

Report of Gabriel Myers Work Group On Child-on-Child Sexual Abuse



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**Charlie Crist
Governor**



**George H. Sheldon
Secretary**



EXECUTIVE SUMMARY

Florida Department of Children and Families Secretary George H. Sheldon established the Gabriel Myers Work Group in April 2009 to examine the case of Gabriel Myers, a 7-year-old who, on April 16, 2009, was found hanging in the home of his foster parents in Margate, Florida. This report, the second of two prepared by this Work Group, focuses on the issue of child-on-child sexual abuse. The first report, submitted to the Task Force on Fostering Success on November 19, 2009, provided findings and recommendations relating to the administration of psychotropic medications to children in out-of-home care.

On December 17, 2009, the Work Group held the first of seven public meetings on child-on-child sexual abuse and heard testimony that emphasized the prevalence of child-on-child sexual abuse nationally and in Florida. It is estimated that adolescents account for one-half of all child molestation cases each year, a figure that may be significantly under-reported and which supports the need for better data collection in order to accurately understand and effectively respond to the true magnitude of the problem.

The Work Group determined that children exhibiting sexual behavior problems are often victims themselves and are further traumatized when labeled with terms such as “juvenile sexual offender.” As in its previous report on the use of psychotropic medications, the Work Group identified numerous failures and gaps in the integration of efforts, in decisions to place children, and in information sharing and communication among involved agencies. These failures and gaps were also evident in the training, supervision, and monitoring of child welfare personnel, all of which impact the ability of Florida’s child welfare system to effectively protect the children in its charge.

Florida must act aggressively to protect the children in its care and to break the cycle of abuse. Child-on-child sexual abuse presents unique challenges to foster parents, child welfare workers, supervisors, and the children involved. The damage caused by such abuse requires the use of innovative and integrated approaches to treatment, such as trauma informed care, and the involvement of professionals who possess the necessary education, expertise, and practical skills. While this report focuses on children in care of the State, the Work Group also recognizes that it is the primary responsibility of parents--natural, adoptive or foster--to educate their children on appropriate sexual activities, sexual boundaries, and the consequences of violating laws relating to sexual conduct.

This report to the Task Force on Fostering Success articulates 107 findings and makes 84 recommendations for action to improve the State’s child welfare system. It should be noted, however, that without strong, timely, positive, and sustained action, our child welfare system remains vulnerable to a similar tragedy in the future. The Secretary of the Department of Children and Families has demanded a transparent, timely study of Gabriel’s case and, through this Work Group, has provided unprecedented visibility of the specific circumstances contributing to Gabriel’s death. The true impact of this work will be only as effective as the subsequent efforts to recognize, implement, sustain, and institutionalize the solutions to the recommendations respectfully provided.

REPORT OF GABRIEL MYERS WORK GROUP ON CHILD-ON-CHILD SEXUAL ABUSE

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Report of the Gabriel Myers Work Group on Child-on-Child Sexual Abuse

Introduction

On April 29, 2009, Department of Children and Families (DCF) Secretary George H. Sheldon convened a work group to determine the facts and circumstances surrounding the death of 7-year-old Gabriel Myers on April 16, 2009. The police report indicated he hanged himself in the shower of his foster parents' Margate home. His death has been ruled by the Margate Police Department and the Broward County Medical Examiner as "an accidental death by hanging." Gabriel was brought into State custody on June 29, 2008, and, during the subsequent 10 months, was in foster care. He was prescribed psychotropic medications at the time of his death, and documentation in his case files indicated that, while living in Ohio prior to his move to Florida, he had been sexually abused by an older child and exposed to pornography by an adult relative. Gabriel exhibited sexual behavior problems while in foster care, which were reported in school and in an additional out-of-home placement and increased stress in his already troubled life.

Charge to the Work Group

The Work Group was charged with examining three issues:

- The specific case of Gabriel Myers
- The use of psychotropic drugs to treat children in foster care
- Child-on-child sexual abuse

The Work Group was specifically asked to provide a comprehensive analysis of the issues involved which would allow the Task Force for Fostering Success, chaired by former Attorney General Bob Butterworth, and the Department of Children and Families to identify and implement improvements to the system in order to reduce the chances of such a horrible event from occurring in the future. It was anticipated that the Work Group would complete its tasks with the sense of urgency that is expected in DCF and by Florida's children.

The Work Group focused its initial deliberations and the resulting initial report on the first two issues. In its November 19, 2009, report to the Task Force on Fostering Success, it identified 147 findings and made 90 recommendations for action in ten areas related to the case of Gabriel Myers and the use of psychotropic medication for children in out-of-home foster care. The Work Group determined that a detailed framework of safeguards for Florida's foster children exists and is articulated in statute, administrative rule, and operating procedures. The core failures in the system and in this specific case, however, stem from lack of compliance with this framework and with failures in communication, advocacy, supervision, monitoring, and oversight.

Many of our original findings are applicable to the final issues we address in this report specifically addressing the child-on-child sexual abuse issues. To avoid being redundant, we will not repeat all of them here. **We reaffirm our findings and continue to urge the adoption and implementation of our recommendations.**

Members of the Work Group

In order to focus more effectively on the issue of child-on-child sexual abuse and to include appropriate subject-matter experts, Secretary Sheldon reconstituted the membership of the Gabriel Myers Work Group upon submission of its initial report. In conducting this review of child-on-child sexual abuse, the Work Group is composed of nine members:

- Dr. James D. Sewell, Assistant Commissioner (Retired), Florida Department of Law Enforcement, Chair
- Robert Edelman, CEO and Clinical Director, Village Counseling Center, Gainesville
- Betty Busbee, former Chair, Florida Statewide Advocacy Council
- Judge John A. Frusciante, Seventeenth Judicial Circuit
- Dr. Mike Haney, Director, Prevention and Intervention, Children's Medical Services, Department of Health
- Bill Janes, former Assistant Secretary for Substance Abuse and Mental Health, Department of Children and Families
- Craig Latimer, Chief of Staff, Office of the Hillsborough County Supervisor of Elections
- Mez Pierre, 4Kids of South Florida and Forever Family
- Robin Rosenberg, Deputy Director, Florida's Children First

Personnel from the Department of Children and Families provided staff support for the Work Group.

Meetings of the Work Group

In preparing its findings and developing its recommendations, the Work Group held seven public meetings:

- December 17, 2009, in Tampa at the DCF Suncoast Regional Office
- January 7, 2010, in Ft. Lauderdale at the DCF Southeast Regional Office
- January 29, 2010, in Jacksonville at the DCF Northeast Regional Office
- February 17, 2010, in Tampa at the DCF Suncoast Regional Office
- March 11, 2010, in Tallahassee at the offices of the Big Bend Community Based Care Lead Agency
- March 25, 2010, in Ft. Myers at the DCF 20th Circuit Office
- May 5, 2010, in Tampa at the DCF Suncoast Regional Office

The Work Group heard presentations and testimony from 38 individuals who were invited or requested the opportunity to speak.

In addition to these presentations, members of the Work Group reviewed myriad materials, including studies, reports, previous investigations, statutes, operating procedures, and model policies related to the issue of child-on-child sexual abuse and the impact of children exposed to traumatic events. Copies of this material and PowerPoint presentations made to the Work Group are maintained on the website created to support this Work Group (www.dcf.state.fl.us/admin.GMWorkgroup/index).

On May 5, 2010, the Work Group held its final meeting to review and discuss its recommendations to the Task Force on Fostering Success. This document includes all findings and recommendations that result from the tenure of this Work Group.

Findings and Recommendations of the Gabriel Myers Work Group

The initial Work Group Report on psychotropic medications documented a number of recommendations for system improvement which also have applicability in confronting the issue of child-on-child sexual abuse. These findings and recommendations fall into four areas and have been modified or supplemented by specific child-on-child recommendations:

- The Case of Gabriel Myers
- Information Contained in the Florida Safe Families Network
- Information Sharing
- Individual and Agency Accountability

The Work Group also found a number of topics unique to the issue of child-on-child sexual abuse:

- Labeling of Sexual Behaviors
- Identification, Screening, and Assessment of Behavior, including Comprehensive Behavioral Health Assessments
- Trauma Informed Care
- Training, Certification, and Competency of Professionals
- Ensuring Best Practices

Cumulatively, then, this Work Group has identified 107 findings and 84 recommendations relating to the issue of child-on-child sexual abuse.

Issue: The Case of Gabriel Myers

On April 16, 2009, 7-year-old Gabriel Myers hanged himself in the residence of his foster parents. Gabriel had been adjudicated dependent on September 2, 2008, following the arrest of his mother and the filing of the abuse report that brought him into care on June 29, 2008. During the subsequent ten months, Gabriel was initially sheltered in a licensed foster home, then, after a positive home study, placed with relatives. When that placement broke down, he was returned to the licensed foster home in which he was initially placed. When that placement also broke down, he was sent to the licensed foster

home in which he resided when he died. That home had previously served as a respite for Gabriel, and he was familiar with those surroundings. While in care, he received numerous mental health and behavioral assessments and underwent regular treatment from a psychiatrist and two therapists, one of whom documented that “it is clear that this child is overwhelmed with change and possibly re-experiencing trauma.”

Gabriel demonstrated a number of incidents of destructive behavior and conduct problems and was treated with counseling and several psychotropic medications. In February and March 2009, Gabriel experienced a number of significant events in life, including changes in foster homes, therapists, after-school programs, loss of privileges at home, and visitation arrangements with his mother, all of which may have contributed to his mental status at the time of his death.

During his time in care, Gabriel also indicated that he had been sexually abused by a twelve year old and exposed to pornography by an adult relative while living in Ohio. Shortly after coming into care, Gabriel was accused of touching other children inappropriately, which resulted in Gabriel missing school and his relatives asking that he be removed from their care. Child-on-child sexual abuse was clearly a major issue impacting Gabriel Myers, his relatives, foster parents, and the child welfare team. The Work Group saw little evidence that child-on-child sexual abuse issues were effectively managed by any of those affected.

Findings:

1. It is clear that, throughout his placement in foster care and although he was attended by many well-meaning professionals, Gabriel was “no one’s child.” Many stakeholders, with broad or specific roles, were involved in his treatment, but no single individual or agency became a champion to ensure that he was understood and that his needs were identified and met in a timely manner.
2. Specific responsibility for the treatment and care of Gabriel Myers was not clearly fixed or effectively carried out.
3. There appeared to be no sense of urgency driving the agencies and individuals responsible for Gabriel’s welfare. Because the perception of time for a child is compressed, a demonstrated sense of urgency by adults is vital.
4. The case itself was replete with missed opportunities to more effectively serve the needs of this child. Numerous warning signs that Gabriel was in crisis were evident but were not addressed adequately or in a timely manner.
5. Individuals and agencies responsible for Gabriel’s welfare did not communicate regularly or effectively. Reports on his behavior, medication, and life changes were not fully and regularly shared among those charged with ensuring his welfare. Those responsible for his care did not adequately staff recommendations for Gabriel’s case, nor did they exchange information with the treating psychiatrist.

6. Individuals and agencies responsible for Gabriel's welfare did not communicate regularly or coordinate effectively their efforts at caring for his needs.
7. ChildNet is the Community Based Care Lead Agency providing services to foster children in Broward County, which includes the city of Margate. In Gabriel's case, the ChildNet case manager failed to adequately carry out his responsibilities.
8. There was inadequate oversight and supervision of the assigned ChildNet case manager.
9. There was inadequate oversight of the involved agencies by Department of Children and Families personnel.
10. There was inadequate, incomplete, repetitive, and at times inaccurate documentation in Gabriel's case files.
11. There was no documented effort to gather and disseminate all available information on Gabriel's background and case history.
12. Appropriate agencies failed to respond when the foster parent clearly indicated by e-mail a number of behavioral issues and that Gabriel's foster care placement was in jeopardy. No action was taken to deal with the evident stress of the foster parent or his lack of success in managing behavior with punishment.
13. No one followed up with Ohio authorities concerning Gabriel's medical and welfare history, and, specifically, his claims of sexual abuse were not investigated in a timely manner.
14. Recommendations contained in the Comprehensive Behavioral Health Assessment and in reports by other professionals charged with his care, including the Family Services Planning Team, were not effectively communicated or implemented.
15. While Gabriel received general therapy early in his placement, those professionals charged with his care did not provide Gabriel specialized, immediate, and consistent therapy to deal with identified trauma, post-traumatic stress disorder, and depression. The only intensive therapy was directed at the prevention of sexual behaviors; that was not begun until Gabriel had been in care for six months.
16. The case manager and supervisor did not ensure that recommended training to prepare the foster parents to deal with Gabriel's unique background and behavior was provided.
17. Parents and those professionals charged with his care apparently accepted discipline and punishment as the principal solution to Gabriel's behaviors. There is little evidence of any behavioral assessment or behavioral analysis services beyond the initial Comprehensive Behavioral Health Assessment or of positive efforts to support Gabriel and encourage his success. The case demonstrated a critical shortcoming in addressing

the need for a behavioral analyst to support the foster parents and more effectively address Gabriel's behaviors.

18. Too many changes occurred in Gabriel's life and environment in a short period of time, with poor communication among those charged with his care, and without a coordinated assessment or response by caregivers and those charged with his care.

19. Despite the earnest efforts of ChildNet to ensure stability, there was no true placement stability, and Gabriel's final placement was with working parents who were not always available or prepared for his unique needs.

20. The Work Group was not able to obtain sufficient information from the Broward County Schools to ascertain the school's role in Gabriel's care. From the information provided to the Work Group, however, it appears that school staff were not aware or sufficiently involved in resolving Gabriel's problems/concerns. We defer reporting on this specific issue until such time as we can review appropriate records.

21. As a result of the death of Gabriel, the Broward County child welfare community has identified a number of measures which, if vigorously implemented, monitored, and institutionalized, should ensure more effective and comprehensive treatment of children in the future.

22. Findings and corrective actions related to Gabriel's case have and will continue to impact children across this State.

23. Reports that Gabriel was sexually abused and displayed sexual behavior problems were not prioritized and handled expeditiously.

24. In some parts of the State, caseloads for case workers and their supervisors may be excessive, contributing to poor decisions, incomplete and poorly coordinated documentation, and an inadequate, unacceptable response to sexual behavior problems.

25. Children with sexual behavior problems have often themselves been victims of sexual abuse and/or exposed to sexual activity. Sexually abused children in foster care are at greater risk of sexual behavior problems.

26. The child welfare system is not effectively assisting children with sexual behavior problems or their families.

27. Although he received a Comprehensive Behavioral Health Assessment which noted sexual behavior issues, Gabriel did not receive a timely and more comprehensive psychosexual assessment related to his own sexual abuse and sexually reactive behaviors he was reported to have displayed.

28. Child on child sexual behavior problems, like multiple prescriptions for medications, are "red flags" requiring management by exception by case workers, supervisors, partner

agencies, families and stakeholders. “Red flag” situations are not being identified and adequately addressed throughout many parts of the State.

Recommendations:

R1. The Department of Children and Families, working with its community partners, should continue to work with the Broward County School District to examine what school-related issues existed with Gabriel Myers and to strengthen future efforts at collaboration and information-sharing. Lessons learned should be shared with school districts throughout the State.

R2. The Department of Children and Families should require their lead agencies to develop and implement procedures that:

- **Designate responsibility during a crisis involving a child in the care of the State**
- **Identify and hold accountable a champion, normally the case manager, to ensure the child is treated as a prudent parent would treat their own child**
- **Involve the child and consider the child’s opinion in all decision-making**
- **Ensure presenting needs are identified and met in a timely fashion**
- **Require transparency, collaboration, and a demonstrated sense of urgency among those responsible for a child’s care.**

R3. The Department of Children and Families and its lead agencies should develop and implement a priority response system for warning signs indicating a child is in crisis, particularly when exhibiting symptoms of child-on-child sexual abuse.

R4. The Department of Children and Families should require its Community Based Care lead agencies to develop and implement procedures to identify and to assist foster parents who are not able to manage their child’s behavior or have reached a high level of stress. Such procedures should include 24/7 availability for support and intervention during times of crisis.

R5. The Department of Children and Families and its Community Based Care lead agencies should develop and implement procedures to obtain timely out of state information essential to a new placement in Florida.

R6. The Broward County child welfare system should provide a semiannual report to the Task Force on Fostering Success, documenting its on-going efforts to implement, monitor, and institutionalize the measures taken to ensure more effective and comprehensive treatment of children under the care of the state.

R7. The Department of Children and Families and its Community Based Care lead agencies must educate staff, families, and partner agencies

regarding the prevalence and importance of identifying and responding properly to sexual behavior problems.

R8. The Department of Children and Families and its Community Based Care lead agencies must prioritize the care of children who are involved in child on child sexual abuse and who have been victims of sexual abuse. Case workers and their supervisors must be adequately trained in managing these issues. An acceptable caseload involving children with sexual behavior problems must be determined. The use of designated case workers, assigned and trained to deal with the unique issues of sexual abuse, should be considered and is already a practice in some areas of the State.

R9. The Department of Children and Families and its Community Based Care lead agencies must prioritize prevention of child on child sexual abuse.

R10. The Department of Children and Families and its Community Based Care lead agencies must identify, track, and provide appropriate services to victims of sexual abuse and those children exhibiting sexual behavior problems.

R11. The Department of Children and Families and its Community Based Care lead agencies must ensure that meaningful interagency agreements, involving all partners at the State and local level, are implemented and fix responsibility for action to prevent and protect children involved in inappropriate sexual conduct. Prevention and provision of appropriate therapy should have priority over merely responding to an incident.

R12. The Department of Children and Families must use data systems and other signals to identify “red flag” scenarios and charge all caseworkers, supervisors, families, and stakeholders to respond accordingly. The response of the State’s child welfare system to these priority cases must be immediate, monitored, and continuous until satisfactorily resolved in the best interest of the child.

Issue: Information contained in the Florida Safe Families Network (FSFN)

The Florida Safe Families Network (FSFN) serves as the Statewide Automated Child Welfare Information System (SACWIS) for the State of Florida and is the repository of extensive information about the history, needs, and care of individual children in out-of-home care. The system provides linkage to previous behavior issues and is a source of transparency in the system. Child-on-child sexual behavior problems can be documented without inappropriate labeling causing stigma. Labeling and stigma caused by the database can be prevented by a common language among regions, agencies, stakeholders, and families. Education and training are very important to optimizing the effectiveness of data in FSFN related to child-on-child sexual behavior problems.

Findings:

29. FSFN data are frequently incomplete and inaccurate. The information contained in FSFN is only as good as the information entered from the field; errors in input, regardless of the reasons for such errors, will continue to yield faulty information.

30. The Department of Children and Families and its Community Based Care lead agencies staff indicated that, as currently structured, FSFN is a data capture system that provides little support for effective case management. Several pilot projects being conducted throughout the State offer better analytical and case management applications of FSFN data.

31. FSFN has too many “free text” and “other” sections which complicate timely and effective use of the data system as an adequate monitoring device.

32. It must be recognized that FSFN is only a data system; by itself, it does not replace adequate supervision and monitoring.

33. A number of Community Based Care organizations in Florida have developed alert systems and other data sets relating to children with sexual behavior problems. Not every Community Based Care organization has such a mechanism; existing alert systems lack statewide uniformity; and connectivity among systems is problematic. The result is inconsistent tracking, prevention, treatment, and documentation of sexual behavior problems in the data system.

34. Data concerning reports of sexual misconduct by children aged 13-17 year olds are currently not captured in FSFN, although it reportedly is accessible in a compatible program.

Recommendations:

R13. The Department of Children and Families should require its lead agencies to continue its efforts to ensure the quality, completeness, timeliness, usefulness, and accuracy of case documentation and information contained within the Florida Safe Families Network.

R14. The Department of Children and Families should continue to utilize technology and identify technology solutions, including enhancements to the Florida Safe Families Network, to resolve problems identified in this report including:

- **Eliminating duplication of data entry**
- **Allowing all parties access to verify information**
- **Establishing a “stop” or flag system when an action does not occur**
- **Facilitating and documenting information exchange**
- **Facilitating supervisory monitoring/review and management oversight**
- **Strengthening and aligning data systems**

R15. The Department of Children and Families should continue refinements to the Florida Safe Families Network to increase its “user friendliness” and to reduce the number of free text and “other” entries.

R16. The Department of Children and Families, working with its community partners, must continue to improve the usefulness of the Florida Safe Families Network for case management in the field.

R17. The Department of Children and Families should establish a standardized reporting and alert system among all regions. Access to this information should be controlled to prevent labeling and/or stigma resultant from a sexual behavior problem.

R18. The Department of Children and Families must ensure that FSFN has specific capabilities to capture and track all information regarding sexual abuse and sexual behavior problems for children of all ages.

R19. The Department of Children and Families, recognizing that it is critical to identify children at risk for sexual behavior problems, should develop a system to reassess periodically a child’s risk. Risk levels are not static and fluctuate based on the child’s age, support system, psychological issues, and environment.

Issue: Information Sharing

Florida’s foster care system requires the involvement of a number of agencies, both governmental and private, and myriad individuals to manage successfully the care of these children. When they have unique behavioral or medical needs, the involvement of other professionals becomes even more necessary. In such cases, it is vitally important that all participants in a child’s welfare regularly exchange critical information and continually communicate with other involved caregivers. Especially in complex cases, the use of multidisciplinary teams fosters the focus of a variety of professional expertise and viewpoints on the solution of that child’s specific issues. This process demands a continuous, consistent, coordinated system of care such as that recommended for individuals with both mental health and substance use disorders.

Sharing of information regarding child-on-child sexual behavior problems presents particular problems as criminal behavior may be investigated, treatment is necessary, and the information shared may adversely impact an out of home placement. Transparency remains as a priority not only in the Department of Children and Families but also among partner agencies as we align treatment and family interventions with criminal sanctions. The lack of common assessment instruments and terminology affect information sharing. Failure to share information may result in missed opportunities to prevent child-on-child sexual behavior problems and satisfactory placement in the child welfare system.

Findings:

35. The sharing of information, whether through interpersonal contact or data exchange, must ensure integrated care for Florida's foster children and eliminate fragmentation of efforts.

36. Data available through a number of systems (e.g., FSN, Agency for Health Care (AHCA) Medicaid, and MedConsult Line) are not regularly reviewed to indicate anomalies in information or to ensure accuracy of data.

37. The results of the Comprehensive Behavioral Health Assessment are not always transmitted to and shared among others involved in the child's treatment, including the treating psychiatrist.

38. The results of the Comprehensive Behavioral Health Assessment do not replace a functional behavior assessment.

39. There is a need for a web-based information system which, with proper security safeguards, allows access by those responsible for a child's care.

40. Child abuse death reviews have consistently identified the need for multidisciplinary staffings on complex cases. Currently, multidisciplinary staffings are not routinely conducted.

41. Sharing of information is primarily affected by two Federal laws, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which governs the use and disclosure of private health information, and the Family Education Rights and Privacy Act of 1974 (FERPA, also known as the Buckley Amendment), which protects the privacy of student educational records. It appears that misunderstandings concerning the intent and requirements of these laws foster artificial barriers to and impede the sharing of information among foster children in care, especially with and between schools and among treating professionals.

42. The current system requires numerous pieces of paper, necessitating duplication of information entries and creating a burden for all involved, and may result in inaccurate or incomplete information going to the persons who need it.

43. Technology and technological solutions to many of the problems identified in this report can be better employed to:

- eliminate the duplication of entries; catalogue the treatments and medications of children;
- allow all parties (and counsel) to view and confirm the accuracy of information; generate a "stop" or flag when system requirements, such as informed consent, do not occur; and
- facilitate and document information exchanges

44. All persons with daily contact with a child (caregiver, school, day care) should have access to pertinent information concerning the child's behaviors and conduct.

45. Information systems and information-sharing practices should be capable of triggering a specific response from designated agencies when a pattern of warning signs of crisis for a child in State care emerges.
46. Elimination of needless and duplicative paperwork should result in efficiencies that lead to better care.
47. School teachers and school staff, child welfare personnel, treatment providers, and families are not effectively collaborating in reporting incidents involving and sharing information concerning sexual behavior problems, nor does it appear that school systems actively engage in prevention and safety planning for child-on-child sexual abuse issues.
48. Child welfare staff do not routinely brief school teachers and staff about safety plans that involve sexual behavior problems. School personnel, including school resource officers, are not being included in the development of safety plans to address safety issues during those times when children are under supervision of the school.
49. Foster parents and potential adoptive parents are often not given details of prior sexual abuse and sexual behavior problems or provided the tools for safely incorporating the child into their homes before accepting a child.
50. Current Florida Abuse Hotline procedures are inadequate to deal with this issue, are applied inconsistently, and allow subjectivity in handling reports of sexual behavior problems or child and child sexual abuse.
51. Law enforcement inconsistently handles calls referred by the Florida Abuse Hotline.
52. There is wide variation among law enforcement's response to child on child sexual abuse referred by the Florida Abuse Hotline, especially related to the needs of the children involved.
53. Agencies throughout the State appear to comply inconsistently with State statutes regarding information sharing.
54. Requirements to notify schools of arrest of children by law enforcement, as mandated by State statute, are not consistently implemented throughout the State.
55. Common definitions and alerts must be shared across state and local agencies. Data systems must be compatible to report and to respond to sexual behavior problems consistently.
56. Many judicial circuits have a low limit on the number of times government employees (e.g., law enforcement, child protection team, child welfare personnel) can interview a child who is an alleged victim of sexual abuse. This limit, which is as low as three in some areas, often adversely affects the ability to gather complete information concerning the incident because children are frequently reluctant to fully disclose truthful information concerning sexual activity to adult strangers. This in turn impairs the ability

to share the information necessary to work effectively with the child's issues. It may be unclear whether information gathered is for a criminal investigation or an assessment of the behavioral problem.

57. All children who could benefit from a Multi Disciplinary Team (MDT) staffing do not receive them, nor are therapists and other treating professionals routinely involved in these staffings.

58. The Department of Children and Families Children's Mental Health Program Office and the Mental Health Medical Director are not sufficiently involved in the Department's carrying out of its responsibilities in the child welfare system. Their expertise and knowledge of these programs in Florida is considerable and should be better used by child welfare staff.

Recommendations:

R20. The Department of Children and Families should work with the Department of Education and local school districts, in compliance with state law and existing interagency agreements, to develop procedures to facilitate the release of a child's school information from school officials to those charged with his/her care.

R21. The Department of Children and Families, working with the Department of Education and Department of Health, should ensure that training on the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and the Family Educational Rights and Privacy Act of 1974 (FERPA) is conducted for staff in child welfare, behavioral medicine, and schools to facilitate sharing of treatment and other child welfare information.

R22. The Department of Children and Families, working with its community partners, should develop and implement a web-based information system which, with proper security safeguards, allows access by those responsible for a child's care and facilitates the rapid exchange of information.

R23. The Department of Children and Families, in partnership with the Department of Education and each county school system, should develop and implement procedures to share information regarding treatment, problems, and response for a child in State care in crisis.

R24. The Department of Children and Families, working with its community partners, should implement a training and quality assurance monitoring plan that addresses sharing of information among those responsible for a child's care and stakeholders.

R25. The Department of Children and Families and the Department of Education should establish an interagency agreement specifically formalizing collaboration in preventing, reporting, and responding to sexual behavioral

problems. Similar interagency agreements should be established with all appropriate partners in each local school district.

R26. The Department of Children and Families should include the sharing of safety plans as part of the interagency agreement with the Department of Education and, in local agreements, with local school districts and other appropriate partners.

R27. The Department of Children and Families Quality Assurance process should include a periodic review of implementation of interagency agreements and compliance with other statutory requirements to ensure the agencies are sharing information.

R28. The Department of Children and Families and its community based care partners must ensure that foster and adoptive parents receive full disclosure of the child's prior sexual abuse and sexual behavior problems and are provided the necessary and appropriate education, training, and tools prior to the placement of the child and, after placement, needed on-going support.

R29. The Department of Children and Families should reexamine Florida Abuse Hotline procedures to ensure information useful to the Child Protection Team and other child welfare professionals is captured and that reports for all ages of children in the child welfare system are handled consistently.

R30. The Department of Children and Families, working with its law enforcement partners, should review, revise, and standardize its criteria for transferring calls to local law enforcement. As part of this, the Department should develop a process to ensure adequate feedback from law enforcement agencies on child-on-child sexual abuse issues. This process must ensure that at least one entity follows up on all allegations of child-on-child sexual abuse so that no child is overlooked when calls are transferred.

R31. The Department should expand its involvement with law enforcement agencies and their professional associations, including the Florida Sheriffs Association, Florida Police Chiefs Association, and Florida Association of School Resource Officers, in policy development and training relating to child-on-child sexual abuse.

R32. All state agencies must prioritize alignment of data systems and sharing of information in a consistent, non-threatening manner.

R33. The Department of Children and Families, working with its law enforcement partners, prosecutors, and the judiciary, must clarify the distinction between criminal investigative interviews, forensic interviews, and

assessment for treatment so that sufficient information can be obtained to provide appropriate care to children.

R34. The Department of Children and Families must strengthen the operation of the treatment team to include multi-discipline team members and other stakeholders.

R35. The Department of Children and Families must better align and more effectively integrate the services provided by each of its program offices.

Issue: Individual and Agency Accountability

The care of Florida's foster children demands the accountability of those concerned with ensuring their welfare and protecting their interests. To that end, each participating individual and agency in the child welfare system must clearly understand, commit to, and fulfill their defined role. In particular, agencies throughout the State must accept and exercise their responsibility for the accountability of those in their charge, and the Department of Children and Families must effectively exercise its responsibility for the oversight of those who work within this partner-driven system.

The complexity of child-on-child sexual abuse complicates accountability as our law enforcement partners have an increasingly important role. Investigations may delay assessments for clinical treatment. With increased agency involvement, we often do not fix responsibility for addressing the problems across systems. Interagency agreements and trainings can assist in reducing these problems.

Findings:

59. The responsibilities for the treatment of a foster child are well established in statute and administrative code. However, in application and particularly within local systems of care, the child welfare system lacks a clear delineation of and education on the roles and responsibilities of all those involved in the treatment of a foster child, including the case worker, foster parent, physician, judge, Guardian ad Litem, attorney, and contracted providers.

60. Within the Department of Children and Families, issues related to the mental health of children fall within the responsibilities of both the Office of Family Safety and the Office of Children's Mental Health, each reporting to a different Assistant Secretary and with no clear definition of the responsibilities or coordination required of each. It is critical to the welfare of children that the efforts of these two Departmental entities be effectively integrated.

61. Regardless of any other areas of personal skills or expertise, it is critical that the case manager be viewed as the subject matter expert on a single item: each child assigned to his/her care.

62. There is a need for enhanced oversight of children in the care of the state by the judiciary assigned to dependency cases.
63. Assigned responsibility, and the subsequent accountability, for ensuring on-going compliance with agreements among agencies (e.g., the Interagency Agreement to Coordinate Services for Children Served by the Florida Child Welfare System) and for action plans resulting from cases such as Rilya Wilson or the Red Item Report, are lacking.
64. Performance measures for the Department of Children and Families and their community based partners should reflect the core issues related to the effective treatment of Florida's foster children, including compliance with statutory safeguards. What gets measured gets done!
65. Contractual accountability and performance requirements for community-based care agencies and the providers with whom they contract appear to be loosely monitored and enforced by the Department of Children and Families.
66. Administrative requirements placed on those involved in the system with meeting the needs of the child are duplicative, excessive, and often not followed.
67. Despite a decrease in the average caseload statewide, many agencies still assert caseloads as the reason they do not have the capability to effectively manage special situations such as children with sexual behavior problems or sexual abuse victims.
68. Case workers and supervisors often fail to document the fact that sexually inappropriate behavior is the reason that a child is moved from his or her placement and, as a result, may impact the appropriate care of the child and the failure to protect other children.
69. Transparency and accountability in the decision to move a child from his/her placement must be recognized as a necessary hallmark of this State's child welfare system.
70. The availability of providers required to identify, screen, assess or follow up on behaviors needing specialized training, expertise, or experience, such as sexual behavior problems, is impacted by State funding .

Recommendations:

R36. The Department of Children and Families should clearly articulate the relationship, responsibilities, integration of services, and communication required between the Office of Family Safety and Office of Children's Mental Health on issues related to children's mental health.

R37. The Department of Children and Families, working with its community partners, must clearly define and fix expectations and responsibilities for treatment and care among those charged with the care of the child, including

the case worker, foster parent, physician, judge, Guardian ad Litem, attorney, and contracted providers.

R38. The Department of Children and Families, working with its community partners, must clearly define and ensure appropriate training on the roles, responsibilities, and expectations of all persons involved in the child's life and case.

R39. The Department of Children and Families, working with its community partners, must clearly develop and utilize management indicators to monitor agency performance in child welfare system

R40. The Department of Children and Families, working with its community partners, must clearly define warning signs of crisis indicating when a child is in trouble and identify who is responsible to respond.

R41. The Department of Children and Families, working with its community partners, must review rules, policies, and practices to eliminate duplicative requirements for case documentation.

R42. The Department of Children and Families must clearly define, continually monitor, and actively enforce contractual accountability and performance requirements for lead agencies and the providers with whom they contract.

R43. The Department of Children and Families and its lead agencies should implement quality assurance procedures to monitor effectively actions required by case managers and supervisors.

R44. The Department of Children and Families and its lead agencies should maintain an on-going review of all items noted in quality assurance reports to ensure continued compliance with identified deficiencies and recommendations.

R45. The Department of Children and Families, in conjunction with appropriate State and community partners, should develop and promulgate an action plan for the implementation of the recommendations contained in this Report on Child-on-Child Sexual Abuse by July 31, 2010. Monitoring of this action plan should occur through both Departmental management and quarterly reports to the Task Force on Fostering Success.

R46. The Community Based Care agencies must determine ways to provide administrative relief for case workers and their supervisors. Special attention must be given to those providing support to sexual abuse victims and children experiencing sexual behavior problems. Case workers and their supervisors must have time to complete education and training regarding sexual behavior problems.

R47. The Department must develop procedures to assist in maintaining transparency, providing education and training to the family, and providing appropriate care to children involved in sexual behavior problems.

R48. The Department of Children and Families, through its contractual process, should require that each Community Based Care lead agency has in place a clear and consistent process for providing and approving every change in residence or placement for its children, especially for high risk children, including those with sexual behavior problems, and children placed in specialized treatment programs such as Statewide Inpatient Psychiatric Programs (SIPP), Specialized Therapeutic Foster Care, or Residential Group Homes. Such process must ensure adequate and appropriate staffings prior to any move and continuity and provision of appropriate services in the new residence/placement.

Issue: Labeling of Sexual Behaviors

Current Florida Law frequently causes labeling of children as sex offenders or predators. These labels cause stigma that adversely affects children in whatever setting they are in. The label follows them through their child welfare existence and may continue into adulthood. Treatment programs are often labeled “sex offender programs”. This is not conducive to positive treatment outcomes. The state’s child welfare system must change its language to encourage prevention and research-based treatment. Research clearly shows that children seldom reoffend as adults. The system should encourage supportive treatment experiences and minimal out of home placement. If not, case workers will avoid discussing case histories because it may be detrimental to the new placement. Labeling may frighten potential foster parents who have not been educated and prepared to support children who have been sexually abused or display sexually inappropriate behavior.

Findings:

71. The child welfare, juvenile justice and adult criminal justice systems use a variety of terms, such as sex offender, juvenile sex offender, sexual abuser, and predator in ways that are not consistent among systems. The inconsistency makes the terminology confusing. Oftentimes children who display sexual behavior problems but have not perpetrated a crime are labeled as “sex offender, abuser, predator,” or other terms that carry a negative stigma impacting future home placements; interactions with staff, teachers, and families; and their general well-being.

72. The 1995 enactment of legislation that criminalized sexual behavior problems and labeled some children as juvenile sex offenders has further complicated the ability to treat effectively children with sexual behavior problems and to protect other children from child on child sexual abuse. (See *1995 Task Force on Juvenile Sex Offenders and Victims of Juvenile Sex Offense and Crimes*) This terminology should be avoided unless criminally proven and the child is assessed and a professional determination is made that

the child poses a risk to society. Research has proven that the significant majority of children with sexual behavior problems do not become adult sex offenders or predators; those who receive proper and timely assessment and treatment have an even lower risk of future sexual behavior problems.

73. Many treatment and supervisory programs are labeled as “sex offender” programs, which creates a negative label for participants and an ongoing stigma as they are involved in the child welfare system and sometimes, as they continue into adulthood.

74. While this report focuses on children in care of the State, the Work Group recognizes and reinforces its belief that it is the primary responsibility of parents--natural, adoptive or foster—to educate their children on appropriate sexual activities, sexual boundaries, and the consequences of violating laws relating to sexual conduct.

Recommendations:

R49. The Children and Youth Cabinet should convene a workgroup to develop a uniform nomenclature for use by State agencies, including alternatives to negative terms such as “sex offender, sex abuser, predator” when describing sexual behavior problems. Such nomenclature must be institutionalized throughout the social service and criminal justice systems, and, especially in child welfare, the Department of Children and Families and partner agency staff must be educated on the impact of labeling and alternatives to describe behaviors.

R50. The Department of Children and Families and its law enforcement partners should examine the current criteria for defining sexual behavior problems according to inequality, force, and aggression to determine if these criteria are adequate, consistently applied, and beneficial in determining criminal behavior versus a sexual behavior problem.

R51. The Legislature should conduct a special study regarding the impact of the current law on children participating in treatment programs as victims or with sexual behavior problems.

R52. While certification of therapists who treat children with sexual behavior problems should continue to be required, the title “Certified Juvenile Sex Offender Therapist” should be re-examined or changed to avoid labeling young children with sexual behavior problems in order to receive appropriate services

R53. The Department of Children and Families working with its Community Based Care lead agencies should ensure that all of its training for foster and adoptive parents includes a component on the responsibility of such parents to educate their children on appropriate sexual activities, sexual boundaries, and the consequences of violating laws relating to sexual conduct.

Issue: Identification, Screening, and Assessment of Behavior

The current child welfare system reacts after a child-on-child sexual behavior incident has occurred. The system should instead identify at-risk youths upon entry into state care or as soon as possible after the child is involved in an incident that should give rise to concern. Whether it is via a Comprehensive Behavioral Health Assessment (CBHA) or other event, children identified as potentially at risk must be screened, assessed, and then provided appropriate treatment. Failure to immediately and appropriately assess and treat children increases the likelihood of reoccurrence of the behavior and therefore places other children at risk. Child welfare personnel must also be aware of ancillary issues, such as suicide ideation and acting out, that signal the need for treatment or other care.

The Comprehensive Behavioral Health Assessment (CBHA) is a psycho-social assessment that allows a comprehensive look at a child's behavioral health needs. Required within 30 days in all shelter cases and allowed under other circumstances, the purpose of the Comprehensive Behavioral Health Assessment is to integrate and interpret existing information and provide functional information to decision-makers in determining:

- The most appropriate out-of-home placement;
- Intervention strategies to accomplish family preservation, reunification, or re-entry and permanency planning; and
- Comprehensive service plans and behavioral health services that, when indicated, are incorporated into the child's case plan.

Comprehensive Behavioral Health Assessments must be performed by a licensed mental health practitioner or under the supervision of such a practitioner. Each must include direct observation of the child in multiple settings: home, school, and community. Children who are enrolled in Medicaid who meet specific criteria may have a CBHA performed once a year, and a CBHA may be requested when a child faces significant changes in his life or environment.

It is clear to this Work Group that all children in out-of-home care should receive a Comprehensive Behavioral Health Assessment in a timely manner. CBHAs often provide indicators of sexual behavior problems which must be screened and if appropriate, lead to more detailed psychosexual evaluations. CBHAs must be used to identify areas for further evaluation. This screening and follow-up for sexual behavior problems will help prevent reoccurrence of behavioral issues and identify victims who require specialty care. Individuals completing the CBHA must be trained in identifying sexual behavior problems and indicators of victims of sexual behavior problems. Certification of assessors in sexual behavior problems is a demonstrated need in this report.

Findings:

75. The goal of the Department of Children and Families is that all children entering out-of-home care are provided a Comprehensive Behavioral Health Assessment (CBHA). Testimony before this Work Group, however, indicated that not every child in foster care

is eligible for a Medicaid-reimbursed CBHA and, for that and other reasons, not all children receive a Comprehensive Behavioral Health Assessment upon entry into care.

76. Children currently entering State care who do not always receive Comprehensive Behavioral Health Assessments include children who are not Medicaid eligible (primarily immigrant children); children who do not enter via or remain in "shelter status" long enough for a CBHA to be ordered; and children who are placed in unlicensed settings (relative or non-relative placements).

77. While often used early in a foster child's involvement with the Department of Children and Families, the Comprehensive Behavioral Health Assessment is not used on a regular basis to indicate progress of the child within the system unless there are clear emotional disturbances and a follow-up is requested.

78. While subsequent CBHAs may be performed in certain circumstances, this Work Group received no evidence that CBHAs or other more targeted assessments are routinely ordered for all children whose behaviors are deteriorating and whose emotional needs are escalating.

79. Case plans often show a gap between those services identified in the CBHA and those reflected in the child's case plan.

80. Children's records often reflect a gap between services identified in the CBHA and included in the case plan and those actually being provided to the child.

81. There is insufficient follow-up if the CBHA suggests sexual behavior problems.

82. The Agency for Health Care Administration does not pay for specialized assessments and/or treatment of children with sexual behavior problems.

83. Psychosexual assessments are not uniformly available statewide, consistently administered, or consistently provided by a qualified professional certified in working with children with sexual behavior problems.

84. The correlation between suicidal thoughts or acts and prior sexual abuse often goes unrecognized.

85. Prevention efforts for at-risk children are inadequate.

86. Efforts at prevention of child on child sexual abuse and sexual behavior problems must be viewed as an investment in Florida's future.

87. The mental health treatment system is diagnosis driven, as a result of administrative requirements established by Medicaid, other State programs, and private payors, making it difficult to obtain services without a diagnosis.

88. The Children's Mental Health Program Office is not staffed to be involved in the

oversight of CBHAs, in training related to CBHAs, or in any review process to ensure that the results of CBHAs are utilized in the further treatment of a child.

89. Children often do not receive needed services if Medicaid funding is not available.

Recommendations:

R54. The Legislature should allocate sufficient funding to provide Comprehensive Behavioral Health Assessments (CBHA) to children who are not eligible to have CBHAs paid for by Medicaid.

R55. The Department of Children and Families should require its lead agencies to ensure multi-disciplinary staffings are conducted for all children with complex needs and for those who remain in care for longer than eighteen months.

R56. The Department of Children and Families should require its lead agencies to develop and implement a process to determine, at least once a year, whether each child in State care for more than eighteen months would benefit from an updated psychological or behavioral health assessment; provide that assessment; and provide the services recommended therein. The services recommended in the assessment should be added to the child's case plan.

R57. The Department of Children and Families should require its lead agencies to ensure that all children entering the child welfare system receive a Comprehensive Behavioral Health Assessment.

R58. The Department of Children and Families should require each lead agency to ensure that the Comprehensive Behavioral Health Assessment is always made available to the prescriber of psychotropic medications prior to the prescribing of psychotropic medications for the child.

R59. The Department of Children and Families, working with its lead agencies, should develop and monitor quality assurance standards to ensure the implementation of recommendations contained in the Comprehensive Behavioral Health Assessments.

R60. All Comprehensive Behavioral Health Assessments should include screening for indications of sexual behavior problems and follow-up should be mandated and tracked as a matter of record in the child's medical record.

R61. The Department of Children and Families and the Agency for Health Care Administration in concert should ensure sufficient, available, and readily accessible funding for specialized screening, assessment, or care involving children with sexual behavior problems and/or sexual abuse victims.

R62. The Agency for Health Care Administration should examine the feasibility of funding specialized assessments for sexual behavior problems.

R63. The Department of Children and Families should inventory existing psychosexual assessments and determine which are evidence-based and optimum for use statewide.

R64. The Department of Children and Families should work with the Office of Suicide Prevention in the Governor's Office to prioritize education and training about the signs of suicide and appropriate response for all case workers, partner agencies, and families with a child displaying sexual behavior problems.

R65. The Department of Children and Families should prioritize prevention efforts and identification of at-risk children with appropriate follow-up.

R66. The Department of Children and Families, in partnership with the Agency for Health Care Administration and the Community Based Care lead agencies, should ensure that needed services are provided in a timely manner regardless of the availability of Medicaid funding.

R67. The Department of Children and Families should work with the Agency for Health Care Administration and other appropriate State agencies to develop services that may be delivered without a diagnosis.

R68. The Department of Health should request the Legislature to amend Section 39.303 (2), F.S., to include allegations of child on child sexual abuse as required referrals to child protection teams.

R69. Interagency agreements should optimize the capability of child protection teams to identify and to assist in providing treatment services.

Issue: Trauma Informed Care

Trauma must be presumed for all children in State care by virtue of the fact that something serious enough has occurred in their lives to warrant removal from the care of their parents. All trauma impacts the child's well-being and can result in significant changes to a child's brain that will affect his/her ability to relate to people and effectively handle situations. Children who experience trauma are at increased risk of being the victims of sexual exploitation and, to some extent, of displaying sexual behavior problems. Florida's system of care is not trauma sensitive and, in fact, institutionalizes trauma-causing practices.

Trauma informed care, then, is a new initiative for the Department of Children and Families and our partners and focuses on five key issues:

- Trauma awareness

- Emphasis on safety
- Provision of opportunities to rebuild power and control
- A strength based approach
- Research-based treatment interventions to address trauma and trauma-informed care practices to avoid retraumatization

Significantly, this approach uses a comprehensive assessment of the child's traumatic experiences and their impact on his/her development, behavior, and relationships to guide treatment and the provision of services. Equally important, it emphasizes the need to provide education, support, and guidance to the child's family and caregivers.

Findings:

90. Victim services and follow-up for victims of sexual abuse are inadequate.

91. Trauma informed care is a new initiative for Florida. The principles of trauma informed care are not currently integrated into the work of all child-serving agencies, including the Department of Children and Families and its Community Based Care partners.

92. Children who have been sexually abused have experienced trauma; their care must be trauma related or informed.

93. Child victims of sexual abuse often do not disclose involvement for years. Many children recant or deny being victimized even though strong evidence supports the allegation.

94. Children experiencing multiple out of home placements are often re-traumatized with each move by the child welfare system.

95. The child welfare system has numerous built-in trauma inducing events, such as changes of placement, caseworker, and therapist, yet has no built-in mechanism to prevent or mitigate such trauma.

Recommendations:

R70. The Office of Attorney General should expand its efforts to work with the State's child welfare system to educate child welfare personnel and victims about available services and resources.

R71. The Department of Children and Families should prioritize the trauma informed care initiative statewide, emphasizing child-on-child sexual behavior problems in the child welfare population.

R72. The Department and its Community Based Care partners should integrate trauma informed practice in all programs, services and training provided to foster parents, adoptive parents, relatives, caregivers, and all child welfare personnel.

R73. All state human service agencies should train and educate staff regarding early identification of potential child sexual abuse victims in the child welfare system and the impact of trauma on children, recognition of signs of trauma, recantation or denial of abuse, and proper response and referrals.

R74. The Department of Education should work with local school systems to provide mandatory training on the impact of trauma on children, recognition of signs of trauma, recantation or denial of abuse and proper response and referrals.

R75. The Criminal Justice Standards and Training Commission should require mandatory training of all law enforcement, correctional and corrections probation personnel on the impact of trauma on children, recognition of signs of trauma, recantation or denial of abuse, and proper response and referrals.

R76. The Department of Juvenile Justice should require mandatory training of all personnel on the impact of trauma on children, recognition of signs of trauma, recantation or denial of abuse, and proper response and referrals.

R77. The Office of the State Courts Administrator should require mandatory training of all judicial personnel on the impact of trauma on children, recognition of signs of trauma, recantation or denial of abuse, and proper response and referrals.

R78. The Department of Children and Families should revise the procedures that govern the change of placement for all children in State care to ensure that all reasonable efforts are made in a timely manner to safely maintain the child's current placement, that changes occur only when absolutely necessary, and that all persons involved with the child participate in facilitating a smooth transition to minimize trauma to the child. Appropriate interventions and assistance must be made available from the onset.

Issue: Training, Certification, and Competency of Professionals

Prevention and treatment of sexual behavior problems is a specialty requiring training, certification, and competency in a specific field. Too often, treatment specialists have not received this training, are not certified, and lack competence to identify, screen, assess, and treat our children who are at risk or who are involved in a child-on-child sexual behavior problem. As the Work Group heard in presentations before it, there are a variety of treatment issues related to children with sexual behavior problems:

- Lack of specialized treatment providers
- Most treatment providers only address the symptoms and fail to address trauma and victim issues

- Many children with sexual behavior problems are frequently misdiagnosed by mental health professionals
- Diversity within the ranks of counseling professionals is a problem. Male counselors and counselors of color are significantly underrepresented.
- Specialized treatment standards do not exist for Statewide Inpatient Psychiatric Program (SIPP) facilities that treat children with sexual behavior problems
- There is a scarcity of services and providers for children with cognitive impairments

Effective treatment of both victims and children displaying sexual behavior problems is, of course, critical. As a presentation concerning the results of the 2005 Task Force on Juvenile Offenders and Their Victims noted:

Juveniles who sexually offend are generally treatment responsive. The overall sex offense recidivism rate for juveniles is relatively low, usually between 5% and 15%. Juveniles who successfully complete sexual offender treatment have been found to have a lower recidivism rate than their untreated counterparts.

Findings:

96. Many providers of sexual abuse education and/or treatment are not certified and are often inadequately trained.
97. State law (491.0144, F. S.) specifies who may hold themselves out as a certified juvenile sex offender therapist. That law is not enforced by any government agency. The certification requirements also do not appropriately and sufficiently address issues related to young children and children in foster care.
98. Existing certification requirements do not appropriately and sufficiently address sexual behavior problems in young children and children in the care and custody of the State.
99. Many children are not properly diagnosed during their assessment due to lack of expertise and certification of professionals involved in assessing sexual abuse or sexual behavior problems.
100. There is inadequate understanding about age appropriate sexual behavior and sexual behavior problems.
101. Education and training about sexual behavior problems are not multi-disciplinary.
102. Effective treatment must be both stable and of sufficient duration to have the necessary impact on a child's behavior.

Recommendations:

R79. The Department of Children and Families, in conjunction with the Agency for Health Care Administration, should develop certification requirements for providers of sexual abuse education and/or treatment.

R80. The Department of Children and Families should work with the Department of Business and Professional Regulation and Certification Board to establish a certification for professionals who assess and treat victims of sexual abuse and children with sexual behavior problems.

R81. The Department of Children and Families should require that affected children in State care receive services from professionals who have been certified to assess and treat victims of sexual abuse and children with sexual behavior problems.

R82. The Department of Children and Families in partnership with its Community Based Care lead agencies should provide education and training about age appropriate sexual behavior to all child welfare personnel and caregivers.

Issue: Ensuring Best Practices

In its initial report on psychotropic medications, this Work Group identified nine principles which should guide the delivery of services to children within the child welfare system and lead to the identification of best practices for protecting these children. These principles are just as applicable in ensuring the protection of children who are victims of sexual abuse or who demonstrate sexual behavior problems.

During the course of its hearings and deliberations, the Work Group heard from a number of programs and projects which, upon adequate evaluation, offer best practices for replication throughout the State. The Work Group commends such exemplary practices and the initiative displayed by those responsible for their implementation.

Findings:

103. There appears to be no consistent method within the child welfare system to identify, evaluate, and promulgate best practices on a statewide basis.

104. The results of the efforts of the Neighbor to Family Program in dealing with siblings in out-of-home care and reducing the impact of sibling separation offers a best practice that should be further studied and, if appropriate, replicated.

105. The Sexual Abuse Intervention Network (SAIN), currently engaged in Hillsborough and Broward Counties, is a best practice which should be funded by the State or locally in other major counties.

106. The Child-on-Child Sexual Abuse Prevention Task Force is currently operational in the Department of Children and Families Northeast and Suncoast Regions and is a best practice which should be replicated in other counties. The Task Force is a multidisciplinary group that focuses on prevention, training, and intervention/treatment and has been effective in reducing the prevalence of child on child sexual abuse in the areas served.

107. The Trauma Recovery Initiative, funded by a grant from the U.S. Department of Health and Human Services, offers a model for service delivery and community engagement which, upon its completion, should be replicated in other areas of the State.

Recommendations:

R83. The Department of Children and Families, working with appropriate federal, state, and private sector funding sources and with public and private research institutions or entities, should identify model programs and practices for implementation, replication, and evaluation.

R84. The Department should establish an on-going informational mechanism to promulgate best practices and innovative programs throughout the child welfare system.