

## **Practice Improvement Protocol 13**

### **CHILDREN AND ADOLESCENTS WHO ACT OUT SEXUALLY**



**Developed by the  
Arizona Department of Health Services  
Division of Behavioral Health Services**

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**ISSUE:**

Sexually inappropriate behavior often results in tragic consequences for those who are victimized by such behavior and for the child or adolescent involved in such behavior. Children and adolescents who act out sexually or display sexually inappropriate behaviors are frequently involved with multiple agencies that must approach interventions with coordinated perspectives and consistent goals and outcomes. A collaborative and integrated approach to care, with values, priorities and expectations agreed upon by all child-serving systems, can promote improved treatment outcomes.

**PURPOSE:**

To establish protocols for behavioral health interventions for children and adolescents who display sexually inappropriate behavior that effectively serve their psychosexual and behavioral health needs, that are consistent with the Twelve Arizona Principles, that increase safety for all, and that complement and reinforce the interventions of other child serving agencies.

**TARGET POPULATIONS:**

All Title XIX and Title XXI eligible children and adolescents who are enrolled in Arizona's public behavioral health system and who

- Exhibit developmentally or socially inappropriate sexual behaviors or preoccupations; or
- Have initiated and engaged in sexual behavior that was illegal, coercive, forced, or otherwise non-consensual; or
- Have initiated and engaged in sexual behavior that was aggressive, threatening or violent in nature, or resulted in physical injury to another person.

**BACKGROUND:**

ADHS is committed to the provision of services through family focused practice in the context of Child and Family Teams (CFTs). In order to extend this commitment to children and adolescents with sexually inappropriate behavior, service provision and planning should:

- Explore and document the strengths and needs of the child or adolescent and family;
- Establish and prioritize service goals;
- Identify the most appropriate services and supports necessary to meet those goals;
- Ensure that the services provided are of sufficient intensity to accomplish identified service goals;
- Describe a course of action encompassed in a written service plan developed by team members, with input from all involved agencies;
- Monitor the accomplishments of the child and family; and
- Determine the responsibilities of all team members involved in these efforts.

## **CHILD AND FAMILY TEAMS:**

All assessments, service planning and service provision should occur within the context of the CFT process. When out of home services are used, the providers should ensure the continuation of a child's CFT during transitions into and out of their facilities, or the establishment of a CFT for children admitted without a functioning team. Child and Family Teams should include a broad representation by both professionals and community members, as described in the [ADHS/DBHS Child and Family Team Practice Improvement Protocol](#). Representatives from Child Protective Services (CPS), Arizona Department of Juvenile Corrections (ADJC), Department of Developmental Disabilities (DDD), the Juvenile Probation Officer (JPO), local schools, etc. should participate in CFT meetings and their schedules considered in the planning of all team meetings. Even when their representatives cannot directly participate with the CFT, their input into the CFT process should always be solicited, and their perspectives should be given consideration in all decisions made. The CFT should strive to provide agencies with behavioral health expertise and with any relevant information that would help inform their decision-making processes.

The CFT must fully respect the mandates of each involved system (e.g. conditions of probation, court orders, no contact orders) and strive to implement them in the most appropriate and clinically sound manner.

Victim participation on a CFT must always be voluntary and not coerced. The willingness and ability of a victim to effectively and beneficially participate must be cautiously considered and weighed against potential personal trauma. The victim should be provided a thorough understanding of the benefits and risks.

## **ASSESSMENTS:**

The assessment and service planning processes must be carefully tailored to the individual. The assessment of all children and adolescents should begin with the ADHS/DBHS assessment process and a thorough review of already existing documents and historical information. All relevant life domains should be explored to the depth necessary to determine the next appropriate service and the level of current risk of danger to self or others. Referrals prompted by specific concerns about sexually aggressive behavior, and by affirmative answers to questions in the Abuse/Sexual Risk Behavior section should trigger deeper explorations of any concerning behavior; of the child's depth of awareness, understanding and perceptions of those behaviors; and of associated risk factors (e.g. the level of anger and impulse control, the presence of pervasive emotional or developmental deficits, the presence of academic problems, the presence of substance abuse issues).

The behavioral health assessment should explore the quality of family relationships, the child's social skills, the extent of his/her own trauma, his/her attitudes towards sex and relationships, and the level of accountability for inappropriate sexual behavior. If not explored fully at the initial assessment, these domains should be explored by the Clinical Liaison during an ongoing assessment process, and in ongoing clinical interviews with the child and other family. Ongoing assessment should explore the thoughts, feelings,

and historical precipitants that lead to inappropriate sexual behavior, and the level of victim empathy present. Past behavioral health, medical, school, police or investigational records, and, when applicable, victim statements and juvenile court records should always be reviewed.

Before a diagnosis is made, or an assessment concludes that a child is exhibiting inappropriate sexual behavior, the Clinical Liaison must carefully consider the wide spectrum of developmentally congruous presentations of sexuality. Prematurely and improperly defining a child as sexually inappropriate, or as a sexual perpetrator, can be unnecessarily stigmatizing and have long-term adverse effects on the child's stability including school placements, treatment setting options and overall stability and societal acceptance. At the same time, the absence of a particular diagnosis or distinct clinical presentation must not preclude the implementation of specific assessment processes that can enhance the understanding of a child's needs or underlying condition, nor aspects of a service plan that can successfully resolve problematic behaviors.

Family interviews must be done with a well-developed understanding of and sensitivity to the family's culture and their cultural needs. Interviews should explore possible contributing family issues, the family's beliefs regarding the child or adolescent's sexual behavior, their knowledge of the sexual exposure the youth has had, their attitudes towards the sexual acting out, their potential contribution to or hindrance of assessment and treatment, and their sense of the service approaches most likely to be successful.

The Clinical Liaison must recognize that effective service plans for children and adolescents are built on explorations of individual, family and community strengths, skills and resources, not only on an understanding of deficits and limitations. These areas should be explored during the initial assessment and during the Strengths, Needs and Culture Discovery process that is a part of it.

The Clinical Liaison should carefully consider whether formal testing is indicated, whenever possible with input from the full CFT. Psychological testing (including intelligence testing, personality inventories, and, when specifically indicated, neuropsychological testing) can be useful in combination with other assessment procedures to create a clinical picture of the child, to identify target areas for clinical intervention, and to determine the most appropriate treatment modality. Psychological testing can help identify previously undiagnosed conditions such as Attention Deficit Hyperactivity Disorder (ADHD), Bipolar Disorder, Conduct Disorder, Post Traumatic Stress Disorder (PTSD), Affective Disorder, or Learning Disabilities that may coexist, and can identify service determinants relating to intellectual, neurological, and personality functioning. Psychological testing should be used in situations where less intrusive assessment processes like psychiatric evaluations need to be enhanced or expanded upon in order to secure a diagnosis or clinical formulation, when clinical needs can be clearly articulated, and when testing outcomes will likely lead to more effective service plans.

Psychosexual testing includes specific tools like the Multiphasic Sex Inventory II (Juvenile), the Abel Assessment for Sexual Interest, the Abel and Becker Card Sort and other specialized testing tools that assess an individual's sexual interests, sexual behavior analyses, level of sexual preoccupation and deviant arousal patterns, and risk of sexually offending. They can enhance the clinician's understanding of the most

pertinent underlying concerns and aid in the development of individualized service plans. Psychosexual testing must only be undertaken and interpreted by clinicians with specialized expertise and training in their use.

Decisions to secure or avoid psychological or psychosexual testing should be made in the context of the CFT process and in consultation with a well-informed Clinical Liaison. Consultation with a clinician experienced in psychological and/or psychosexual testing is advised.

Polygraphy focuses on the honesty of the individual about sexual history. It has been increasingly used in the assessment of adjudicated offenders for the purpose of facilitating more complete disclosures of sexually inappropriate behaviors and for maintaining and monitoring compliance with treatment. Polygraphy should require the full informed consent of the youth, parent or guardian and must only be administered by practitioners qualified in its use. As polygraphy is not a covered behavioral health service; its utilization requires coordination with agencies that can access it.

Neither penile plethysmography nor vaginal photoplethysmography should be utilized to identify sexual arousal patterns as they lack reliability and validity for use with this population, and present significant ethical dilemmas.

## **TREATMENT OVERVIEW:**

Comprehensive service plans must be based on an awareness that behaviors are founded on the child's needs, strengths, history, culture, developmental stage, environment and emotional makeup as described by the comprehensive assessment. The presence or absence of early abuse, the age and gender of the child, the presence of developmental delays, etc. should lead the provider towards specific and well-considered strategic approaches and away from others. These factors should not preclude the provision of services to any distinctive population. This holds particularly true for young people with developmental disabilities or delays, whose limitations should not interfere with the delivery of interventions tailored to their unique needs.

While the overall purpose of treatment is to help children and adolescents gain control over problematic sexual behavior, it cannot ignore likely coexisting and contributing factors.

Service plans should include services offered by family members, community supports, and agency representatives as well as by trained, experienced professionals, and should address the following objectives:

1. *Facilitation of disclosure and acceptance of responsibility for behaviors.*  
Denial is an issue for most sexually aggressive or sexually inappropriate youth. Providers should be aware of the level of denial specific to the individuals and families they serve. Reducing denial is often a starting point, as well as a gradual but ongoing process during treatment.

The purposeful functions of denial (e.g. protection from shame and stigma, protection from rejection by family, protection from legal sanctions or other

consequences) need to be understood and resolved through relationship building, support for accurate disclosure, and progressive confrontation. The existence of denial should not preclude a child from treatment. Persistent denial may become a factor in making placement decisions. Community based treatment may be inappropriate for a child or adolescent who is in complete denial, especially those who have been adjudicated for sexual offenses.

2. *Re-education and resocialization.* Antisocial and sexually aberrant thoughts and behaviors need to be replaced with prosocial ones. The child or adolescent must be helped to acquire a positive self-concept and improved attitudes and self-expectations. Vocational and living skills training, assistance with academics, the development of prosocial relationships with peers, dating skills, and sex education are examples of replacements to be considered. In addition, the service plan should include specific strength-based interventions adapted to the individual strengths, resources and interests of the child or adolescent.
3. *Gaining and exercising control.* Treatment should assist the child or adolescent in learning to intervene in or interrupt his/her own aggressive patterns and to call upon specific tools, methods, and procedures to suppress, control, manage or stop problematic behaviors.
4. *Assistance with co-occurring medical and behavioral health disorders, deficits and disabilities.* Although there is insufficient evidence to identify substance abuse as a causative factor in the development of sexually aggressive behavior, it is clear that substance abuse has a disinhibiting potential. Issues such as poor impulse control, problem solving difficulties, and poor social skills are often exacerbated by even small quantities of drugs or alcohol and may consequently increase the risk of inappropriate sexual behavior. Service plans should address appropriate substance abuse interventions in addition to those targeting sexual behavior.

Treatment of coexisting mental health disorders such as depression, anxiety, conduct disorders, PTSD, and ADHD should also be provided with interventions commonly accepted as appropriate for those diagnoses, along with services targeting sexual behavior. Comprehensive service plans should also define interventions that target the child's academic and vocational needs, as well as any intellectual and cognitive impairment. Children and adolescents with developmental disabilities should be assessed and treated in a manner that accommodates their particular limitations and capabilities and, when appropriate, referred to DDD for additional supportive services.

Treatment of coexisting medical disorders should be coordinated with primary care providers. Referral for Early Periodic Screening, Diagnosis and Treatment (EPSDT) services should be included in the service plan when appropriate.

5. *For those who have been victimized themselves, resolution of the effects of personal victimization experiences.* It is current best practice to target an

individual's problematic sexual behavior before attempting to resolve issues relating to their own victimization experiences. Occasionally, however, sexually aggressive children and adolescents may be unable to fully acknowledge responsibility for harming others until they are effectively able to discard self-blame and guilt over their own victimization.

The timing and prioritization of treatment strategies must therefore be carefully considered for each individual. Eventually, efforts need to be made to provide victimized children and adolescents with group and/or individual counseling related to their own victimization as early as indicated in their treatment process. At the same time, both providers and families must be cautious not to overreact to a child's victimization and adversely impact outcomes of treatment by condoning, justifying or minimizing a child's problematic behavior.

6. *Resolution of dysfunctional values and attitudes.* Children and adolescents who have displayed inappropriate sexual behavior are frequently confused about how to relate to others sexually. Distorted or unattainable gender stereotypes, devaluing gender stereotypes, values about masturbation, and confusion about the difference between mutually-consenting and victimizing sexual behavior can be approached by exercises that clarify values and attitudes, by clinical challenges to cognitive distortions, by sex education, and by counseling to promote the development of positive sexual identities. Interventions should also be directed toward the development of an awareness, appreciation and respect for the experience and feelings of the child or adolescent's victims.
7. *Resolution of family problems and impaired sibling relationships.* If family dynamics are not compromised before a child or adolescent's problematic sexual behaviors are identified, the confusion, disappointments, anger, shame, embarrassment and fear that result frequently lead to significant family difficulties. Children and adolescents in treatment have the best opportunity to recover when they are supported, encouraged and embraced by family, even while being challenged to change their inappropriate behaviors. Family members should be included in the treatment process whenever possible, and contributing or resulting family dynamics explored and resolved. At the same time, the feelings of victims within the family must always be respected, and their safety always secured.
8. *Inter-agency Collaboration.* Children and adolescents exhibiting sexually aggressive behavior should be held accountable for their actions. To accomplish this, collaboration among all agencies and individuals responsible for initiating and implementing effective treatment and supervision is essential. All parties should share a clear set of operational expectations, in order to minimize the child or adolescent's ability to circumvent treatment, accountability, or goals of supervision. Collaborative efforts must extend beyond simple case management associations. Behavioral health representatives must work closely with supervising agencies (e.g. probation) and all others involved with enforcement and the management of services (e.g. law enforcement officers, defense attorneys, judges, prosecutors, school

and child welfare officials, victims, and families). All should actively participate in the CFT process to establish mutually agreed upon goals, strategies and compatible service plans. Court attendance by the behavioral health representatives at hearings in which significant decisions will be made should be considered an important part of ensuring continuity of treatment and services.

9. *Avoidance of relapse.* This includes teaching children and adolescents, and their supervising adults, to understand the cycle of thoughts, feelings and events that are antecedent to acting out sexually, identifying environmental circumstances and thought patterns that should be avoided due to increased risk of inappropriate behavior, and identifying and practicing coping and self control skills necessary for managing their own behavior.
10. *Service provision in the least restrictive and most appropriate setting.* The Arizona Vision clearly articulates a core value that services are provided in the most appropriate, least restrictive environment, and whenever possible, in the child's home and community. These values apply equally to children and adolescents who act out sexually. Although careful consideration must be given to the safety of the community and to others living in the home, all resources required to meet service needs in the child's home or community must be explored before other options are considered. Inter-agency collaboration and joint service planning can assist in this endeavor.

In order to meet the complex service needs of all sexually inappropriate children, providers working with them should have training and expertise specific to the unique service needs identified, be knowledgeable about issues of victimization, and have a strong interest in and a commitment to working with this population.

### **SERVICE PLANNING:**

The Clinical Liaison assigned to a Child and Family Team is responsible for outlining and advising the CFT of all clinical options, assisting the CFT in determining who can best provide identified clinical and supportive needs, and providing clinical guidance to the development of the service plan. Clinical Liaisons working with this population should therefore have specialized training and demonstrated expertise in the evaluative and treatment aspects specific to this population.

1. *Strengths, Needs and Options:* With the assistance of the Clinical Liaison, the CFT should begin by defining the child or adolescent's unique strengths and needs rather than the specific services they feel may meet those needs. This will support the Clinical Liaison's ability to provide appropriate consultation to the CFT about the various intervention strategies and service options that will lead to desired outcomes.

The CFT should incorporate into the service plan the input, recommendations, and system mandates of participants from all involved systems. Participants should advise the CFT on issues germane to their systems (court orders and legal responsibilities within which treatment must



operate from juvenile probation officers; safety, well-being and permanency needs from CPS; educational needs from schools).

The behavioral health representative on the CFT is responsible for securing all services agreed upon by the CFT (consistent with the [ADHS/DBHS Child and Family Team Practice Improvement Protocol](#)). If the CFT, with input from the Clinical Liaison, requests services from a provider with specialized expertise in the treatment of sexually inappropriate behavior, then those services should be secured through the Tribal or Regional Behavioral Health Authority (T/RBHA).

2. *Safety Plans*: Community-based treatment of children and adolescents considered at risk of offending or exercising sexually inappropriate behavior requires a thorough and detailed safety plan with input from all involved agencies. Community safety, consideration of victims' needs, feelings and security (whether they reside in the home or in the community), and the avoidance of provocative situations, environments and experiences should be considered and ensured in all safety plans.
3. *Crisis Plans*: The CFT should develop crisis plans so that all parties understand and accept their role if the clinical picture worsens. Detailed plans (e.g. which next steps will be followed, who will be called, where the child or adolescent will be taken, by whom) should be worked out carefully in advance. In this way, an organized, coordinated interagency response to a potential crisis (with the behavioral health agency planning its response to the behavioral health needs of the child, supervising agencies determining their response to the needs for public protection, CPS assessing the child's welfare needs, etc.) will be in place well before the predicted crisis might occur. There will usually be significant overlap in the content of crisis and safety plans.
4. *Transition Plans*: Transitions from restrictive environments to community-based services require a high level of coordination and planning for continuity of care. Communication between service providers, sharing of successful (and less successful) intervention strategies, continuity of service plans, assurance of timely service provision, follow up and monitoring approaches should be a part of every transition plan, and should be carefully documented well in advance of the change in placement. Attempts should always be made to assure continuity of service providers.

At the time of transition, careful consideration should be given to the level of risk the individual poses to re-offend or relapse (based on the historical level of sexually deviant behavior, the level of impact of treatment to date, clinical judgment and, when indicated, appropriate clinical instruments). When making decisions about placement options, always balance the risk with the most normalized, community-integrated placement possible.

For children approaching the age of majority, continuity of care poses unique challenges. Ongoing care must be arranged with providers who work with young adults. Whenever possible, the continuation of the CFT should be

promoted and encouraged. Children reaching the age of 17 with functional impairments indicative of a serious mental illness should be referred for SMI determination (see the [ADHS/DBHS Transitioning to Adult Services Practice Improvement Protocol](#)).

### **CLINICAL SUPERVISION:**

Given the complexity of issues that surface during the treatment of children who act out sexually, all care providers require sound clinical supervision by professionals experienced with this population. Unconscious prejudices, information gaps, emotional blind spots, and subliminal or unspoken expectations or feelings about individual clients can all interfere with good clinical judgment. Without the provision of regularly scheduled, formal and high-quality clinical supervision, these barriers can remain unrecognized and compromise services provided. Therapists, case managers, support staff and all other care providers should be provided with regularly scheduled, dependable clinical supervision.