national wraparound initiative

NWI webinar starting soon!

In the meantime, please note…

- We recommend that you close all file sharing applications and streaming music or video.
- Check your settings in the audio pane if you are experiencing audio problems.
- During the presentation, you can send questions to the webinar organizer, but these will be held until the end.

*This webinar and the PowerPoint will be available on the NWI website. http://www.nwi.pdx.edu/webinars.shtml

national wraparound initiative

Preventing Sexual Harm

June 24, 2014

Stephen A. Gilbertson, M.S.

Wisconsin Licensed Psychologist

Clinical, Consulting & Forensic Psychology

Wraparound Milwaukee Clinical Program

Eric J. Bruns, Ph.D.,

Co-Director, National Wraparound Initiative

Member, Technical Assistance Network

Preventing Sexual Harm

A System of Care Approach to Youth and their Sexually Harmful Behavior

Presented by Stephen A. Gilbertson, M.S. Wisconsin Licensed Psychologist/ Wraparound Milwaukee

Greetings from Milwaukee!

Presentation Goals

- Share *Wraparound Milwaukee* Story of program development specific to youth and families affected by sexual aggression/abuse
- Reflect on values and some lessons learned as a product of coming to serve a particularly complex needs group

Wraparound Milwaukee

- *System of Care* serving approximately 1100 complex needs youth and families daily
- 1994 Initial System of Care federal grant
- Public (ASO)---private (providers) partnership
- Medicaid (capitated) HMO with blended funding from JJ and CW
- Serves system-involved and non-system involved youth
- Mobile Urgent Treatment Team serves community to address youth and family MH crises
- Wraparound Milwaukee has been a catalyst for significant system reform since mid 1990's with the persistent aim of promoting a core set of values shared with NWI and the System of Care movement

Identifying and Addressing Gaps

- ***Wraparound Milwaukee*** (1996) became provider for juvenile justice-involved youth at risk for restrictive/out of home care, including youth with *sexual assault* history
- A very high percentage (approximately 60%)of youth adjudicated of sexual assaults were being placed in residential treatment centers, for up to many years, or in correctional facilities (approximately 18%).
- Only one local community-based program with weak credibility

Key Research Findings and National Task Force Recommendations

- Youth who have engaged in sexually harmful behavior are a **diverse group** reflecting various family, environmental and mental health needs and risk of reoffending
- Critical to the viability of community-based programming is **early determination** of which youth can be safely and effectively treated in the community
- There is a need for **local data** to inform the development of programming for these youth
- There is a need for viable, credible and comprehensive community based **alternatives to institutional care** for those youth appropriate for a community based approach

Early enhancements

- Awarded Technical Assistance grant from CSOM (1999); see csom.org
- Provided training to community providers and legal partners to raise awareness of best practices and to promote extending the ***continuum of care*** and improving ***front-end assessment***
- Created a policy level cross-system and multi-disciplinary team to study best practices, identify community gaps and needs and strategically plan with assist of new data streams
- Began prospective data collection on **all youth referred** on sexual assault charges and **tracked legal and mental health outcomes** and shared within policy team meetings
- Implemented specialized probation intake workers
- Awarded Federal VAWA/DOC enhancement award for sex offender management (2000-2003)
- Completed a retrospective study to establish comparison
- Created a 'high risk consultation and review' process

Early Outcomes: *Community Safety & Resource Development*

- During the first year of implementation, $400,000 public dollars saved, despite an increase in **families** (including parents and child victims) served
- This was due, largely, to the implementation of front-end specialized offense-specific assessment, resource development, mental health-legal collaboration & more appropriate utilization Institutional care vs. community-based alternatives
- Only 8% of adjudicated juvenile sex offenders were incarcerated in 2001, in contrast to 19% in 2000 and 20% in 1996.
- Despite a significant shift toward community-based approaches----sexual recidivism= 7%

What do we need to know to improve our approach to youth who have been sexually harmful?

Comprehensiveness to match Complexity

- To work with youth who have been sexually abusive, their families and victims, one needs to become and remain aware of the **bigger picture of *child sexual abuse*; it's impact, incidence, etiology, and best practice interventions**
- CSOM.org and CMHS *National Center for Trauma Informed Care* are great resources for literature and curricula

Psychological Indicators of *Secondary* Trauma

- Anger
- Sadness
- Depression
- Anxiety
- Fear
- Mistrust of others
- Imbalance between work and personal life
- Paranoia

Severity and Length of Exposure—Research Findings

- A 2003 study of judges found:
  - 63% of judges reported one or more symptoms they identified as work-related secondary trauma, including sleep disturbances, intolerance of others, physical complaints, depression, and a sense of isolation; and
  - Judges who had seven or more years of experience reported experiencing more of these symptoms compared to judges who had six or less years of experience on the bench.

(Jaffe, Crooks, Dunford-Jackson, & Town, 2003)

Professional Self-Care Strategies

Stress Reducing Activity

- Cultivating a sense of humor
- Having healthy intimate and family relationships
- Having one or more healthy relationships at work in which I can express emotions related to my work experience
- Having enjoyable hobbies or leisure activities
- Maintaining relationships with professional peers who work outside the human services field
- Having one or more close friendships away from work in which I can express my emotions related to my work experience
- Avoiding or self-monitoring potentially harmful approaches to stress management (e.g., smoking, drinking, risk-taking, cynicism, and negativity)

Sexually *Abusive* Behavior

Sexually abusive behavior is any sexual interaction with persons of any age that happens:

- *Against the victim's will*
- *Without consent*
- *In an aggressive, exploitative, manipulative, or threatening manner*

Gail Ryan (1997)

Reporting of Sexual Abuse
(National Survey of Adolescents, 2000)

- 86% **NOT** reported to the authorities
- 13% reported to police
- 5.8% reported to child protective services
- 5% reported to school authorities
- 1.3% reported to other authorities
- We want to increase the likelihood of reports

*Some cases were reported to more than one authority.

Adverse Childhood Experiences are Common

Of the 17,000 HMO Members:

- **1 in 4** exposed to **2** categories of ACEs
- **1 in 16** was exposed to **4** categories.
- **22% were sexually abused as children.**
- **66% of the women** experienced abuse, violence or family strife in childhood.

Child Sex Abuse Incidence

It is highly likely that you know a child/person who has been or is being abused.

Fact: 1 in 4 girls and 1 in 6 boys are sexually abused before their 18th birthdays

Who sexually abuses children?

Fact: In more than 90% of child sexual abuse incidents, the child and the child's family *know and trust* the abuser.

- **Approximately 1/3 of sexual offenses against children are committed by teenagers**

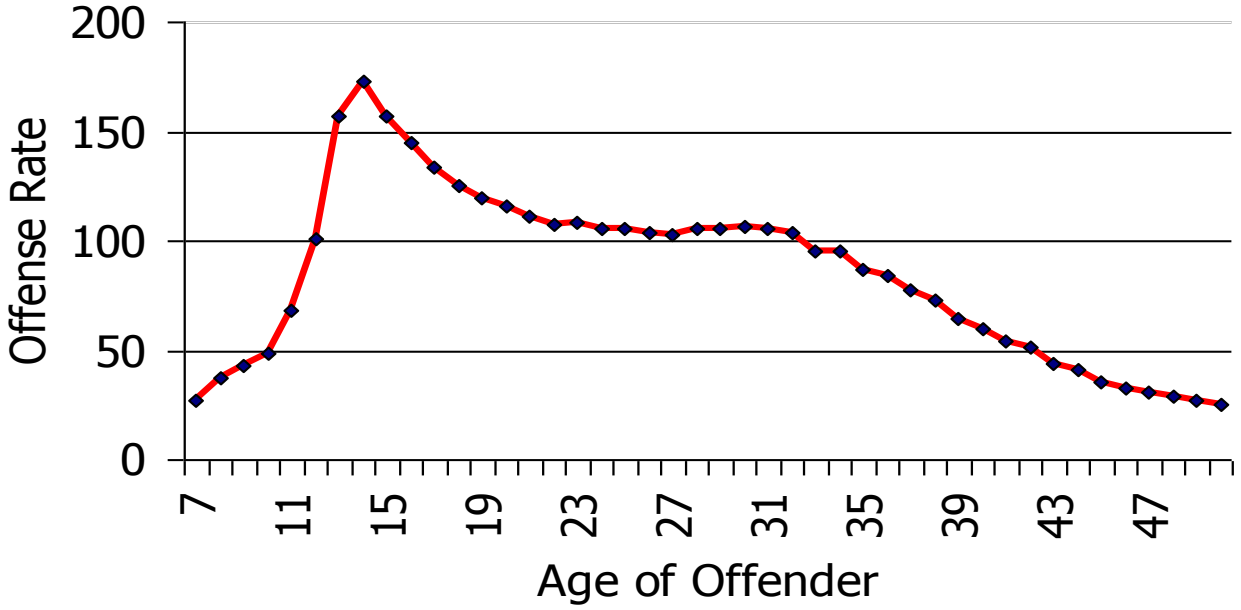
Facts: Of ALL Wisconsin Sexual Assault (Wisconsin Department of Justice)

- 86% female
- Median age: **9 years old**
- Most common: forced fondling (48%)
- **Only 4% of SA by strangers**

Who are "Juvenile Sex Offenders"

- Youth who commit illegal sexual behavior or "sexual assault" and are found delinquent
- Know the LAW; age of consent
- *Most* youth who sexually abuse are never involved in Juvenile Justice due to **lack of reports**
- **Diverse** group with regard to risk, needs & strengths
- Commit a wide range of illegal sexual behaviors, ranging from limited exploratory, 'curious' behavior to repeated, aggressive assaults; different MO's
- Requires a continuum of care

We do Know: Incidence and Prevalence (NCSBY)



Early adolescence is a high-risk, and to some extent transitory, developmental period for committing illegal sexual behaviors (NCSBY). Average age of referred in Milwaukee County: 13.6 years

Milwaukee County & Wraparound Milwaukee

- 95 out of 350 adjudicated annually
- In 1998- 9% of those adjudicated *enrolled* in Wraparound Milwaukee
- At present approximately 75-90%
- Decline in DOC placements (from 19.5 to 8%) as product of Wraparound diversions
- Most 1st degree offenders (status)
- Mostly boys, with female victims
- Average Age: Juvenile-12.9; Victim-8.4
- Most victims intra-familial

Natural & Healthy Sexual Behavior

(Finkelhor, 1983; Friedrich, et al., 1991)

- 40-85% of children engage in at least some sexual behaviors before 13 yrs of age
- Children in healthy sex play are of similar age, size and developmental status and participate on a voluntary basis
- Most sex play is between children who have an ongoing mutually enjoyable play and/or school friendship
- Sexual behaviors are limited in type and frequency
- Child's interest in sexuality is balanced by curiosity about other aspects of life
- Natural sexual exploration may result in embarrassment but does not usually leave children with deep feelings of anger, shame, fear or anxiety
- If discovered and instructed to stop, the behavior generally diminishes, at least in the view of adults

Problematic Child Sexual Behaviors

(Finkelhor, 1983; Friedrich, et al., 1991)

- No mutual ongoing play relationship between children
- Children are of different ages or developmental levels
- Sexual preoccupation vs varied interests
- Too much knowledge, mimics adult behavior
- Sexual behavior stands out relative to peers
- Sexual behavior persists in spite of requests to stop
- Child appears driven
- Sexual behavior is eliciting complaints or is adversely affecting others
- Sexual behavior directed toward adults causing discomfort
- Sexual behaviors which progress in frequency, intensity or intrusiveness over time

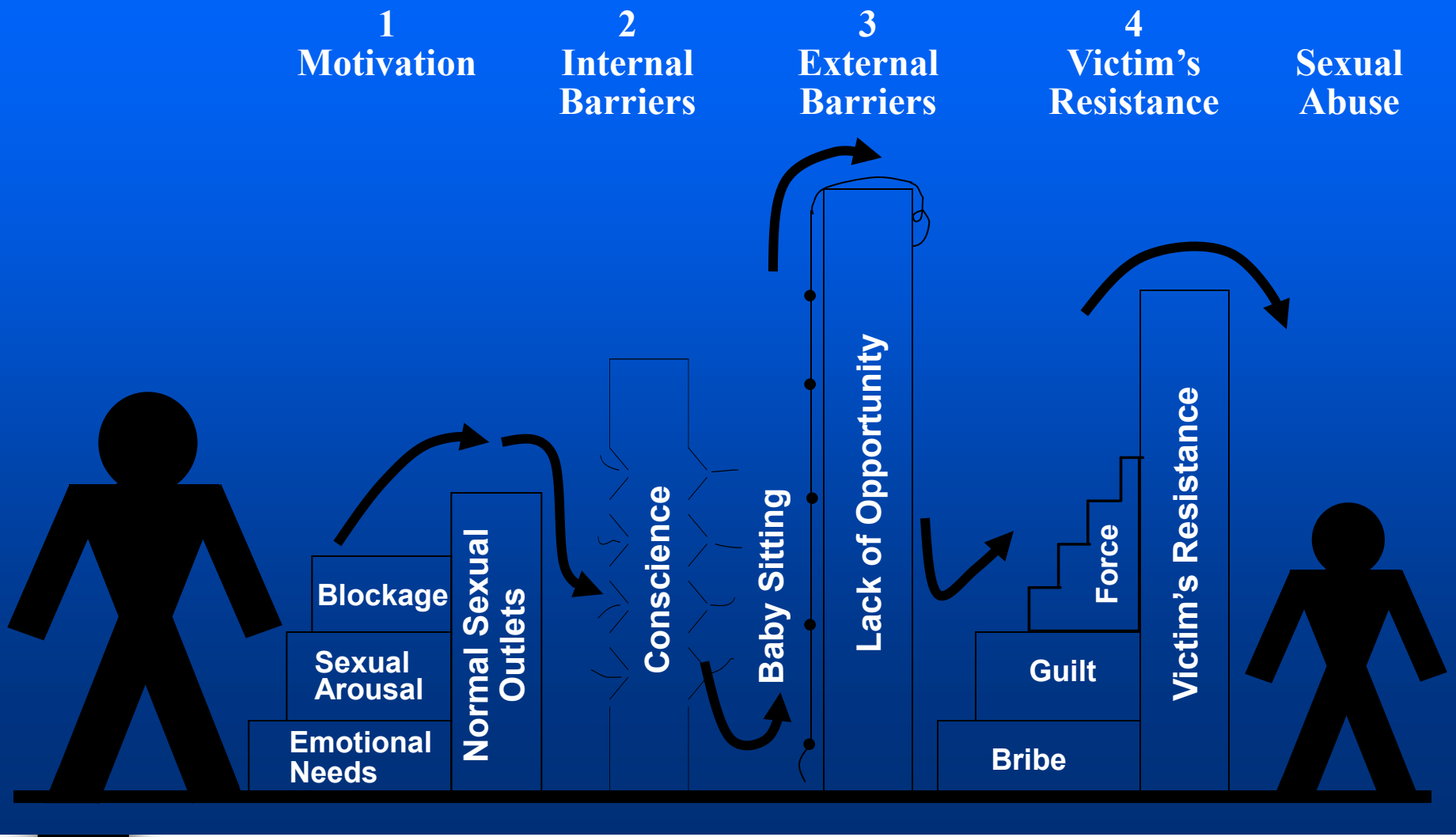
Why do kids do this stuff?

Where are kids learning about sex?

- Wisconsin has no standardized, required curriculum for sexual health education; many youth report no formal or at home sex education experience (WICASA)
- American Academy of Pediatrics (2001) reported that media **has replaced parents and teachers as "educators, role models, and the primary source of information about the world and how one behaves in it"**
- Many teenagers rank the media as their major source for sexual ideas and information (Brown & Keller, 2000)
- There appears to be a strong link between exposure to sexual content in the media, sexual attitudes and behavior (Brown and Keller, 2000)
- Study (Ford & Linney, 1995) found sexually abusive youth were exposed to pornography earlier and to harder core pornography than non-sex offending but delinquent youth

Four Preconditions of Sexual Abuse

(Finkelhor, 1984)



So, Why did *this* happen?

- What is our theory re factors which may have contributed to THIS youth engaging in the behavior when, where and with whom they did?
- What vulnerability or history is reflected in this act?
- What is the " need" reflected in this behavior?
- Heterogeneity, every youth is an individual
- We may not have all the answers right away
- Create hypotheses to guide POC; review risk assessment/psychological
- What needs to change (inside and out) in order for youth to be at a lower risk to engage in further abusive behavior if the opportunity presented itself?
- Strive for a holistic understanding of youth and family. Some risk factors may be more "treatable than others"

Risk Factors: Multiple systems

- Complex developmental trauma
- Poverty, parental incarceration, frequent moves
- Parent challenged to provide supervision and to insure treatment compliance
- Trouble engaging meaningfully in treatment
- Trouble following a safety plan
- Truancy/running away
- Peer group concerns
- Substance use
- History of multiple sexual offenses, especially after offense-specific treatment
- History of repeated non-sexual offenses
- Persistent sexual preoccupation & behavior (porn, sex talk, boundary problems, sexual interest in children)

Eco-systemic understanding

Person X E nvironment = R isk

Residential Instability

Evidence-Informed Risk Assessment

- JSOAP-II; ERASOR
- Most, if not all, adjudicated JSO should have a front end risk assessment prior to enrollment
- Most, if not all, will be required to participate in risk assessment prior to completion of delinquency order
- Change in *Dynamic* factors is the aim of tx
- Questions re SO Registry requirement

Typology-based on *Offense* Characteristics

- **Offenders of Young Children**
  - Lower psychosocial functioning
    - Lack of social confidence
    - Depression/social withdrawal
    - Anxiety
    - Pessimism
  - Less physically aggressive in their sexual offending
  - More likely to offend against relatives
  - Most commonly served by Wraparound

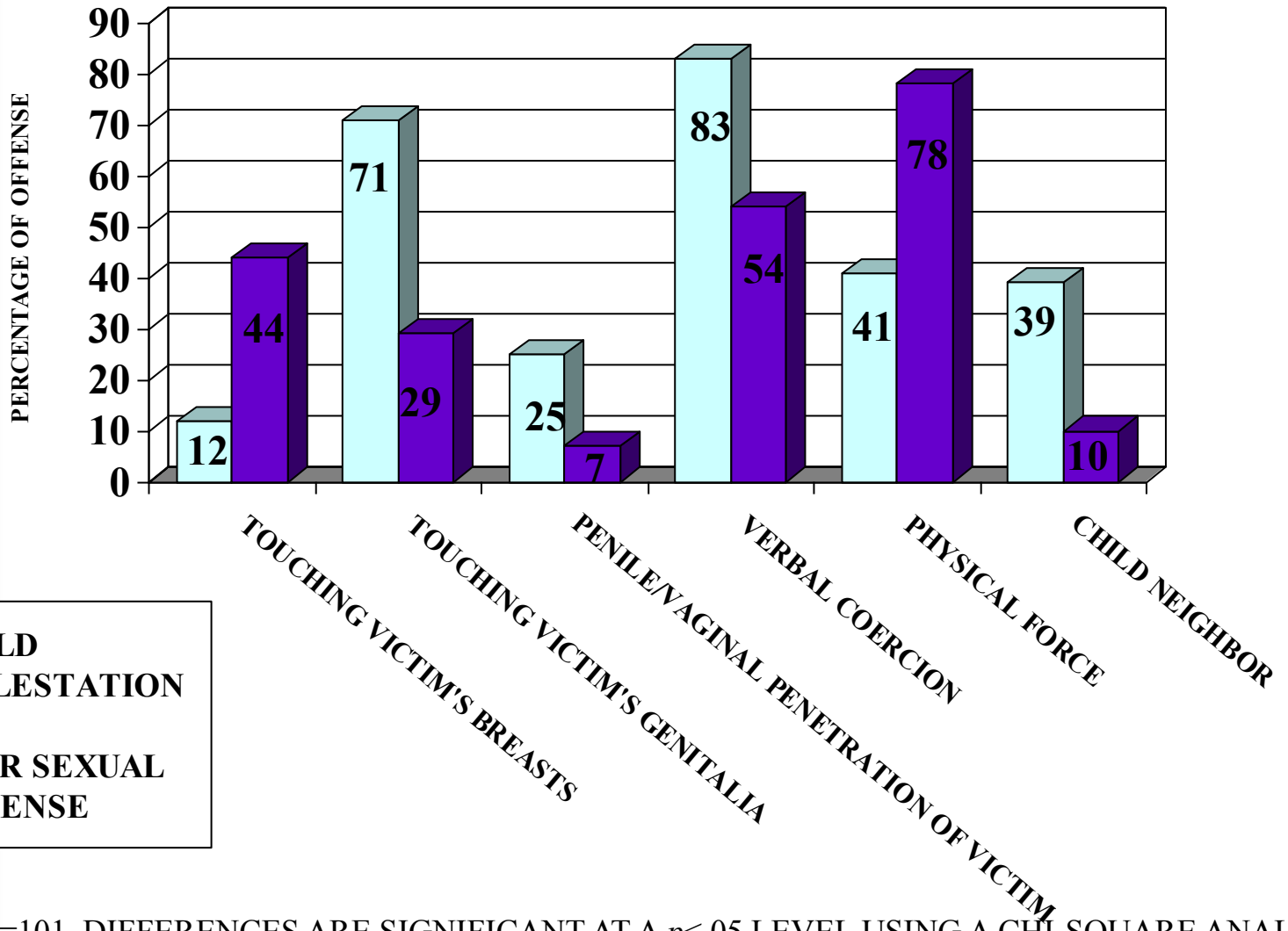
Hunter, et al. (2003)

Typology based on *Offense* characteristics

- Offenders of peers/adults
  - More likely to offend against females
  - More physical force
  - More likely to be under the influence of substances
  - More likely to have previous and subsequent arrest for nonsexual crime

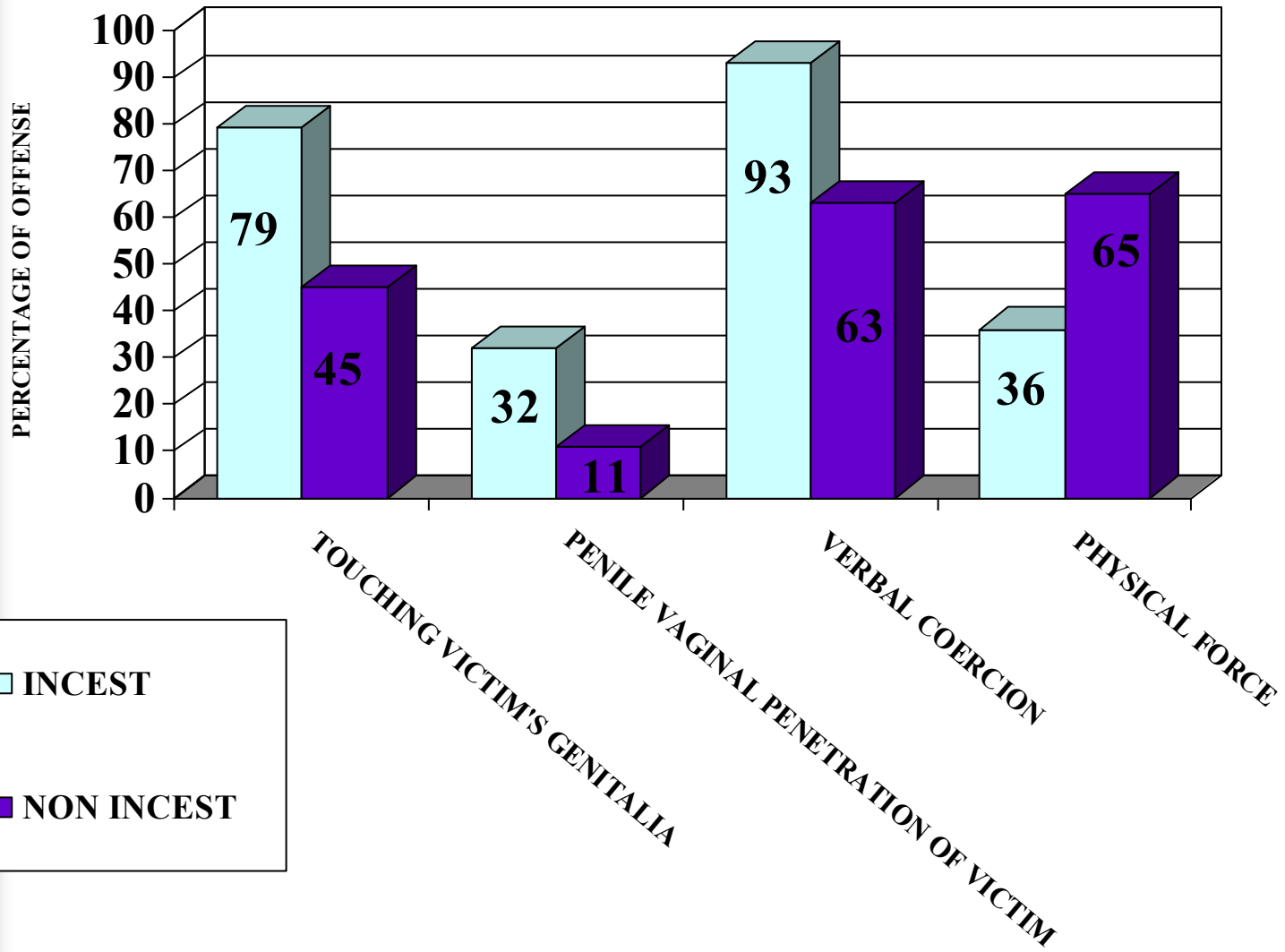
Hunter, et al. (2003)

OFFENSE CHARACTERISTICS OF CHILD MOLESTATIONS AND PEER SEXUAL OFFENSES- Milwaukee



N=101, DIFFERENCES ARE SIGNIFICANT AT A $p<.05$ LEVEL USING A CHI-SQUARE ANALYSIS

Comparisons OF JUVENILE INCESTUOUS AND NON-INCESTUOUS OFFENSES- Milwaukee



N=101, DIFFERENCES ARE SIGNIFICANT AT A $p<.05$ LEVEL USING A CHI-SQUARE ANALYSIS

Care coordinator roles & responsibilities

- If you are assigned a “high risk youth” take the responsibility seriously
- Read and remain aware of youth and family history; Petition(s), psychological, risk eval reports; abuse/trauma exposure history
- Complete *High Risk Consult Forms* in Synthesis and submit to supervisor prior to each high risk review
- Insure Court Orders are followed, e.g. offense-specific treatment completion and supervision are standard
- Document well and keep up to date
- Don’t be a Lone Ranger; consult regularly, follow recommendations; promote active team work!
- Build a team who is very positive, holistic, strength-based, collaborative, honest and open, victim-centered, trauma-informed, pragmatic and aimed at building competencies while also managing risk
- Complete Critical incident reports

High Risk Consultation Form

High Risk Meeting Date

History resulting in high risk review (static risk factors; specific behavior resulting in adjudication)

Victim Specifics

Treatment?

Stage of Change ((select one))

Treatment (youth and family) provided (Include strategies to address reasons for enrollment and static risk factors)

Is youth currently attending offense or trauma-specific treatment

○ Yes ○ No

IF YES, response to treatment

IF YES, has a recent progress report been submitted by the provider?

○ Yes ○ No

List other youth or caregiver compliance with court conditions.

What is the team priority at present?

Most recent school-based concerns

Most recent home/family concerns

Most recent community concerns

Recommendations (to be filled out by Steve Gilbertson only)

What is the first order of business?

- Be very aware of the specifics of the Petition, what did youth do and to whom?
- Engage victim centeredness-sensitivity and concern
- Engage caretakers to address supervision needs; assess caregiver capacity (high rate of depression)
- Co-create a safety/prevention plan which reflects the risk to others; who could be at risk; how are we protecting them; what are risky situations we want to *prevent ???*
- What does the caretaker need from us in order to insure the level of supervision needed?
- Bottom line: Prevent from happening again
- Placement may be necessary

Where does child sexual abuse happen?

- **More than 80% of sexual abuse cases occur in:**
- **one adult or adolescent /one child situations**
- **Most occurs in the home of the victim and/or of the offender**

Decision Making & Needs

- **Immediate Safety & Supervision**
  - ✓ Eliminate access and opportunity
  - ✓ Build alternatives to neglect and abuse based on theory of underlying needs
- **Education and Treatment**
  - ✓ Quickly arrange for offense-specific education & treatment
  - ✓ Insure victim and family access to needed services
  - ✓ Help family with *Wisconsin Crime Victim Compensation*
  - ✓ Treatment engagement & outcome needs to be monitored via high risk consults, POC reviews, team meeting discussions, JSO/provider progress reports, offense-specific risk assessments, and Achenbach symptom checklists

Treatment: What works?

- Almost all *therapeutic* intervention approaches have low rates of sexual recidivism (base rate: 10% or lower)
- Non-sexual delinquency appears to be more consistently a problem, particularly for peer offenders (8-58%)
- Mentoring can be powerfully effective
- Motivational interviewing
- Improve emotional understanding and expression
- Group should not include disclosure, ***deviancy training;*** cognitive behavioral, skills-based approaches supported
- Only approach with randomized control trial (RCT) support is MST, a short-term, eco-systemic, general delinquency, family oriented intervention
- Functional Family Therapy & Wraparound considered promising practices; both family oriented and skill building
- **Trend toward community-based, multi-modal, collaborative strength-based models with access to continuum of intervention which individualizes and matches needs and risks (Hunter, Gilbertson, et.al. 2003)**

Stages of Change

- The stages of change are:

- **Pre-contemplation:** Not yet acknowledging that there is problem behavior that needs to be changed
- **Contemplation:** Acknowledging that there is a problem but not yet ready or sure of wanting to make a change
- **Preparation/Determination**: Getting ready to change
- **Action/Willpower**: Actively Changing behavior
- **Maintenance**: Maintaining the behavior change
- **Relapse**: Returning to older behaviors and abandoning the new changes
- **Transcendence** -Eventually, if you "maintain maintenance" long enough, you will reach a point where you will be able to work with your emotions and understand your own behavior and view it in a new light. This is the stage of "transcendence". In this stage, not only is your bad habit no longer an integral part of your life but to return to it would seem atypical, abnormal, even weird to you.

Girls with Sexually Aggressive Behavior

- Wraparound does serve some female offenders
- No large sample empirical study
- Baby-sitting
- Very high rate of prior sexual and other abuse (90%)
- High co-morbid PTSD, affective disorders, substance abuse, eating disorders
- Holistic, trauma-informed approach which emphasizes limiting opportunity, reconstruction of self-esteem, coping and relationship development
- Course of treatment often more complex and of longer duration
- Many referrals are for “consensual” but illegal acts
- Lower adjudication rate relative to boys

Developmental Disabilities and Sexual Assault

- It has been estimated that 83% of women with a disability will be sexually assaulted in their lifetime
- Males with disabilities are twice as likely than males without to be sexually abused in their lifetime
- Juveniles with pervasive developmental disabilities and sexual aggressive behavior need services which carefully take into consideration literacy/ learning concerns and caretaker capacity
- Family education, limiting opportunity and access, safety planning, recreation (staying busy) and specialized youth education and behavioral interventions work most effectively
- Recidivism risk can be higher for those with cognitive limitations

Victimized Child

Offending Adolescent

Intra-familial Juvenile Sexual Aggression Reunification: Preferred Preconditions

Non-Offending Adult(s)

The Family

Victimized Child

- independent wish to reunify (amplify voice)
- can acknowledge and discuss the sexual abuse (age-appropriate)
- does not blame self for sexual abuse
- likely to report any further abuse or high-risk situations
- can honestly and realistically feel safe and protected in the home if perpetrator is to be returned
- Age of victim is heavily weighted, along with extent of abuse exposure

Offending Adolescent

- Accepts full responsibility for sexual abuse
- Has apologized with genuine remorse
- Demonstrates empathy for victimized child and understanding of impact of his/her sexual aggression; CARES
- Has some sense of WHY the sexual abuse occurred and how to prevent further abuse
- Knows high-risk situations and how to avoid them
- Can discuss and demonstrate strategies for coping differently with high-risk factors (e.g., deviant arousal, emotional precursors to offending, thinking errors, etc.)
- Wish to reunify

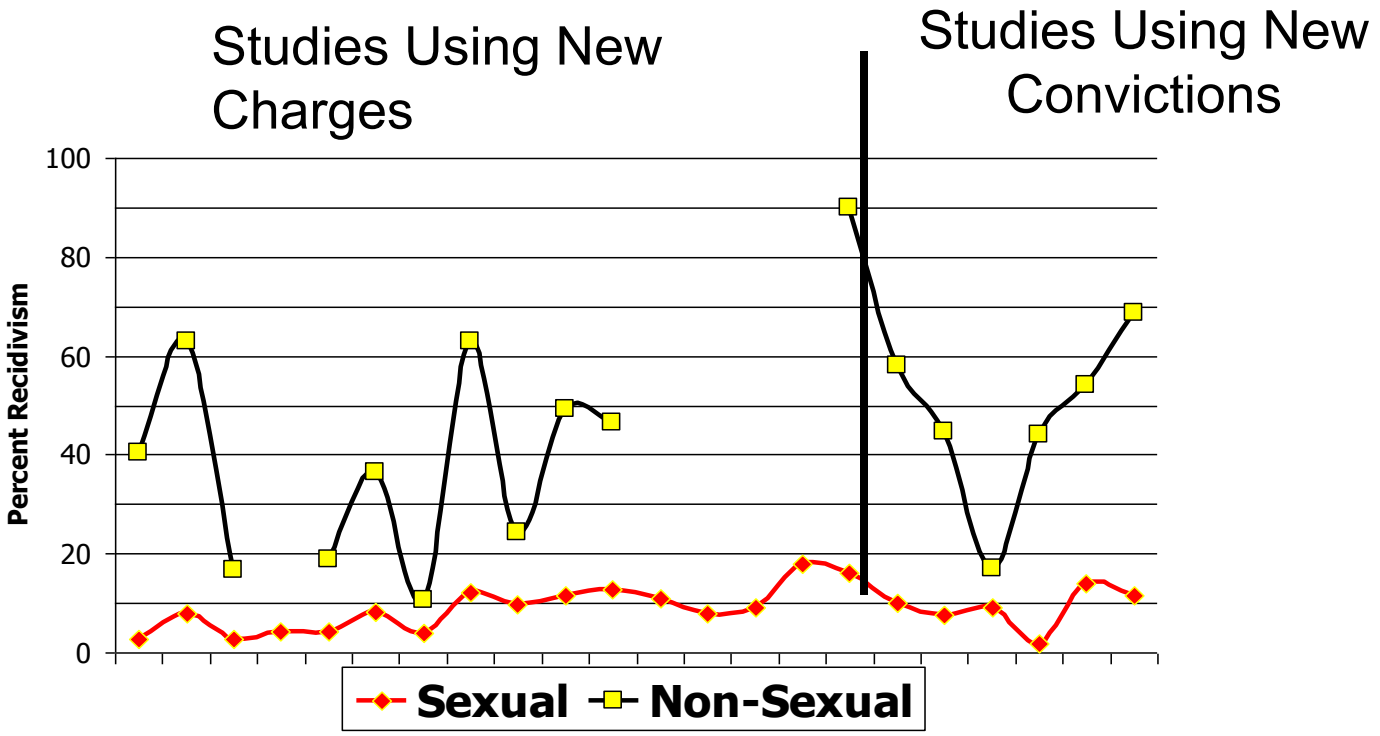
Caretakers

- Able/willing to put victimized child's need for protection first
- Able to hold offending adolescent accountable and enforce safety plan
- Able to discuss the abuse openly
- Aware of offending adolescent's risk factors and supervision needs
- Willing to collaborate and ask for help as needed
- Able/willing to report any further abuse or high-risk situations
- Wish to reunify

Wraparound Current AJSO Placements

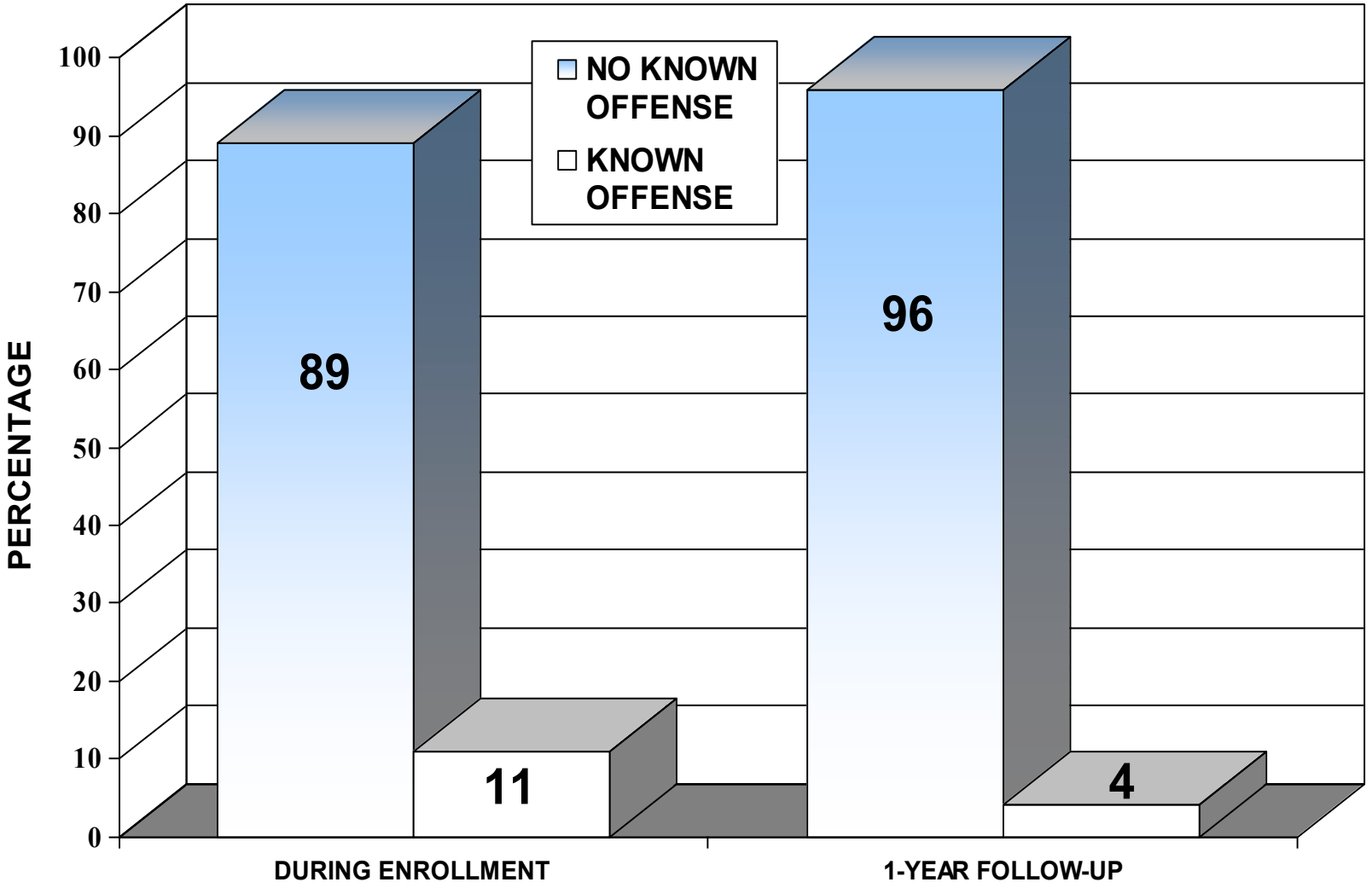
- Currently Enrolled: 58
- 2 Detention
- 5 Residential Treatment
- 4 Treatment Foster care
- 14 Group home
- 6 Relative/Kinship
- 23 Home

ASO Sexual and Non-Sexual Recidivism Across 20+ Studies



Studies following at least 50 youth for at least one year. Average length of follow-up = 5 years. Includes various treatment interventions and settings (NCSBY)

WRAP JSO SEXUAL OFFENSE RECIDIVISM DURING AND AFTER ENROLLMENT



N=202 DURING ENROLLMENT, 100 1- YEAR FOLLOW-UP

Importance of remaining true to our Values and constantly striving to Improve

Lessons Learned in System Reform:

- Wraparound values represent a *paradigm shift* away from a system reliant on restrictive forms of intervention which have often done more harm than good to family relationships and youth development
- Wraparound care coordinators need high levels of support to remain somewhat rebellious in challenging system partners and standing up for youth and families
- We know it's important to stay on top of <u>what</u> we are doing and <u>why</u> we are doing it ---<u>access to real time data</u> and remaining conscious of and testing our *theory of change* helps with focus and clarity of purpose
- Being well prepared, with the assistance of consultation, is critical to remaining a best practice and maintaining our credibility in the community

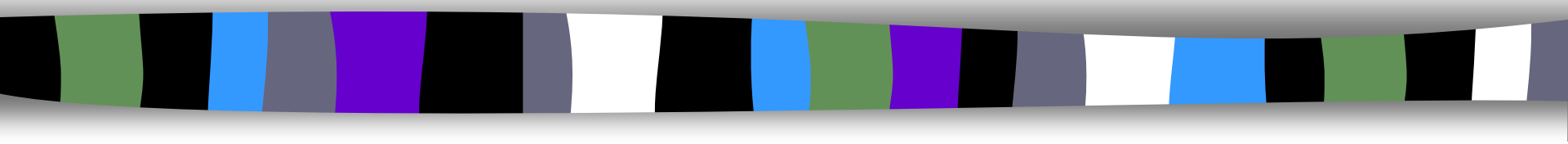
Fidelity: Drift is likely

- Being faithful to the Wraparound values is not easy, particularly with growth and frequently changing players
- The more restrictive, more professionally driven and less family-focused ways can feel safer, more comfortable; system partners/team members can vary in the beliefs and experiences; conflict happens
- The facilitation skills and seasoning required to implement and sustain a high quality Wraparound process do not develop overnight; turnover and slippage happens
- Fidelity to any model, but certainly one as complex as Wraparound, requires lots of support, both in the form of coaching but also in the form of strategic planning, resource development, innovation & quality improvement enriched by real time information & aimed at knowing what we are doing (process) & whether it is working (outcomes) now

All humans, somewhere within, have the urge to be heroic; to transcend circumstances, to develop one's powers, to overcome adversity, to stand up and be counted."

Dennis Saleebey

Thanks for your attention



Resources

- **San Diego Sex Offender Management Council; Standards for the Treatment of Sexually Abusive Youth**
- J.Schladale & K.A.Fredricks, 2007. **Community-Based Standards For Addressing Sexual Harm By Youth** (PDF available by request)
- **Clinical Guidelines for the Management of Disorders of Sex Development in Childhood** Consortium on the Management of Disorders of Sex Development (2006)
- **Center for Sex Offender Management, www.csom.org, A Project of the Department of Justice**
- Hunter,J., Gilbertson, S., Vedros, D., & Morton, M. (2004). **Strengthening community-based programming for juvenile sexual offenders: Key concepts and paradigm shifts.** ***Child Maltreatment*****, 9:2.**
- ***National Center on Sexual Behavior of Youth (www.ncsby.org)*** **:** national training and technical assistance center developed by the Office of Juvenile Justice and Delinquency Prevention and the Center on Child Abuse and Neglect, University of Oklahoma Health Sciences Center.

Darkness2light.org, Darkness to Light 7 Radcliffe Street, Suite 200 Charleston, SC 29403