these children as “mini adult sex offenders.” Two quotes illustrate this theme:

"The idea that somehow victims and offenders are different, you know, and you get a therapist kind of putting kids in those categories. I've had people call me up, you know, wanting to refer a 'three-year-old offender.'"

"They're all good kids, and they get a bad name, and people's responses to sexualized behaviours are so blown up; like, honestly, there's so much need for education for people."

This limited education amongst professionals is of great concern to many interviewed. Without adequate knowledge, professionals can inadvertently cause harm and miss opportunities to respond appropriately and connect families with support. Further, families can be given the wrong information, which can perpetuate the stigma of children/youth with problematic sexual behaviour as being mini-adult offenders. This ongoing stigmatizing perception can result in programs and services declining to work with these families.

"So many professionals don't want to touch these kids."

"If we can just bring down the fear level. Understanding this behaviour developmentally rather than perversion- based...It's like this belief that once you've sexually acted out, you are irredeemable."

Victim advocates and sexual assault centre staff were also identified as needing more general training and education about problematic sexual behaviour. Respondents shared that even if these services are not working explicitly with this population, understanding the nature of the issue remains important as there is often a blurring between “victim” and “offender” in the work.

"I think anybody working with victims of sexual abuse needs to also understand offenders and kids with sexual behaviour problems because they're more related [to victims] than you think."

"These kids are coming through [your services] in some way, shape or form."

Parents, caregivers and families also have limited understanding of sexualized behaviours, sexual health and development of children. This results in fear-based responses with parents/caregivers unwilling to come forward and ask for help.

Impact of Limited-Service Access

The trajectory of children and youth with problematic sexual behaviours is hard to determine due to the multi-layered factors involved in this behaviour. Several experts and service providers were clear that without intervention and treatment, some children and youth will continue these behaviours and may reappear in the youth or adult criminal justice system. Others cautioned, however, that many children, once the behaviour is identified, will develop out of it and lead normal lives, stating that “previous sexualized behaviour is not a known risk factor for later sexual violence perpetration.”

"It's setting up the stage, and has been at the stage for years, where parents just give up and so where you almost wait for the juvenile justice system, or something like that, to take in to come in."

"There is a continuum of sexual behaviours for kids; some might be fine with minimal intervention and/or develop out of the behaviour, others will require more intensive intervention. If this is absent, there are some that may continue with these behaviours and be at greater risk for probably several things."

Identifying and intervening early is important for all children. Whether it be to prevent future violence, or other harms such as criminal activity, mental health, and other social and relational consequences that may occur if the behaviour is left unchecked.

Recommendations

This project sought to conduct an annotated bibliography, literature review and environmental scan of available services for children/youth with problematic sexual behaviour in Alberta to deepen AASAS' understanding of service needs. Based on the information revealed in the project, the following recommendations are put forth for consideration:

1. **Identify clinicians/agencies willing to work with children/youth with problematic sexual behaviour in Alberta and seek funding to provide specialized training.** This work revealed more accessible and specialized services are needed in the province. Training interested clinicians in working with children/youth with problematic sexual behaviour is a needed step to increasing the number of available services.
2. **Formalize access to regular expert clinical supervision and consultation for service providers across the province.** Findings from this project underscored the need for clinicians to have regular access to expert clinical supervision. Creating a space for individual or group supervision with known experts in the field will help ensure quality services are provided, children and youth are well supported, and clinicians themselves are supported in their learning and well-being. Clinical supervision will also foster capacity building and support clinicians to stay in the field. Depending on the number of clinicians, several experts could be engaged to cover various areas across the province, such as north, central and south.
3. **Establish a community of practice amongst clinical service providers to establish standards of practice, review evidence-based interventions and create new knowledge in the Alberta context.** A community of practice among clinical service providers would support enhanced service provision by establishing practice standards and ethics and reviewing the evidence base for treatment. Membership and association with ATSA is important in this regard, as is ongoing learning with experts, conferences and training. Once the network has reached a point of competency and proficiency, it could act in an advisory/consultative role for various communities, advance new knowledge and forward the work in Alberta.
4. **Examine efficacy of virtual services for families in rural/remote communities.**⁶ Results from this work found that smaller communities struggle to find specialized therapists and many families must drive several hours for treatment. Yet, services in larger areas already face waitlists, thereby adding to an already stressed

⁶ Radius Child & Youth Services is undergoing research into virtual service provision to children/youth with problematic sexual behaviour. Interview respondents reported to date, the results have been positive. Connecting with this organization would be a worthwhile step.

service system. Exploring if and how virtual services could increase access for smaller jurisdictions would be a worthwhile endeavour.

5. **Provide general education about children/youth with problematic sexual behaviour to organizations and individuals supporting children impacted by sexual abuse, including but not limited to: sexual assault services, child advocacy centres and other clinicians.** One of the most notable findings in this report is the limited understanding and awareness about children/youth with problematic sexual behaviour generally amongst service providers in the anti-violence sector, and the detrimental effect it can have on families. There is a compelling argument for all who work in the field to have a foundational understanding of this population and their treatment needs. Working to reduce stigma and the false association of children with adult sex offenders is an important step forward, as is the ability to appropriately assess, respond and refer.
6. **Develop an education program for schools and other community partners.** Like those working in sexual assault services, child advocacy centres and other trauma-related services, other community partners also require education to reduce stigma and increase awareness. Schools, daycares, preschools, churches, community organizations, youth clubs and more were identified as key stakeholders who could benefit from learning and support a community-focused response to the issue.
7. **Develop an information source for parents/caregivers.** The project revealed limited information and supports available to parents/caregivers of children/youth with problematic sexual behaviour. While services do their best to support these families and provide information as they can, a more formalized and developed information source would be more impactful and increase access to accurate information. A shared website, a downloadable PDF and/or videos would be a great source of information for families and would allow them to access information anonymously. This could be a provincial initiative, and the source shared widely.
8. **Collaborate with Children's Services to strengthen the response for children and youth with problematic sexual behaviour and their families.** Findings from this project identified opportunities to strengthen assessment, service pathways, access to specialized treatment, and coordinated responses for children, youth, and families affected by problematic sexual behaviour. Supporting Children's Services staff through education and increased awareness of problematic sexual behaviour is one component of strengthening the response. Participants also identified the need for ministry-level review of current policies and practices governing Children's Services involvement, including thresholds for opening files, to determine whether changes could improve access to specialized assessment, treatment, coordinated safety planning, and ongoing monitoring where appropriate.

9. **Develop a province-wide safe internet usage and anti-pornography campaign for both parents and young people.** Findings determined the need for greater awareness amongst parents about the ease with which children and youth can find or be exposed to extreme sexual material and pornography online. Children and youth themselves would benefit from information that helps them navigate safely online and what to do when they encounter material of this nature – either accidentally or deliberately by a peer or adult. A campaign such as this would be a primary prevention initiative aimed at reducing exposure to this material and /or seeking adult help (or stopping) with first exposure.
10. **Collaborate with child advocacy centres to strengthen service pathways for children and youth with problematic sexual behaviour and their families.** This work presents an opportunity for child advocacy centres in Alberta to review the interpretation and implementation of national guidelines related to child-focused settings and consider how children and youth with problematic sexual behaviour can be safely supported within these environments. This report has underscored that children under 12 are not offenders. Recent work out of the United States refers to the multi-disciplinary team and the child advocacy centre model as “an ideal vehicle for the provision of the resources needed for the development and implementation of an integrated and comprehensive systems approach” to these families and puts forth several recommendations for how the child advocacy centre model can integrate this work.⁷ Since several child advocacy centres in the province are connected to sexual assault centres, there may be a unique opportunity to develop service pathways between the two and ensure all members of a family receive treatment. Lastly, exploring mechanisms to facilitate appropriate information sharing and consent processes among child advocacy centre system partners would allow child advocacy centres to contact families directly and offer support.
11. **Establish a prevention-focused committee in the province.** There is an opportunity to examine this issue through a prevention lens and establish more sexual violence prevention strategies in the province. ATSA advances the need for victim services and those that work with children/youth with problematic sexual behaviour and sex offending behaviour to collaboratively discuss and identify prevention efforts. They state:

What ATSA and ATSA members offer is a unique focus on efforts to stop the perpetration of unhealthy, harmful, dangerous, and illegal sexual behavior...ATSA's work considers both risk and protective factors for the perpetration of sexual violence. Emerging research, and the focus of our frame, is informing our understanding of what puts someone at risk for sexual violence and what may

⁷ Sites, J. & Widdifield, J. (2020). Children with problematic sexual behaviour: recommendations for the multidisciplinary team and CAC response. Page 3. Retrieved from <https://www.ojp.gov/ncjrs/virtual-library/abstracts/children-problematic-sexual-behavior-recommendations>

prevent the first-time perpetration of sexual abuse, as well as prevent further sexual abuse by those who have abused. The ultimate goal, and center point for our frame, is making our society a safer place to live.⁸

An interesting example of primary prevention is www.whatsok.org. This is a space where young people can check their sexual behaviours, thoughts and actions through text, chat, email or phone. Developing innovative, effective prevention strategies with insights from the offending field would be an impactful way forward.

⁸ ATSA (2014). Talking about prevention: Framing the picture. Retrieved from <https://www.atsa.com/learn/prevention>

References

- Aebi, M., Landolt, M. A., Mueller-Pfeiffer, C., Schnyder, U., Maier, T., & Mohler-Kuo, M. (2015). Testing the "sexually abused-abuser hypothesis" in adolescents: A population-based study. *Archives of Sexual Behavior*, 44(8), 2189–2199.
- Allen. (2017). Children with Sexual Behavior Problems: Clinical Characteristics and Relationship to Child Maltreatment. *Child Psychiatry and Human Development*, 48(2), 189–199.
- Allen, B., Tellez, A., Wevodau, A., Woods, C. L., & Percosky, A. (2014). The impact of sexual abuse committed by a child on mental health in adulthood. *Journal of interpersonal violence*, 29(12), 2257-2272.
- Amado, B. G., Arce, R., & Herraiz, A. (2015). Psychological injury in victims of child sexual abuse: A meta-analytic review. *Psychosocial Intervention*, 24(1), 49-62.
- ATSA. (n.d.a). Fast facts about children who display problematic sexual behaviours. Retrieved from <https://www.atsa.com/learn/children>
- ATSA. (n.d.b). *Risk assessment*. Retrieved from <https://www.atsa.com/risk-assessment>
- ATSA. (2017). *Practice guidelines for assessment, treatment and intervention with adolescents who have engaged in sexually abusive behaviour*. Author.
- Azzopardi, Eirich, R., Rash, C. L., MacDonald, S., & Madigan, S. (2019). A meta-analysis of the prevalence of child sexual abuse disclosure in forensic settings. *Child Abuse & Neglect*, 93, 291-304.
- Beek, E., Spruit, A., Kuiper, C. H. ., van der Rijken, R. E. ., Heniks, J., & Stams, G. J. J. . (2018). Treatment effect on recidivism for juveniles who have sexually offended: A multilevel meta-analysis. *Journal of Abnormal Child Psychology*, 46(3), 543–556.
- Bertele, N., & Talmon, A. (2021). Sibling sexual abuse: a review of empirical studies in the field. *Trauma, Violence, & Abuse*. <https://doi.org/10.1177/15248380211030244>
- Blasingame, G. D. (2018). Risk assessment of adolescents with intellectual disabilities who exhibit sexual behavior problems or sexual offending behavior. *Journal of Child Sexual Abuse*, 27(8), 955-971.
- Borum, R. (2006). *Manual for the Structured Assessment of Violence Risk in Youth (SAVRY)*. Odessa, FL: Psychological Assessment Resources
- Briere, J. & Scott, C. (2015). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (2nd ed.). Thousand Oaks, CA.: Sage Publications.

- Cale, & Lussier, P. (2017). Sexual behaviour in preschool children in the context of intraparental violence and sexual coercion. *Criminal Behaviour and Mental Health*, 27(4), 387–388
- California Evidence-Based Clearing House for Child Welfare. (2022). Sexual behaviour problems treatment (Adolescents). Retrieved from <https://www.cebc4cw.org/topic/sexual-behavior-problems-in-adolescents-treatment-of/>
- Caldwell, M. (2016). Quantifying the Decline in Juvenile Sexual Recidivism Rates. *Psychology, Public Policy, and Law*, 22(4), 414–426.
- Carpentier, M., Silovsky, J. F., & Chaffin, M. (2006). A randomized trial of treatment for children with sexual behavior problems: Ten year follow-up. *Journal of Consulting and Clinical Psychology*, 74(3), 482–488.
- CDC. (2016b). *Stop SV: A technical package to prevent sexual violence*. <https://www.cdc.gov/violenceprevention/pdf/SV-Prevention-Technical-Package.pdf>
- Chaffin, M., Berliner, L., Block, R., Johnson, T. C., Friedrich, W. N., Louis, D. G., Lyon, T. D., Page, I. J., Prescott, D. S., Silovsky, J. F., & Madden, C. (2008). Report of the ATSA Task Force on Children With Sexual Behavior Problems. *Child Maltreatment*, 13(2), 199–218.
- Christiansen, A. K., & Vincent, J. P. (2013). Characterization and prediction of sexual and nonsexual recidivism among adjudicated juvenile sex offenders. *Behavioural Sciences and the Law*, 31, 506–529.
- Conroy, S., & A. Cotter. (2017). *Self-reported sexual assault in Canada, 2014* [Data set]. Retrieved from <https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2017001/article/14842-eng.pdf?st=Hhk8zFBY>
- Cotter, A & Beaupré, P. (2014). *Police-reported sexual offences against children and youth in Canada, 2012*. Retrieved from <https://www150.statcan.gc.ca/n1/pub/85-002-x/2014001/article/14008-eng.htm>
- Dawson, K., Tafro, A., & Štulhofer, A. (2019). Adolescent sexual aggressiveness and pornography use: A longitudinal assessment. *Aggressive behavior*, 45(6), 587–597.
- Department of Justice Canada. (2018). *Understanding the development and impact of Child Advocacy Centres (CACs)*. http://wfpquantum.s3.amazonaws.com/pdf/2018/94478_CAC%20Report%202018%20EN.pdf

- DeLago, C., Schroeder, C. M., Cooper, B., Deblinger, E., Dudek, E., Yu, R., & Finkel, M. A. (2020). Children who engaged in interpersonal problematic sexual behaviors. *Child Abuse & Neglect*, 105, 1–10.
- Elkovitch N, Latzman RD, Hansen DJ, Flood MF. (2009). Understanding child sexual behavior problems: a developmental psychopathology framework. *Clin Psychol Rev* 29, 586–598.
- Epperson, D. L., Kaul, J. D., Huot, S., Goldman, R., Hesselton, D., & Alexander, W. (2005). *Minnesota Sex Offender Screening Tool-Revised (MnSOST-R) scoring guidelines—updated*.
- Finkelhor, D., & Browne, A. (1985). The traumatic impact of sexual abuse: a conceptualization. *Am J Orthopsychiatry* 55, 530–541.
- Finkelhor, D., & Jones, L. M. (2012). *Have sexual abuse and physical abuse declined since the 1990s?* Retrieved from Durham, NH: Crimes against Children Research Center.
- Gewirtz-Meydan, & Finkelhor, D. (2020). Sexual Abuse and Assault in a Large National Sample of Children and Adolescents. *Child Maltreatment*, 25(2), 203–214.
- Godbout, N., Briere, J., Sabourin, S., & Lussier, Y. (2014). Child sexual abuse and subsequent relational and personal functioning: The role of parental support. *Child Abuse & Neglect*, 38(2), 317–325.
- Grossi, L.M., Brereton, A., Lee, A. F., Schuler, A., & Prentky, R. A. (2017). Sexual reoffense trajectories with youths in the child welfare system. *Child Abuse & Neglect*, 68, 81–95
- Gotch, K. & Hanson, K. (2016). Risk assessment for males who have engaged in harmful or illegal sexual behaviour. ATSA.
- Hackett, S., Masson, H., Balfe, M., & Philips, J. (2013). Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers. *Child Abuse Review*, 22, 232–245.
- Hailes, H. P., Yu, R., Danese, A., & Fazel, S. (2019). Long-term outcomes of childhood sexual abuse: an umbrella review. *The Lancet Psychiatry*, 6(10), 830–839.
- Halpern, Schuch, F. B., Scherer, J. N., Sordi, A. O., Pachado, M., Dalbosco, C., Fara, L., Pechansky, F., Kessler, F., & Von Diemen, L. (2018). Child Maltreatment and Illicit Substance Abuse: A Systematic Review and Meta-Analysis of Longitudinal Studies. *Child Abuse Review*, 27(5), 344–360.

- Hébert, M., Tourigny, M., Cyr, M., McDuff, P., & Joly, J. (2009). Prevalence of child sexual abuse and timing of disclosure in a representative sample of adults from Quebec. *Canadian Journal of Psychiatry*, 54, 631–639.
- Irish, L., Kobayashi, I., & Delahanty, D. L. (2010). Long-term physical health consequences of childhood sexual abuse: A meta-analytic review. *Journal of pediatric psychology*, 35(5), 450–461.
- Jespersen, A. F., Lalumière, M. L., & Seto, M. C. (2009). Sexual abuse history among adult sex offenders and non-sex offenders: A meta-analysis. *Child abuse & neglect*, 33(3), 179–192.
- Kellogg, N.D. (2010). Sexual Behaviors in Children: Evaluation and Management. *American Family Physician*, 82(10), 1233–1238.
- Krienert, J. L., & Walsh, J. A. (2011). Sibling sexual abuse: An empirical analysis of offender, victim, and event characteristics in National Incident-Based Reporting System (NIBRS) data, 2000–2007. *Journal of Child Sexual Abuse*, 20(4), 353–372.
- Larance, L., Kertesz, M., Humphreys, C., Goodmark, L., & Douglas, H. (2022). Beyond the Victim-offender Binary: Legal and Anti-violence Intervention Considerations With Women Who Have Used Force in the U.S. and Australia. *Affilia*, 37(3), 466–486.
- Leach, C., Stewart, A., & Smallbone, S. (2016). Testing the sexually abused-sexual abuser hypothesis: A prospective longitudinal birth cohort study. *Child Abuse & Neglect*, 51, 144–153.
- Lindert, von Ehrenstein, O. S., Grashow, R., Gal, G., Braehler, E., & Weisskopf, M. G. (2013). Sexual and physical abuse in childhood is associated with depression and anxiety over the life course: systematic review and meta-analysis. *International Journal of Public Health*, 59(2), 359–372.
- Lussier, P., McCuish, E., Mathesius, J., Corrado, R., & Nadeau, D. (2017). Developmental Trajectories of Child Sexual Behaviors on the Path of Sexual Behavioral Problems: Evidence From a Prospective Longitudinal Study. *Sexual Abuse*, 30(6), 622–65.
- Lussier, P., Chouinard-Thivierge, S., McCuish, E., Nadeau, D., & Lacerte, D. (2019). Early life adversities and polyvictimization in young persons with sexual behavior problems: A longitudinal study of child protective service referrals. *Child Abuse & Neglect*, 88, 37–50.
- Malvaso, C. G., Proeve, M., Delfabbro, P., & Cale, J. (2020). Characteristics of children with problem sexual behaviour and adolescent perpetrators of sexual abuse: A systematic review. *Journal of Sexual Aggression*, 26(1), 36–61.

- Maniglio. (2013). Child Sexual Abuse in the Etiology of Anxiety Disorders. *Trauma, Violence & Abuse, 14*(2), 96–112.
- McCann, & Lussier, P. (2008). Antisociality, Sexual Deviance, and Sexual Reoffending in Juvenile Sex Offenders: A Meta-Analytical Investigation. *Youth Violence and Juvenile Justice, 6*(4), 363–385.
- McCuish, E., Lussier, P., & Corrado, R. (2016). Criminal careers of juvenile sex and nonsex offenders: Evidence from a prospective longitudinal study. *Youth Violence and Juvenile Justice, 14*(3), 199–224.
- McKibbin, & Humphreys, C. (2020). Future directions in child sexual abuse prevention: An Australian perspective. *Child Abuse & Neglect, 105*, 104422–104428.
- Mesman, G., Harper, S. L., Edge, N. A., Brandt, T. W., & Pemberton, J. L. (2019). Problematic Sexual Behavior in Children. *Journal of Pediatric Health Care, 33*(3), 323–331
- Miccio-Fonseca, L.C. (2010). MEGA-J: An Ecological Risk Assessment Tool of Risk and Protective Factors for Assessing Sexually Abusive Children and Adolescents. *Journal of Aggression, Maltreatment & Trauma, 19*, 734 - 756.
- Miccio-Fonseca, & Rasmussen, L. A. L. (2018). Scientific Evolution of Clinical and Risk Assessment of Sexually Abusive Youth: A Comprehensive Review of Empirical Tools. *Journal of Child Sexual Abuse, 27*(8), 871–900.
- Miccio-Fonseca, L. C., & Rasmussen, L. A. (2015). MEGA-J: Empirical Support for Nomenclature on the Anomalies: Sexually Violent and Predatory Youth. *International Journal of Offender Therapy and Comparative Criminology, 59*(11), 1222–1238
- MNCASA. (2017). *Children with sexual behavior problems: improving Minnesota's ability to provide early identification and intervention services through policy and practice recommendations*. Retrieved from [https://mn.gov/doc/assets/Children with Sexual Behavior Problems MNCASA%202017%20Report_tcm1089-503197.pdf](https://mn.gov/doc/assets/Children_with_Sexual_Behavior_Problems_MNCASA%202017%20Report_tcm1089-503197.pdf)
- Ogloff, J., Cutajar, M., Mann, E., & Mullen, P. (2012). Child sexual abuse and subsequent offending and victimization: A 45-year follow-up study. Trends and Issues in Crime and Criminal Justice, 440 Canberra: Australian Institute of Criminology Retrieved from <https://www.aic.gov.au/publications/tandi/tandi440>
- Olafson, E. (2011). Child sexual abuse: Demography, impact, and interventions. *Journal of Child & Adolescent Trauma, 4*(1), 8-21.

- Prentky, R.A. & Righthand, S. (2003). *Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II): Manual*. Washington, DC: U.S. Department of Justice.
- Perry, B. D. (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the neurosequential model of therapeutics. *Journal of Loss and Trauma*, 14(4), 240-255.
- Peter, J., & Valkenburg, P. M. (2016). Adolescents and pornography: A review of 20 years of research. *The Journal of Sex Research*, 53(4-5), 509-531.
- Rasmussen. (2018). Comparing Predictive Validity of JSORRAT-II and MEGA With Sexually Abusive Youth in Long-Term Residential Custody. *International Journal of Offender Therapy and Comparative Criminology*, 62(10), 2937-2953
- Rotenberg, C. (2017). From arrest to conviction: Court outcomes of police-reported sexual assaults in Canada, 2009 to 2014. *Juristat*, 1-57.
- Sanjeevi, S., Houlihan, D., Bergstrom, K. A., Langley, M. M., & Judkins, J. (2018). A Review of Child Sexual Abuse: Impact, Risk, and Resilience in the Context of Culture. *Journal of Child Sexual Abuse*, 27(6), 622-641.
- Schmucker, M., & Lösel, F. (2015). The effects of sexual offender treatment on recidivism: An international meta-analysis of sound quality evaluations. *Journal of Experimental Criminology*, 11, 597-630.
- Shawler, P., Silvis, V. G., Taylor, E. K., Shields, J., Beasley, L., & Silovsky, J. F. (2020). Early identification of youth with problematic sexual behavior: A qualitative study. *Child Abuse & Neglect*, 105, 104317-10.
- Silovsky, J., Letourneau, E. J., & Bonner, B. L. (2020). Introduction to CAN special issue: Children with problem sexual behavior. *Child Abuse & Neglect*, 105, 104508-104508.
- Silovsky, J. F., & Niec, L. (2002). Characteristics of young children with sexual behavior problems: A pilot study. *Child Maltreatment*, 7, 187-197.
- Silovsky, J.F., Swisher, L.M., Widdifield, Jr., J. W, & Turner, V.L. (2013). Children with Sexual Behaviors. *Handbook of Child and Adolescent Sexuality*, Chapter 20, 497- 518.
- Seto, M. C., & Lalumière, M. L. (2010). What is so special about male adolescent sexual offending? A review and test of explanations through meta-analysis. *Psychological Bulletin*, 136(4), 526-575.
- Smith, T. J., Lindsey, R. A., Bohora, S., & Silovsky, J. F. (2019). Predictors of intrusive sexual behaviors in preschool-aged children. *The Journal of Sex Research*, 56(2), 229-238.

- Stoltenborgh, M., Van Ijzendoorn, M., Euser, E., & Bakermans-Kranenburg, M. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment*, 16(2), 79-101.
- Tharp, A. T., DeGue, S., Valle, L. A., Brookmeyer, K. A., Massetti, G. M., & Matjasko, J. L. (2012). A systematic qualitative review of risk and protective factors for sexual violence perpetration. *Trauma, Violence & Abuse*, 14(2), 133-167.
- UN Women. (2015). *A framework to underpin action to prevent violence against women*. <https://www.unwomen.org/en/digital-library/publications/2015/11/prevention-framework>
- Vega, V., & Malamuth, N. M. (2007). Predicting sexual aggression: The role of pornography in the context of general and specific risk factors. *Aggressive Behavior: Official Journal of the International Society for Research on Aggression*, 33(2), 104-117.
- Vera-Gray, F., McGlynn, C., Kureshi, I., & Butterby, K. (2021). Sexual violence as a sexual script in mainstream online pornography. *The British Journal of Criminology*, 61(5), 1243-1260.
- Viljoen, J. L., Mordell, S., & Beneteau, J. L. (2012). Prediction of adolescent sexual reoffending: A meta-analysis of the J-SOAP-II, ERASOR, J-SORRAT-II, and Static-99. *Law and Human Behavior*, 36, 423-438.
- Walker, D. F., McGovern, S. K., Poey, E. L., & Otis, K. E. (2004). Treatment effectiveness for male adolescent sexual offenders: A meta-analysis and review. *Journal of Child Sexual Abuse*, 13, 281-293.
- Worling, J. (2017). PROFESOR: Protective + risk observations for eliminating sexual offense recidivism. Retrieved from <https://www.profesor.ca/>
- Worling, J.R. & Curwen, T. (2001). *Estimate of Risk of Adolescent Sexual Offense Recidivism Version 2.0*. Toronto, ON: SAFE-T Program, Thistletown Regional Centre.
- Worling, J. W., & Långström, N. (2003). Assessment of criminal recidivism risk with adolescents who have offended sexually: A review. *Trauma, Violence & Abuse*, 4, 341-362.
- Worling, J. W., & Långström, N. (2005). Risk of sexual recidivism in adolescents who offend sexually: correlates and assessment. In Barbaree, H. E., & Marshall, W. L. (Eds.). *The Juvenile Sexual Offender*, 2nd ed. New York: Guilford.
- Wright, P., Tokunaga, R. S., & Kraus, A. (2016). A Meta-Analysis of Pornography Consumption and Actual Acts of Sexual Aggression in General Population Studies. *Journal of Communication*, 66(1), 183-205.

Ybarra, M. L., & Thompson, R. E. (2018). Predicting the emergence of sexual violence in adolescence. *Prevention Science, 19*(4), 403–415

Ybarra, M. L., Strasburger, V. C., & Mitchell, K. J. (2014). Sexual media exposure, sexual behavior, and sexual violence victimization in adolescence. *Clinical Pediatrics, 53*(13), 1239–1247.

Appendix A: Interview Questions

Interview Questions – Alberta Community-Based Service Providers

1. Are you seeing children with sexual behaviour problems in your agency?
 - a. Tell me about this population.
 - b. What do they present with?
2. How do you currently respond?
 - a. Do you have a formal program for this population? Please tell me about it.
3. What are some of the key issues for children with sexual behaviour problems?
4. What are the current service gaps for this population from your experience?
5. Where should we focus our efforts in Alberta?

Interview Questions – Experts

1. Tell me about children that have sexual behaviour problems. Who are they?
 - a. What are their characteristics, risk factors, abuse history?
 - b. Who do you consider to be a part of this group?
 - i. Those under the age of 12 who are engaging in the problematic sexual behaviours
 - ii. Those over the age of 12 engaging in problematic sexual behaviour (up to 18)
 - iii. Those over 12 who are facing charges for their sexual behaviour.
2. What are some of the key issues surrounding children with sexual behaviour problems?
 - a. Parenting/families - response
 - b. Harm to other children (is the harm minimized because it is another child or sibling?) – misconceptions about harm?
 - c. Sibling/family reunification
 - d. Safety, risk assessment, reintegration
 - e. Disability (spectrum disorder)
 - f. Pornography, drugs/alcohol, non-consensual photo sharing
 - g. Social media/video games
 - h. Family violence/abuse history
3. I'd like to understand how these children interact with services.
 - a. How do they get connected to services? (pathway)
 - b. How do they present at services?
 - c. How do they do in services?
 - d. How do they do afterwards?

4. What happens when there are no services available?
 - a. Where do they go?
 - b. What is the harm/consequences of little to no services?
5. What are the best practices for intervention with this population?
 - a. As a provincial umbrella organization representing SAS across the province, where should we focus our efforts?
6. What are some of the system-level issues that occur with this social problem? (i.e. children's services, criminal justice, health?)
7. Anything else that's important for us to know or consider?

Interview Questions – Canadian Programs

1. Tell me about the population you work with?
 - a. characteristics, risk/protective factors
2. What are the key issues in working with this population we should be aware of?
 - a. Key issues clinically, key issues at family level, key issues with systems
3. Tell me about your program - how do you work with this population?
 - a. best practices, what works, how do they do in services
4. What is the trajectory for these children when services are not available?
5. What do you recommend for anyone wanting to increase/create services for this population?

Appendix B: Results from the Online Environmental Scan

METHODS

The rapid environmental scan was guided by the following question: What services are available for children with sexual behaviour problems in Alberta and Canada?

Identifying services for the following three groups of children and youth was also a focus for this scan:

- Those under the age of 12 engaging in problematic sexual behaviours
- Those over the age of 12 engaging in problematic sexual behaviour (up to 18)
- Those over 12 who are facing charges for their sexual behaviour.

Services in Alberta and Canada were identified through a Google search using combinations of the following keywords: (children OR youth OR adolescent) AND (harmful sexual behaviours OR problematic sexual behaviours OR intrusive sexual behaviours OR sexual offences OR sexual perpetration) AND (Alberta OR Calgary OR Edmonton OR Canada). As interviews were conducted, the project team learned of more services not found through the Google search. These have been added in Alberta.

32 services identified through this search have been included in the report below, divided into provincial categories: services in Alberta, services in British Columbia, services in Manitoba, services in Saskatchewan, and services in Ontario. A brief description and details pertaining to the target population, criteria for access, setting, modality, approach/components, accessibility, type of professionals involved, types of clinical and/or risk assessments, availability of post-intervention supports, and additional relevant information are provided for each service, where available.

Limitations

There were a few potential limitations to this rapid environmental scan. One potential limitation was the ability to identify services across all provinces and territories in Canada. It is possible that including search terms for all Canadian provinces and territories (i.e., not just Alberta) would have yielded results from all provinces and territories. Similarly, it is also possible that searching for services using terms for specific cities other than Edmonton and Calgary could have generated more results from within Alberta. Another potential limitation of this scan was the way problematic sexual behaviour of children and youth was labelled (or not labelled) within program/service information online. For example, many programs identified providing treatment and support for children and/or youth with “behavioural problems” or “behavioural concerns”, without distinguishing whether sexual behaviour was included. Because services were not included in this scan if they did not clearly identify providing treatment or support for sexual behaviour problems within the population of interest, it is possible additional programs providing services to children and youth with sexual behaviour problems were not included in the results.

FINDINGS

Services in Alberta

Six organizations and seven private clinicians providing services to children and youth with sexual behavioural problems were identified in Alberta. These included:

- *Sexual Behaviour Support Program* in Red Deer
- *Phoenix and Child Abuse Services*, Psychologist Dr. Lawrence Deck, and Clinical Social Workers Sandie Forsythe and Dr. Gary Brayton in Calgary
- *Sexual Behaviour Program* in Lloydminster
- *Personal Safety and Wellness Program* in Bonnyville
- *Sifton Family and Youth Services* in Lethbridge
- Sexual Psychologist Ashley Barlow, Psychologist Dr. Ann Marie Dewhurst, Therapist Ian Mackenzie, and Clinical Social Worker Carolyn Barker in Edmonton.

Sexual Behaviour Support Program (SBSP)

Central Alberta Sexual Assault Support Centre (CASASC)

Description:	Helps children and youth up to age 18 who are presenting with individual sexual behaviour problems or concerns.
Location:	Red Deer, Alberta.
Target Population & Criteria:	Available to children and youth up to the age of 18 for behaviour that can't be managed or redirected by caregivers' typical strategies. *Cannot provide services to youth 12 years and older involved in a legal investigation.
Setting & Modality:	Sexual assault centre. Counselling sessions offered in-person, by phone or virtually, depending on health restrictions.
Accessibility:	Referral required – accept referrals from Red Deer and surrounding area. Free of charge. May be a waitlist. Childcare not provided during appointments.
Service Approach/ Components:	Individual counselling. Family work - Parent/caregiver involvement is essential.
Risk/Clinical Assessment:	CASASC does not do risk assessments
Source:	https://casasc.ca/sexual-behaviour-support-program/

Child Abuse Service

Alberta Health Services

Description:	A multidisciplinary, specialized service that provides therapeutic and medical services (i.e., 2 streams) to children who have experienced physical/ sexual abuse and/or neglect. Also provide assessment and treatment to children under the age of 12 who are exhibiting problematic sexual behaviour.
Location:	Calgary, Alberta.
Target Population & Criteria:	Children between 6 & 11 years of age who are exhibiting problematic sexual behaviour for which clinical assessment or treatment is needed. A history of abuse is not required to be eligible for the problem sexual behaviours group therapy.
Setting & Modality:	In-person through Alberta Health Services facility.
Accessibility:	Referrals accepted from: AHS internal referral, community physicians, children's services assessors/case workers, parents/legal guardian/ self-referral. *Contact with legal guardian required to complete the referral. Interpreter/translation serviced available.
Service Approach/ Components:	Group Therapy Therapeutic intervention to children and their caregivers to address emotional, behavioural, and relational challenges.
Source:	http://fcrc.albertahealthservices.ca/professional/cds/forms/Child-Abuse-Services-Clinic-Criteria.pdf https://calgarypaeds.org/wp-content/uploads/2018/04/AHS-Child-Abuse-Service-Info-for-Comm-Peds.pdf

Phoenix

Wood's Homes

Description:	Phoenix addresses sexually intrusive behaviour of male youth by providing an ecological, competency-based model of intensive residential treatment closely linked with the young person's family and community.
Location:	Calgary, Alberta.
Target Population & Criteria:	Male youth ages 12-17 exhibiting sexually intrusive behavior.
Setting & Modality:	Therapeutic campus-based care (residential). In-person.
Mandate/Police:	Youth in the program typically have some form of forensic involvement.
Accessibility:	Available by referral only. Access to Occupational therapy, expressive arts therapy, speech and language therapy for additional cost.

Service Approach/ Components:	<p>Specialized, trauma-sensitive treatment informed by the Halton Trauma Centre's Safe T Program.</p> <ul style="list-style-type: none"> • 24-hour supervision and milieu treatment • 24-hour crisis support for children on-site and their families in community • Individual and family therapy - families are provided opportunities to participate in the treatment process and receive informed supervision training • Psychosexual education • Access to occupational therapy, expressive arts therapy, speech and language therapy • Recreation and wilderness opportunities • Structured community engagement and citizenry • Nursing services and health monitoring • On-site educational services - all clients attend George Wood Learning Centre • Therapeutic Crisis Intervention (TCI)
Risk/Clinical Assessment:	Functional assessment using Child and Adolescent Functional Assessment Scale (CAFAS). Access to additional assessment services at an additional cost.
Training of Professional(s)	Comprehensive inter-professional team
Post-Intervention Support:	Offer <i>On The Way Home program</i> - provides post-treatment community care and follow-up services
Additional Info:	<p>Typical treatment length is 13 months. Provided in partnership with the Ministry of Children's Services. Annual reports available at: https://www.woodshomes.ca/about-us/annual-reports/</p> <p>Organization also has a research department: Research Department - Learn - Wood's Homes Children's Mental Health (woodshomes.ca)</p>
Source:	https://www.woodshomes.ca/programs/phoenix/

Sexual Behaviour Program

Lloydminster Sexual Assault Services (LSAS)

Description:	Program supports children under the age of 12 exhibiting sexual behaviours and their families. This is an intensive program where parent/caregiver involvement is integral to education and healing and meant for children who continue to engage in sexual behaviours. Sessions include a focus on boundaries, feelings identification and alternative coping strategies, beliefs, and values recognition, and more.
Location:	Lloydminster, Alberta.

Target Population & Criteria:	Children under the age of 12 (and their families) experiencing problematic sexual behaviour.
Setting & Modality:	Sexual Assault Centre. Outreach sessions also available.
Accessibility:	Program is Free. Accessible in-house or via outreach sessions (i.e., mental health, school, etc.). Referral required. Referrals from organization (e.g., mental health, school, etc.) and self-referrals accepted.
Service Approach/ Components:	<p>Family is assigned to a crisis Interventionist or team of interventionists.</p> <p>Group sessions including children, siblings, parents/caregivers, and anyone else involved with the child closely.</p> <p>Sessions are individualized to the needs of each child and family. Topics include: understanding the brain, values & beliefs, emotions & feelings, communication skills, making amends, okay vs. not okay touching, coping strategies, identifying hopes and worries, and anger resolution.</p>
Training of Professional(s)	Crisis interventionist.
Source:	http://www.lloydminstersexualassault.com/sexual-behaviour-program/

Sifton Family and Youth Services

ALIGN Association of Community Services

Description:	Sifton Family and Youth Services provides an eight bed 24-hour broad-based treatment program for young people with behavioural and or emotional problems and has expertise in the treatment of youth who are sexually intrusive.
Location:	Lethbridge, Alberta.
Target Population & Criteria:	Youth who are sexually intrusive.
Setting & Modality:	8 bed, 24-hour residential treatment program.
Service Approach/ Components:	Broad-based treatment.
Additional Info:	Very little information found online for this program.
Source:	https://alignab.ca/members/sifton-family-youth-services/

Personal Safety & Wellness Program

Dragonfly Counselling & Support Centre

Description:	Dragonfly Counselling & Support Centre (DCSC) is a charitable organization and the primary sexual violence service provider for North East Region of
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	Alberta devoted to addressing the widespread issues related to sexual violence.
Location:	Bonnyville, Alberta.
Target Population & Criteria:	Children and youth aged 4-18 who are displaying problematic sexualized behavior, exhibiting offending behaviors towards others, or engaging in problematic behaviors that lie outside of normal, healthy sexual exploration. Youth 12-17 with forensic involvement.
Setting & Modality:	Individual and group counselling.
Mandate/Police:	Treatment provided for youth with forensic involvement related to problematic sexual behaviour.
Accessibility:	All counselling and support services are provided free of charge. Outreach model: main office in Bonnyville and three (3) satellite offices in Cold Lake, Lac La Biche and St. Paul. The counselling and support teams travel across the Region to meet with clients by appointment.
Service Approach/ Components:	Psycho-educational approach. Individualized Problematic Sexual Behaviour (problematic sexual behaviour) Clinical Counselling for children 6-12 yrs. Group and Individual Problematic Sexual Behaviour Clinical Treatment for youth 12-17 years with forensic involvement.
Training of Professional(s)	Master of Arts, Counselling Psychology
Source:	https://thedragonflycentre.com/wp-content/uploads/2021/08/Annual-Report-2020-2021.pdf

Sexual Psychologist, Ashley Barlow

Ashley Barlow Psychological

Description:	Ashley Barlow specializes in assisting adults and adolescents with a variety of concerns related to sexuality, recently specializing in working with adolescents who have sexual behavior problems.
Location:	Edmonton, Alberta.
Target Population & Criteria:	Adolescents 10 years and older with sexuality related concerns.
Setting & Modality:	Therapy. In-person and online appointments.
Mandate/Police:	Provides court-ordered psychological assessments and treatment for youth with sexual behaviour problems.
Accessibility:	Approx. \$200 an hour. Easy online booking.

Service Approach/ Components:	Trauma-informed, client centered therapy (individual).
Risk/Clinical Assessment:	Provides psychoeducational assessments (cognitive ability, academic functioning, psychosocial functioning, ADHD). Court-ordered psychological assessments for youth. Forensic Assessment.
Training of Professional(s)	Registered Clinical Psychologist, specialization in Forensic Psychology.
Source:	https://ashleybarlowpsychological.ca/services/sexual-problems/

Registered Psychologist, Dr. Lawrence Deck

Wayfound

Description:	Dr. Lawrence Deck has been practicing as a psychologist since 2009. Dr. Deck completed his research in the area of violence and aggression and has specialized training in working with individuals who have offended sexually.
Location:	Calgary, Alberta.
Target Population & Criteria:	Adolescents
Setting & Modality:	Individual and group therapy. In-person and virtual options available.
Accessibility:	Wayfound has a standard \$200/hr fee.
Service Approach/ Components:	Prolonged Exposure, Cognitive Behavioral Therapy, Eye Movement Desensitization, Independent Medical Exam, Dialectical Behavior Therapy, Aggression replacement training
Risk/Clinical Assessment:	Cognitive assessments, social-emotional assessments, capacity assessments, risk assessments (sexual or violent risk), and comprehensive psychological evaluations. Dr. Deck has been formally recognized by the Alberta Provincial Court as an expert in the area of risk assessment and psychometrics.
Training of Professional(s)	PhD in psychology. Registered Psychologist.
Source:	https://wayfound.ca/health-team/calgary/

Registered Psychologist, Dr. Ann Marie Dewhurst

Valerian Consulting Ltd.

Description:	Dr. Ann Marie has been registered in Alberta since 1994 and has two areas of practice: Clinical/Counselling and Forensic Psychology. As a forensic
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	psychologist, Ann Marie specializes in working with people who have been victims or perpetrators (or both) of domestic violence and/or sexual abuse.
Location:	Edmonton, Alberta.
Target Population & Criteria:	Unspecified on website.
Setting & Modality:	Individual counselling. Traditionally in-person, but primarily Teletherapy during COVID.
Accessibility:	Individual counselling is \$200/session.
Service Approach/ Components:	Primarily Cognitive Behavioural Therapy. Also employs clinical hypnosis, EMDR and Prolonged Exposure therapy when appropriate.
Risk/Clinical Assessment:	General psychological assessments and risk assessments regarding potential for future sexual offending.
Training of Professional(s)	PhD, Psychology; Registered Psychologist.
Source:	https://valerianconsulting.ca

Counselling and Consulting, Sandie Forsythe

Sandie Forsythe Counseling

Description:	Sandie has been providing support and counselling to children and families since 1994 through her child and family-focused private practice. Sandie has a special interest in the areas of attachment and trauma, and specializes in working with children and youth who have experienced trauma and/or exhibit sexual behavior problems.
Location:	Calgary, Alberta.
Target Population & Criteria:	Children up to age 12 and youth 13-17 with sexual behaviour problems.
Setting & Modality:	Therapy. Individual, in-person counselling for children and adolescents.
Accessibility:	Fee - \$200/hr.
Service Approach/ Components:	Expressive arts, Trauma-Focused Cognitive Behavioral Therapy, Cognitive Behavioural Therapy, Theraplay, Mindfulness, and strength and solution focused therapy, Eye Movement Desensitization and Reprocessing, Sensorimotor Psychotherapy.
Risk/Clinical Assessment:	Risk and Needs Assessment for Children and Youth with Sexual Behavior Problems (SBP) (unspecified). Trauma-based assessment.
Training of Professional(s)	Master's of Social Work; Registered Clinical Social Worker.
Additional Info:	Sandie's practice also incorporates a diversity, Indigenous and multi-cultural framework.
Source:	http://www.sforsythecounseling.com

Counselling and Consulting, Dr. Gary Brayton

Brayton Consulting Services Inc.

Description:	Dr. Gary Brayton provides therapy and support to youth with concerning/intrusive sexual behaviour and their families through his private practice.
Location:	Calgary, Alberta.
Target Population & Criteria:	Youth age 9-19 years of age who present concerning/intrusive sexual behaviors
Setting & Modality:	Individual, in-person therapy.
Accessibility:	Fee - \$180/hr
Service Approach/Components:	<ul style="list-style-type: none"> • Psychosexual education • Positive psychology • Psychotherapy to address victimization /anxiety/trauma – EMDR, cognitive behavior therapy, positive psychology, ego supportive techniques • Critical thinking skills (BrainWise Program) • Family work/family reunification
Risk/Clinical Assessment:	Risk and needs assessments for youth aged 9-19 years of age who have engaged in sexually concerning/intrusive behaviors (unspecified).
Training of Professional(s)	Clinical Social Worker - PhD, RSW, MSW
Source:	Gary Brayton.

Clinical Social Worker, Ian MacKenzie

North Land Counselling Group

Description:	Private practice focused on individual, marital, and family therapy for adults and adolescents experiencing emotional and behavioral problems. Areas of focus include depression, emotional attachment, relationships, and sexuality.
Location:	Edmonton, Alberta.
Target Population & Criteria:	Adolescents with emotional and behavioural problems related to relationships, sexuality and abuse.
Setting & Modality:	Individual and family therapy. In-person, secure video and telephone options.
Accessibility:	Rates in line with professional fee guidelines – quoted when booking an appointment (190-\$200/hr)
Service Approach/Components:	<ul style="list-style-type: none"> • Attachment-based • Family / Marital • Family Systems • Gottman Method • Mindfulness-Based (MBCT)

	<ul style="list-style-type: none"> • Narrative • Relational • Solution Focused Brief (SFBT)
Risk/Clinical Assessment:	Behavioral/Emotional Assessment is provided through North Land Counselling.
Training of Professional(s)	Clinical Social Worker; Masters of Social Work.
Source:	https://www.northlandcounselling.com Ian MacKenzie, Clinical Social Work/Therapist, Edmonton, AB, T6C Psychology Today

Clinical Social Worker, Carolyn Barker

North Land Counselling Group

Description:	Carolyn Barker is a Clinical Social Worker with a private practice. She works with individuals struggling with a variety of challenges including anxiety, depression, relationship issues, personal growth, and Post Traumatic Stress Disorder.
Location:	Edmonton, Alberta.
Target Population & Criteria:	Teens (unspecified)
Setting & Modality:	Individual therapy.
Accessibility:	Fee - \$190/hr
Service Approach/ Components:	<ul style="list-style-type: none"> • Cognitive Behavioral Therapy • Mindfulness • Solution Focused therapy • Eye Movement Desensitization Reprocessing (EMDR) therapy • Accelerated Resolution Therapy
Risk/Clinical Assessment:	Behavioral/Emotional Assessment is provided through North Land Counselling.
Training of Professional(s)	Masters in Social Work; Registered Social Worker; Clinical Social Worker/Therapist
Source:	https://www.northlandcounselling.com Carolyn Barker, Clinical Social Work/Therapist, Edmonton, AB, T6C Psychology Today

Services in British Columbia

Three organizations were found in British Columbia...

Sexual Abuse Intervention

Community Bridge

Description:	Provide appropriate treatment and support for children and youth who have been sexually abused, as well as children under 12 with sexually intrusive behaviours.
Location:	Peace River-Liard area, British Columbia.
Target Population & Criteria:	Children under the age of 12 with sexually intrusive behaviours.
Setting & Modality:	Community-based organization.
Accessibility:	Must contact program counsellor to access the program.
Service Approach/ Components:	Focus on managing or reducing problematic behaviours. Assisting non-offending family members to support these children and youth. Provide referrals to other agencies and services.
Training of Professional(s)	Sexual abuse intervention counsellor - Masters degree in related field plus 2 years recent related experience. "Graduate Certificate in Complex Trauma and Child Sexual Abuse Intervention" from the Justice Institute is an asset."
Post-Intervention Support:	Community Bridge also offers a supported independent living program for youth.
Additional Info:	Funded by the Ministry of Children and Family Development.
Source:	http://communitybridge.ca/programs-services/sexual-abuse-intervention-program https://workinnonprofits.ca/jobs/view/78710/E

Sexual Abuse Intervention Program

North Coast Transition Society

Description:	Provides specialized assessment and treatment services to children and youth under 19 who have been sexually abused, are at risk of being sexually abused, and/or are exhibiting problematic sexual behaviors (under 12 years).
Location:	Prince Rupert, British Columbia.
Target Population & Criteria:	Children and youth under 12 at risk of or exhibiting problematic sexual behaviours.

Setting & Modality:	In-person. Community-based.
Accessibility:	Offered in English. Disability access to building. Free.
Service Approach/ Components:	Specialized treatment (unspecified). Support also provided to the families of children who are accessing these services.
Additional Info:	Funded by Ministry of Children and Family Development (MCFD). Little info available on webpage about this service.
Source:	https://www.ncts.ca/counselling-programs.html

Sexual Abuse Intervention Program

Canadian Mental Health Association - Cowichan Valley Branch

Description:	Provides counselling and treatment for children and youth who have experienced sexual abuse and or sexual behaviour problems. The program helps children with managing or reducing problematic behaviours and reducing trauma related symptoms.
Location:	Duncan, British Columbia.
Target Population & Criteria:	Children aged 12 and under with sexually intrusive behaviours.
Setting & Modality:	Community-based. Currently meeting clients in-person, by phone and/or video.
Accessibility:	Referral-based (self-referral and referrals from health professionals). Disability access to building
Service Approach/ Components:	Youth participate in individual counselling sessions, which can include parents/caregivers. Treatment modalities used by the SAIP therapist are individualized to meet the needs of our client.
Training of Professional(s)	Therapist/counsellor
Additional Info:	Funded by the Ministry of Children and Family Development.
Source:	https://www.cmhacowichanvalley.com/ https://find.healthlinkbc.ca/ResourceView2.aspx?org=53965&agencynum=17984471

Services in Manitoba

One program was captured in Manitoba using the search strategy employed for this environmental scan: *The Sexual Behaviour Problem Program*.

The Sexual Behaviour Problem Program

New Directions

Description:	Provides therapy to families with children under 12 showing signs of inappropriate sexual behaviour towards another person or themselves.
Location:	Winnipeg, Manitoba.
Target Population & Criteria:	Children under 12 showing signs of inappropriate sexual behaviour.
Setting & Modality:	In-person, community based. In-person, outpatient therapy – meet children and parents/caregivers where they are at.
Accessibility:	Self or agency referral required. Accept referrals from Winnipeg and areas within travel distance. May be a wait list. Services available for free.
Service Approach/ Components:	Family work – parent/caregiver involvement is essential. Group therapy – children and families/caregivers. Therapy includes talking, playing, drawing, games or writing. Provide families with guidelines for supervision (for parents); strategies for coping with thoughts, feelings, images, and behaviour that impacts daily life
Source:	https://newdirections.mb.ca/sexual-behaviour-problems/

Services in Saskatchewan

This rapid environmental scan identified two programs serving children and youth with behavioural problems in the province of Saskatchewan: *Group Homes for Adolescents with Sexual Intrusive Behaviour* in Pilot Butte and the *Young Offender Program* in Saskatoon.

Group Homes for Adolescents with Sexual Intrusive Behaviour

Ranch Ehrlo Society

Description:	Short term intensive treatment program for male and female youth aged 12-16 years old presenting with prenatal exposure to alcohol, childhood trauma, substance abuse, sexually intrusive behaviors, complex developmental needs, suicidal/self-harm behaviors, depression, anxiety, inattention/hyperactivity, language/speech/sensory integration issue or significant problems of conduct and behavior. Sexual behaviour is the primary treatment target.
Location:	Pilot Butte, Saskatchewan
Target Population & Criteria:	Youth aged 12-16 years presenting with sexually intrusive behaviours.
Setting & Modality:	Residential treatment – group home
Accessibility:	Referral required (can be self-referred). Accept referrals from across the country.
Service Approach/ Components:	<ul style="list-style-type: none"> • Intensive therapy groups • Specialized individual counselling • Family work. • Family reunification - typically the goal following discharge • Crisis intervention • Discharge planning and post-discharge follow-up • Youth program incorporates group living services, clinical treatment, education, and recreation for youth. • Art-based therapy
Risk/Clinical Assessment:	<p>Caseworkers conduct psychosocial assessments (history, current functioning, needs for treatment).</p> <p>Youth referred elsewhere for assessment for prenatal exposure to alcohol, childhood trauma and maltreatment, disruptive behaviour, attention problems, and developmental problems.</p>
Training of Professional(s)	Multidisciplinary team of caseworkers: social workers, psychologists, and counsellors.
Post-Intervention Support:	Program helps navigate transition from ranch, focusing on daily life skills, community/ family connectedness, medical resources, community

	involvement and vocational/ educational skills. Program caseworkers also conduct post-discharge follow-up.
Additional Info:	Duration in program typically between 18 months to 24 months, followed by gradual community re-integration.
Source:	https://ehrlo.com/about-us/whats-new/looking-inside-our-group-homes

Young Offender Program

Saskatchewan Health Authority

Description:	The Young Offender program is a multidisciplinary team that provides treatment and assessment services for clients between the ages of 12 and 17 who have committed criminal offences and are involved in the criminal justice system. The central goal of our assessment and treatment service is to reduce the risk of future criminal behaviour by targeting criminogenic needs.
Location:	Saskatoon, Saskatchewan.
Target Population & Criteria:	Youth between the ages of 12 and 17 who have committed a criminal offence - involved in the justice system.
Setting & Modality:	Unclear
Mandate/Police:	Youth are generally referred by the court or youth workers in the justice system.
Accessibility:	Referrals must be submitted by probation officer.
Service Approach/ Components:	Youth may receive individual therapy or a combination of group and individual services, based on their specific needs and abilities. Treatment services address factors that increase risk of future offending.
Risk/Clinical Assessment:	<p>Frequently referred by the court for an assessment of future risk of sexual re-offense</p> <p>Individual and group therapy</p> <p>Occasional cognitive assessments (not court ordered) on a case-by-case basis.</p> <p>Court ordered assessments offered:</p> <ul style="list-style-type: none"> • Violence risk assessment • Sex offender risk assessment • Psychoeducational assessment/ cognitive assessments • Substance management assessments • IRCS assessments • Psychological assessments
Training of Professional(s)	<p>Access to a multidisciplinary team:</p> <ul style="list-style-type: none"> • Addictions Counsellors • Indigenous Cultural Support Worker • Psychologist • Social Worker

Source:	https://www.saskatoonhealthregion.ca/locations_services/Services/mhas/Documents/Pamphlets/Young%20Offender.pdf https://www.saskatoonhealthregion.ca/locations_services/Services/mhas/Pages/YoungOffenderProgram.aspx
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Services in Ontario

13 programs servicing children and youth exhibiting problematic sexual behaviour were identified in the Canadian province of Ontario. These programs and their corresponding service areas are as follows:

- *Sexual Behaviours Team*, London
- *Sexual Abuse Assessment and Treatment Program*, Hamilton
- *Sexual Assault Harms Reduction Program*, Toronto
- *Assessment and Counselling Services*, Toronto
- *Program for Assessment and Treatment for Healthy Sexuality (P.A.T.H.S.)*, Richmond
- *Sexualized Treatment Out-Patient Program (STOP)*, Niagra
- *Sexual Abuse Treatment Program*, Waterloo
- *Child and Youth Sexual Abuse Team (CYSAT)*, Guelph and Wellington
- *Sexual Health and Relapse Prevention (SHARP)*, Thunder Bay
- *ECHO Residential Treatment Program*, Mississauga
- *Second Program and Third Program*, Cornwall
- *Moving Youth Forward*, Dover Centre
- *Youth Centre for Change*, London

Sexual Behaviours Team

Child and Parents Institute (CPRI)

Description:	Program for children and youth who display concerning sexualized behaviour which has a negative impact on their relationships at home, school and in the community
Location:	London, Ontario.
Target Population & Criteria:	Children and youth up to 18 years with varying developmental needs, who demonstrate concerning sexual behaviour (inappropriate, offensive, and/or excessive) and has not stopped with redirection or correction. *CPRI does not provide services to children/youth involved in a legal investigation or proceeding about sexually related matters until the investigation or proceeding is over.
Setting & Modality:	Held in community at CPRI, virtually, or in community (e.g., school or home). Best place for appointment is dependent on child/youth and family circumstances and needs.
Accessibility:	Outpatient referral form signed by the child/youth's doctor required. Free. Virtual options. Services offered in English, but interpretation available upon request.

Service Approach/ Components:	Consultations, education and behavioural support. Provide Team consults with child/youth, caregivers and community partners to determine treatment and safety plan. Children and youth then connected to the appropriate community resources.
Risk/Clinical Assessment:	CPRI does not do risk assessments, emergency or crisis intervention or parent or custody assessments.
Source:	https://www.ontario.ca/page/sexual-behaviours-team#section-1 https://www.wwhealthline.ca/printService.aspx?id=12656

Sexual Abuse Assessment & Treatment Program

Thrive Child and Youth Trauma Services

Description:	This program offers comprehensive assessment and specialized intervention and treatment for children under age 12 who have sexually victimized other children, and for children and youth up to age 18 who have engaged in intrafamilial sexual abuse.
Location:	Hamilton, Ontario.
Target Population & Criteria:	Children under age 12 who have sexually victimized other children Children and youth up to the age of 18 who have engaged in intrafamilial sexual abuse.
Setting & Modality:	Child advocacy centre. In-person.
Accessibility:	Referral required (self or child welfare agency). Residents of the Hamilton area do not pay fees for this service. Services also available in French.
Service Approach/ Components:	Every child and youth, and their non-offending parent/caregiver engage in a comprehensive assessment, followed by treatment planning and treatment. Comprehensive assessment includes: clinical interviews, psychometric evaluation, document review. Treatment/interventions: Primary treatment model used in the SAAT program is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Other approaches may include psychodynamic, psycho-educational, experiential, family systems, play therapy, solution-focused, and specific trauma focused interventions. Counselling is predominantly individual, but family members may be part of some parts of counselling sessions.
Risk/Clinical Assessment:	Psychometric evaluation of child/youth and parents/caregivers using standardized measures (unspecified)
Training of Professional(s)	Clinical members with specialized training and experience working with children, youth and families who have experienced trauma (in particular, sexual abused) or have engaged in concerning sexual behaviour.

	Clinical Psychotherapist, Social Worker, Psychologist, Registered Psychotherapist, Art Therapist, Clinical Therapist, Clinical Supervisors
Post-Intervention Support:	None specified.
Additional Info:	Treatment frequency and duration varies case-by-case, depending on needs of child/youth.
Source:	https://www.thrivechildand youth.ca/programs-services/saat-program.html

Sexual Assault Harms Reduction Treatment

Lumenus Community Services

Description:	Sexual assault harm reduction treatment for offenders who have a developmental disability.
Location:	Toronto, Ontario.
Target Population & Criteria:	Youth ages 12-18 with a developmental disability.
Setting & Modality:	Community -based mental health service. Some services offered in-house, others via outreach.
Mandate/Police:	SORNAT assessment and treatment is both voluntary and provided in response to referral from Youth Justice Services for youth in City of Toronto.
Accessibility:	Limited capacity. Referral required (self or from Youth Justice Services). Some services also offered in French.
Service Approach/ Components:	<i>Dual Diagnosis Service</i> (Mental Health/Development Disability): Assists youth and their families in dealing with conflict with friends or family, problems at school and in the community, discrimination, anger, violence, abuse, substance abuse. <i>Sexual Offending Risk Needs Assessment and Treatment</i> (SORNAT): Community-based assessment for youth 12-18 years with a dual diagnosis (mild developmental disability and mental health challenges) who have engaged in problematic sexual behaviour.
Risk/Clinical Assessment:	Sexual Offending Risk Needs Assessment and Treatment (SORNAT) (unspecific on site with assessments are completed).
Source:	https://211central.ca/record/73198129/ https://www.camh.ca/-/media/files/community-resource-sheets/sexual-behaviours-resources-pdf.pdf

Assessment & Counselling Services

Radius Child and Youth Services

Description:	Clinical assessment and treatment services for children, adolescents and families affected by interpersonal abuse, including youth who have engaged in sexually abusive behaviour and children under 12 who have engaged in problematic sexual behaviour.
Location:	Toronto, Ontario.
Target Population & Criteria:	<p>Comprehensive assessment and specialized counselling services are available to youth up to the age of 18 or up to 19 years of age for youth who are involved with the criminal justice system.</p> <p>For children under the age of 12, the concerning sexual behaviour must have been investigated and verified by the respective child welfare organization.</p> <p>Siblings of children and youth are also eligible for services.</p>
Setting & Modality:	Community-based clinic. Services are provided in-person through two Radius offices and through partner organizations.
Mandate/Police:	Some youth clients are also involved with the criminal justice system.
Accessibility:	<p>Referral-based. Referrals accepted from youth justice system and from youth, parents/caregivers, children's aid societies, and other community partners across Ontario.</p> <p>Services offered in English and French. Translational services are provided if needed.</p> <p>Accessible to those living in Toronto, Peel, York, Durham or Halton region.</p> <p>Assessment and counselling provided for free.</p> <p>Possible wait list.</p> <p>Evening appointments are available.</p>
Service Approach/ Components:	<ul style="list-style-type: none"> • Reunification Counselling (after individual counselling) • Sexual Offence-Specific Counselling • Sexual Behaviour Specific Counselling • Trauma Specific Counselling • Individual Counselling • Family work, individual work, family work • Group counselling for youth who have engaged in sexually abusive behaviour and their parents
Risk/Clinical Assessment:	<p>Assessments offered:</p> <ul style="list-style-type: none"> • Trauma-specific assessment (children and youth up at 18 yrs.), • Sexual behaviour-specific assessment (for children under 12) • Sexual offence-specific risk assessment (for youth 12-18 (up to 19 for clients involved in youth justice))
Training of Professional(s)	Multidisciplinary team comprised of social workers, psychotherapists, psychometrists, researchers, and psychologists.
Additional Info:	Radius is the Ontario's largest provider of this specialized care.

	<p>Provide online training to professionals providing these mental health services to children and youth (in-person prior to COVID)</p> <p>Radius conducts research to examine the populations they provide services to. Program evaluations available here: https://radiuscys.ca/program-evaluation/</p> <p>Information about research projects available here: https://radiuscys.ca/research-projects/</p>
Source:	https://radiuscys.ca/about-us-2/ https://www.camh.ca/-/media/files/community-resource-sheets/sexual-behaviours-resources-pdf.pdf

Program for Assessment and Treatment for Healthy Sexuality (P.A.T.H.S.)

Mackenzie Health: Centre for Behaviour Health Sciences

Description:	Centre provides care for individuals living in York Region or Simcoe County who have a developmental disability with a significant cognitive delay, autism or are living with the effects of an acquired brain injury. The focus of P.A.T.H.S. clinic is on promoting positive sexuality while reducing problematic sexual behaviours, through individualized assessment and treatment.
Location:	Richmond, Ontario.
Target Population & Criteria:	Children and adults must have a confirmed intellectual disability and have engaged in concerning and/or offensive sexual behaviours.
Setting & Modality:	Community-based.
Accessibility:	Must live in York Region or Simcoe County. Referral needed (Self or physician referral).
Service Approach/ Components:	<p>Individual and group support.</p> <p>Behaviour intervention provided through a comprehensive assessment followed by positive-based teaching and programming. A full range of challenging needs are addressed: general management issues, aggression, self injury, skill promotion, and social problem solving.</p> <p>Behavioural skills taught using the mediator model.</p>
Risk/Clinical Assessment:	Comprehensive assessment (unspecified).
Training of Professional(s)	Behavioural Science Team
Source:	https://www.mackenziehealth.ca/programs-services/mental-health/centre-for-behaviour-health-sciences-for-children-and-families

<https://www.camh.ca/-/media/files/community-resource-sheets/sexual-behaviours-resources-pdf.pdf>

Sexualized Treatment Out-Patient Program (STOP)

Pathstone Mental Health

Description:	The Sexual Treatment Outpatient Program (STOP) is a mental health treatment-based program for children/youth over the age of twelve who are exhibiting sexual behaviour problems or have been charged with a sexual offence.
Location:	Niagra, Ontario.
Target Population & Criteria:	Children 4-11 and youth over the age of 12 exhibiting sexual behaviour problems or youth over the age of 12 charged with a sexual offence.
Setting & Modality:	Out-patient program.
Accessibility:	To access treatment, call the organization and complete intake interview. Then a referral forwarded to the Pathstone office and assessment team contacts client for appointment. Some programs have waitlists for weeks or months (unspecified which ones on website). Service provided for free. Translation services may be offered as needed.
Service Approach/ Components:	Mental health treatment (unspecified).
Training of Professional(s)	Forensics, Pathstone Mental Health.
Additional Info:	The STOP program has a proven success rate of over 90% - Evaluation results were not available on their webpage.
Source:	https://pathstonementalhealth.ca/programs-services/high-risk-services/Sexual-Treatment-Outpatient-Program (S.T.O.P) - Partners to End Child Abuse Niagara

Sexual Abuse Treatment Program

Family and Children's Services of the Waterloo Region

Description:	The Sexual Abuse Treatment Program is available free of charge to any child or youth in Waterloo Region under the age of 18. We offer assessment and treatment to children and youth who have experienced sexual abuse or sexual assault, as well as to children and youth showing concerning or sexually abusive behaviours.
Location:	Waterloo Region, Ontario.

Target Population & Criteria:	Children and youth in the Waterloo Region under the age of 18 showing concerning or sexually abusive behaviours.
Setting & Modality:	Community based. In-person.
Accessibility:	Available free of charge. Only available in the Waterloo region. Transportation assistance available.
Service Approach/ Components:	Individual, family and/or group therapy. Consultations to community members with questions about concerning sexual behaviours and healthy sexuality.
Risk/Clinical Assessment:	Complete an assessment of needs (unspecified).
Source:	https://www.facswaterloo.org/helpingfamilies/sexual-abuse-treatment-services Family and Children's Services of the Waterloo Region - Sexual Abuse Treatment Program - wwhealthline.ca

Child and Youth Sexual Abuse Team (CYSAT)

Canadian Mental Health Association

Description:	CYSAT is multi-disciplinary team that focuses on children who have experienced sexual abuse, children who exhibit sexualized behaviour, and youth who have sexually offended.
Location:	Guelph and Wellington, Ontario.
Target Population & Criteria:	<ul style="list-style-type: none"> • Children or youth aged 0-18 presenting with sexual abuse • Children under the age of 12 presenting with sexualized behaviours • Children 12 and over presenting with sexual offending behaviours
Setting & Modality:	Community-based.
Mandate/Police:	Program coordinates with police services when appropriate.
Accessibility:	Call or walk-in to complete a referral.
Service Approach/ Components:	<p>Treatment specific to the presenting concern</p> <ul style="list-style-type: none"> • <i>Case Management:</i> Coordinate with school, family and children's services, Police/OPP, Victim Witness, Guelph General Hospital, Probation, etc., when appropriate. • <i>Family work:</i> Includes family dynamics, boundary issues, communication issues, reunification work between the victim and perpetrator (particularly with sibling sexual abuse), and other topics. • <i>Safety planning:</i> Particularly with sexualized behaviour and sexual offending. • <i>Psychoeducation:</i> For both the child/youth and caregivers • <i>Group services:</i> Depending on need and availability
Risk/Clinical Assessment:	Assessment specific to the presenting concern, including broad assessment of general behaviour and psychological functioning, specific assessment of

	problematic sexualized behaviour, and/or specialized risk assessment for sexually offending youth (according to principles outlined by ATSA (Association for the Treatment of Sexual Abusers))
Additional Info:	<p>Community team members:</p> <ul style="list-style-type: none"> • Family Counselling and Support Services • Family and Children's Services of Guelph Wellington • The University of Guelph • Guelph General Hospital's Sexual Assault/Domestic Assault Centre • The Canadian Mental Health Association, Waterloo Wellington
Source:	https://cmhaww.ca/programs-services/child-and-youth-sexual-abuse-team/

Sexual Health and Relapse Prevention (SHARP)

Children's Centre Thunder Bay

Description:	This is an intensive treatment program for youth who have been charged and convicted of committing a sexual offence and have been referred by a Probation Officer.
Location:	Thunder Bay, Ontario.
Target Population & Criteria:	Youth between the ages of 12 and 18 who have been charged and convicted of committing a sexual offence.
Setting & Modality:	Institutional and/or community based. In-person.
Mandate/Police:	Referred to program by court.
Accessibility:	Can only be accessed through Youth Justice Service Providers, or through a direct referral from the court. Services available during detainment. Free.
Service Approach/ Components:	<p>Support youth and their families - Youth and families can receive support during their detainment in Youth Justice custodial facilities, or involvement with other Youth Justice Service Providers.</p> <p>Services also include dialectical behaviour group therapy (DBT), and/or individual counselling.</p>
Source:	https://www.childrenscentre.ca/en/mental-health-services/youth-justice https://www.northwesthealthline.ca/displayService.aspx?id=196914

ECHO Residential Treatment Program

EveryMind - Mental Health Services

Description:	Residential treatment program for male teenagers in trouble because of sexual behavior.
Location:	Mississauga, Ontario.

Target Population & Criteria:	Male teenagers between the ages of 13 and 17 years who have previously been in trouble with the law because of their sexual behavior.
Setting & Modality:	Residential treatment. In-person.
Accessibility:	Free. French interpretation is provided on request. Must apply to program through Children Central Intake.
Service Approach/ Components:	Mental health team focuses on teenagers' strengths. Help deal with sexual behaviours and feelings. All clients attend a special school next door to the residence. As teens improve, they may be able to go to school in the community and take part in community activities.
Risk/Clinical Assessment:	An assessment is conducted to figure out if the program is right for the teenager (unspecified).
Training of Professional(s)	Mental health team (unspecified).
Post-Intervention Support:	Help also provided when the teenager is ready to return home.
Source:	https://www.centralwesthealthline.ca/displayservice.aspx?id=174145

Second Program & Third Program

The Children's Treatment Centre

Description:	The Second Program provides assessment and counselling services to adolescents, 12 to 17 years who have committed sexual offences against young children. The Third Program is for children ages 5 to 11 years who are sexually reactive or sexually aggressive towards same age peers.
Location:	Cornwall, Ontario.
Target Population & Criteria:	Second Program: Youth between 12 and 17 years old that have sexually offended. Third Program: Children ages 5 to 11 who are sexually aggressive or reactive to peers.
Setting & Modality:	Community-based. Children's treatment centre.
Service Approach/ Components:	<ul style="list-style-type: none"> • Assessment. • Family counselling • Group therapy
Risk/Clinical Assessment:	Estimate of Risk of Adolescent Sexual Offense Recidivism (The "ERASOR") Version 2.0.
Additional Info:	Duration of service typically a few sessions, up to three years. Funded entirely by the community (no government funding)

Source:	https://www.childrenstreatmentcentre.ca/services/ https://www.attorneygeneral.jus.gov.on.ca/inquiries/cornwall/en/report/research_papers/Action_RP/1_Cornwall_Community_Hospital_Assault_and_Sexual_Abuse_Program_en.pdf
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Moving Youth Forward

Choices, Child and Adolescent Services

Description:	Choices, Child and Adolescent Services is a residential and day treatment program that provides assessment, stabilization, and therapeutic interventions for adolescent males with problematic sexual behaviour between the ages of 12 and 18.
Location:	Dover Centre, Ontario.
Target Population & Criteria:	Adolescent males with problematic sexual behaviour between the ages of 12 and 18.
Setting & Modality:	Residential treatment. Day treatment.
Accessibility:	Funding for a placement must be secured through the Ministry of Youth Justice, Children's Aid Societies or other Social Service agencies or resources. Accepts referrals from across Ontario.
Service Approach/ Components:	Highly specialized services and a holistic approach. Youth participate in day and evening psycho-educational programs 4 times weekly. A treatment group facilitated by clinical staff occurs twice weekly. The program is designed as a step-down model with youth receiving less intensive programming and increased trust, responsibility, freedom and community access as they demonstrate success accomplishing treatment goals. A full day school program is also offered from September through June. Service: <ul style="list-style-type: none"> • Individual therapy sessions • Group therapy sessions • Family meetings • Ongoing cognitive restructuring • Structured Problem Solving • Comprehensive sexual education • Psycho-educational and living skills programs, including, conflict resolution, assertiveness training, victim awareness, healthy sexuality • Safety planning, and healthy long-term living strategies • Transitional assistance while making the return to community living
Training of Professional(s)	Full-time special education teacher and an education assistant staff the on-site school program. Unspecified which professionals provide treatment services.

Post-intervention Support:	<p>Transitioning and aftercare support is provided once formal treatment has ended.</p> <p><i>Supported Semi Independent Living:</i> For youth graduating from residential treatment, group, or foster care, ages 15 – 22 who are looking to become independent but aren't quite ready to move out on their own, the PAD Program (P.A.D. Programs – Promoting Ability and Determination) is available. Program offers 24-hour staff supervised living in three large three-bedroom homes in the Chatham Kent community.</p>
Additional Info:	Choices, Child and Adolescent Services adheres to the regulations of the Child and Family Services Act of the province of Ontario and is licensed by the Ministry of Children and Youth Services.
Source:	https://choiceschild.com/

Youth Centre for Change

Youth Centre for Change

Description:	Youth Centre for Change is a residential treatment facility for male youth between 12 and 18 years of age who have demonstrated problematic sexualized behaviours.
Location:	London, Ontario.
Target Population & Criteria:	Male youth 12-18 years old demonstrating problematic sexual behaviour.
Setting & Modality:	Residential treatment - 24-hour supervision at a 3:1 resident to staff ratio.
Mandate/Police:	Some youth mandated by court – priority is given to these clients.
Accessibility:	<p>Priority is given to youth that have been charged, adjudicated, and placed on probation with a mandate to participate in treatment.</p> <p>Only available to males.</p>
Service Approach/ Components:	<p>Treatment plan referred to as YCFC Path.</p> <p>Trauma informed treatment through education and the development of Resilience, Accountability and self-Discipline (RAD), delivered by dedicated professionals in a safe and structured environment.</p> <p>Treatment follows the Association for the Treatment of Sexual Abusers (ATSA) best practices guidelines.</p> <ul style="list-style-type: none"> • <i>Individual therapy:</i> occurs weekly. Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT) and a trauma-informed approach are used to support each youth • <i>Group therapy:</i> psychoeducational group counselling sessions attended twice weekly • <i>Indigenous cultural learnings:</i> group sessions focusing on traditional Indigenous teachings

	<ul style="list-style-type: none"> • <i>Lifelong skills</i>: group sessions for developing lifelong skills such as conflict resolution, prosocial skills, and hygiene • <i>On-site education</i>: each resident attends full-time education via the W.D. Sutton school providing individual education plans for grades 7-12
Risk/Clinical Assessment:	James Worling's strengths-based risk assessment, the PROFESOR, is completed for each resident bi-annually.
Training of Professional(s)	<ul style="list-style-type: none"> • 4 on-site clinicians (MSc Edu, BA Psych/Soc; BA family/social relations; BSW, BA Crim/Soc; MSW, RSW) • 3 shift-leads/supervisors • Staff are trained in medication administration for each resident • Full-time Indigenous youth counsellor • Two licensed teachers and two in-class support workers • Crisis intervention staff trainer - police foundations
Post-Intervention Support:	In collaboration across the youth's care team, YCFC develops an aftercare plan called the YCFC Guidebook to assist youth in being successful in the post-treatment world. When appropriate, YCFC may follow up with the former resident and 'check in' to see how they are applying the new skills that they have learned.
Additional Info:	Licensed by the Ministry of Children, Community and Social Services.
Source:	https://www.ycfc.ca/meet-ycfc

SUMMARY OF FINDINGS

Target Population/Criteria. The number of services identified across the country for children under the age of 12 and youth who are over the age of 12 with sexual behaviour problems was almost equal. However, service provision by province differs. In Alberta and Ontario, service availability for these two populations (i.e., under 12 and over 12) is equivalent. In contrast, all programming identified in British Columbia and Manitoba is designed for children under the age of 12, while all programming identified in Saskatchewan provides services to youth over the age of 12.

Involvement in the criminal justice system was also a criterion for accessing (or being excluded from access) among some programs. The Young Offender Program in Saskatchewan is the only program included in this scan that only services youth who have committed a sexual offence. In contrast, the Sexual Behaviours Team in Ontario and the SBSP in Alberta are the only programs included that specify being unable to provide services to youth 12 and older involved in legal investigations.

Service Location. The majority of programming identified through this rapid environmental scan is provided in the provinces of Alberta and Ontario (13 each). Although only 5 were originally identified, after conducting interviews with stakeholders who provided additional insight into Alberta programming, 13 services were identified. Very few programs were

identified in British Columbia, Saskatchewan or Manitoba. No services or programs were identified in any other provinces.

Setting & Modality. Most programs identified through this scan are provided in a community-based setting. The next most common service setting observed was residential treatment. A few programs are offered through child advocacy centres or sexual assault centres. *SHARP* is the only program that offers some services within the institutional setting.

The majority of programs identified are also provided in-person. That said, the *Sexual Abuse Intervention Program*, the *Sexual Behaviours Team*, the *Sexual Assault Harms Reduction Program*, and the *Sexual Behaviour Support Program* offer services virtually and/or virtually as well. Private clinicians Ashley Barlow, Dr. Lawrence Deck, Dr. Ann Marie Dewhurst, Ian Mackenzie and Carolyn Barker promoted provision of services virtually and/or via phone in addition to in-person appointments. Available only through *The Sexual Behaviour Problem Program*, the *Sexual Behaviour Program*, and the *Personal Safety and Wellness Program*, outreach services for the population of interest in this scan appear to be uncommon.

Accessibility. Almost all services for children and youth with sexual behaviour problems in Canada require a referral, although referrals accepted vary across program. Some programs allow for self-referral, while other required referrals from social service organizations or the justice system. Also common across programs in Canada is the provision of services to children and youth with sexual behaviour problems for free. While it was unclear whether some programs are available for free or not, independent clinicians were the only services found with a set cost of approximately \$200 an hour. Very few programs also highlighted potential waitlists on their webpage, which is hopefully indicative of easy access to services. Limiting female access to residential treatment, *Phoenix*, *ECHO Residential Treatment Program*, *Youth Centre for Change* are available to male youth only.

Service Approach/Components. Across all provinces, the most common types of treatment provided to children and youth with sexual behaviours problems through the programs identified in this scan were individual therapy, group therapy, and family work. Education (school, psychosocial education, and sexual education) was also common across programs. Due to the nature of the behaviour of interest for this scan, some programs identified administering their services using a trauma-informed approach. Cognitive behavioral therapy was also identified across numerous programs as a common approach.

Mandate/Police Involvement. While numerous programs across Canada service youth who have been mandated through the court to attend programming, the Youth Offender Programs in Saskatchewan is the only program which stated they are only accessible through a court mandate/justice system referral. The CYSAT program in Ontario was the only other program to specify coordinating with police services, when appropriate.

Training of Professionals. Most programs did not provide insight into the type of professionals administering their services. Some plainly summarized service staff as “comprehensive” or “interprofessional” teams (e.g., *Phoenix*). Among those who did note the role of their staff, psychologists, social workers and counsellors were most common. Other

professionals identified as being involved in the provision of services for children and youth with sexual behaviour problems include crisis interventionists, teachers, and supervisors.

Clinical/Risk Assessment. Majority of programs included in this scan did not provide detail about the types of clinical and/or risk assessments used in their programming. Most simply stated they offered behavioural or risk assessments to their clients. The few assessment tools that were names included the Child and Adolescent Functional Assessment Scale (CAFAS), the Estimate of Risk of Adolescent Sexual Offense Recidivism (The “ERASOR”) Version 2.0., and the James Worling’s strengths-based risk assessment “PROFESOR”.

Programs offering court-ordered assessment were also limited but offered through the Psychologist Ashley Barlow and the *Young Offender Program*.

Duration. Very few organizations gave insight into the typical length of time clients access their services. Of the three programs that did, treatment length ranged from 13 months to three years. One program included in this scan clarified the length of their treatment is client-specific and dependent on need.

Post-Intervention Support. Few programs across Canada identified having specific post-intervention supports in place for clients transitioning away from accessing their services. All post-intervention supports identified are provided by residential treatment programs to support youth as they transition from supervised care back to community (e.g., *Phoenix, Group Homes for Adolescents with Sexual Intrusive Behaviour*, and *YCFC*).

Additional Information. Radius Youth and Family Services was the only organization identified through this scan that had evaluation results available online. *STOP* was the only other program that indicated having evaluated the effectiveness of their programming.