Florida Department of Children and Families

Child on Child Sexual Abuse Needs Assessment - White Paper

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EXECUTIVE SUMMARY

Cases involving children engaged in sexual assaults against other children are of growing concern in Florida. Research indicates that sexual assaults of children under the age of 12 are most commonly committed by adolescents who are 14 years of age (Chaffin, 2008). The sexual victimization of these youths puts them at greater risk for a multitude of anti-social behaviors including sexualized behaviors (Browne & Finkelhor, 1986; Paolucci et al., 2001). Tragic events, such as the Gabriel Myers case involving a 7-year old boy who had previously been sexually assaulted by another child and later ended his own life, underscore the importance of understanding and addressing childhood sexual behavior problems. In addition, results from the Adverse Childhood Experiences (ACE) Study conducted by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente, involving more than 17,000 study participants, found that childhood maltreatment dramatically increased the risk for heart disease, cancer, diabetes, and several other major illnesses later in life (Dube, Anda, Whitfield, Brown, Felitti, Dong, & Giles, 2005). In an effort to understand and effectively address sexual abuse among children, the Florida Department of Children and Families (DCF) has funded a Needs Assessment to examine the breadth and scope of these abuse cases, including an assessment of the factors relating to the context, frequency, impact, treatment, effects and recovery from such abuse.

The state of Florida has defined these incidents as child-on-child sexual abuse (COCSA). Various terms are used to refer to the children involved in these incidents including, for example, alleged juvenile sex offenders, sex offenders, abusers, perpetrators, sexually reactive children, children with sexual behavior problems, victims, and alleged victims. In an effort to avoid confusion with legal definitions of sexual offending and given the complex nature of COCSA cases, youth engaging in these activities are referred to here as children with sexual behavior problems (SBP). Children victimized in these cases are referred to here as alleged victims.[1]

Understanding the children involved in incidents of child-on-child sexual abuse is critical to effective prevention and intervention efforts. However, the causal pathways associated with perpetration and

[1] DCF Operating Procedure No. 175-88 utilizes the terminology "Alleged Juvenile Sexual Offender" to refer to children 12 years of age or younger who are alleged to have committed a violation of Chapter 794, Chapter 796, Chapter 800, s. 827.071, or s. 847.0133. Given that many of these transgressions do not constitute criminal sexual offending and may be more indicative of inappropriate sexual behaviors, it was determined that the term, Children with Sexual Behavior Problems, would be used here to refer to children engaging in such behaviors. This terminology is in congruence with the Association for the Treatment of Sexual Abusers (ATSA) Task Force on Children with Sexual Behavior Problems (Chaffin et al, 2008).

victimization are complex. Some studies have suggested that a pattern of juvenile sexual offending at an early age may serve as a precursor to later victimization and/or offending (Abel et al., 1987; Hunter and Figueredo, 2000; Knight and Prentky, 1993). Others have found that prior peer sexual victimization does not increase the likelihood for later sexual abuse (Maker, Kemmelmeier and Peterson, 2001). For example, a recent examination of a historical official data set found no increased likelihood for adult *sexual offending* among a cohort of juvenile sex offenders (Zimring et al., 2009). These complex factors can inhibit child welfare and protection efforts in providing appropriate services and establishing state policies that would mitigate current or future incidents of child-on-child sexual abuse. Those efforts may be limited to treating diagnosed risk factors as opposed to the actual underlying causes.

The current paper is intended to provide an overview of COCSA cases in the State of Florida. Such abuse can encompass various age-ranges (early childhood, preteen, and teenage years) and legal/official categorizations (juvenile sex offender, child sexual behavior, dependent child, etc.). While teens engaging in child-on-child sexual behaviors and juvenile sex offenders are generally discussed here, the emphasis is on sexual abuse and sexual behavior problems among children under the age of twelve. This group represents the primary child-on-child sexual abuse service population of the Florida Department of Children and Families.

This paper represents the Justice Research Center's (JRC) final report for the Florida Department of Children and Families, Child-on-Child Sexual Abuse Needs Assessment. The JRC served in the capacity of sub-contractor to the Florida Department of Children and Families (DCF) and provided research and evaluation services associated with the Child-on Child Sexual Abuse Needs Assessment.

The Child-on Child Sexual Abuse Needs Assessment incorporated official data in conjunction with quantitative and qualitative data solicited from DCF child protective investigators (CPI) and treatment providers. The aim of this assessment was to investigate the following seven research questions regarding child-on-child sexual abuse in the State of Florida:

1. What is the extent and nature of child-on-child sexual abuse in the Florida child welfare system?
2. What are the risk factors and characteristics of child-on-child sexual abuse (both alleged victims and children with sexual behavior problems)?
3. What are the needs of alleged victims and children with SBP involved in child-on-child sexual abuse?
4. What treatment interventions and policies need to be in place to adequately serve this population?
5. Are services currently offered to this population in Florida meeting their needs?

6. What changes, if any, need to occur to facilitate effective service delivery to this population?
7. Are there any gaps and/or barriers to effective service delivery to this population?

In order to investigate the above research questions several methodologies were employed. Official data were gathered from the Florida Abuse Hotline Information System[2] (FAHIS) to assess the extent of child-on-child sexual abuse and to conduct a trend analysis of calls made to the Abuse Hotline from FY 2003-04 to FY 2008-09. In order to assess the various types of treatment currently utilized and whether there are any gaps or barriers to providing services to alleged victims of child-on-child sexual abuse and children with sexual behavior problems, additional empirical data were collected. Data sources included focus groups with stakeholders and COCSA case file reviews. Finally, JRC researchers administered two online self-report surveys to treatment providers and CPIs involved in investigating or providing services to COCSA victims and children with sexual behavior problems. The purpose of the online surveys was to solicit feedback from around the state and to triangulate the information gathered in the focus groups on a wider scale.

Prior to engaging in data collection and analysis for the current study, a thorough literature review was conducted. In addition to identifying key characteristics and risk factors associated with child-on-child sexual abuse cases, recent meta-analytic research has documented that children with sexual behavior problems and juvenile sex offenders have relatively *low* future sex offending rates (2% to 15%) (Chaffin, 2008; Chaffin et al., 2008; Carpentier, Silovsky, & Chaffin, 2006). While these findings may seem counterintuitive juxtaposed against adult sex offenders who report childhood onset of their sexual aggression, recent longitudinal studies suggest that childhood sexual behavior problems, and even juvenile sex offending, do not significantly predispose one to engage in adult sex offenses (Carpentier et al., 2006; Zimring, Jennings, Piquero, & Hays, 2009). Furthermore, when children with sexual behavior problems received cognitive behavioral interventions (CBT), they had roughly comparable rates of future sex offenses (2%) compared to clinical comparison groups (3%) (Carpentier et al., 2006). These results have led Chaffin and colleagues (2008) to conclude that, "risk for future sexual offenses can be reduced to baseline levels with appropriate short-term treatment" (p.207).

Summary results of the research findings are presented in the following areas: 1) extent and nature of child-on-child sexual abuse, 2) risk factors and characteristics of children engaging in COCSA, 3) risk factors

[2] Additional information on the Florida Abuse Hotline can be found at http://www.dcf.state.fl.us/abuse/.

and characteristics of COCSA victims, 4) case referral process and Florida Abuse Hotline calls, 5) assessing child-on-child sexual, 6) treatment services for children involved in child-on-child sexual abuse, and 7) barriers to effective training and service interventions in cases involving child-on-child sexual abuse.

Extent and Nature of Child-on-Child Sexual Abuse in the Florida Child Welfare System

- The number of COCSA alleged victims and verified victims remained relatively stable between fiscal year (FY) 2003-04 and FY 2006-07. In FY 2003-04, the total number of alleged victims was 4,981 and in FY 2006-07 this figure was 4,566. There were a total of 799 verified victims in FY 2003-04 and 710 in FY 2006-07.
- When assessing the trends in reporting COCSA, calls to the Florida Abuse Hotline have moderately decreased since FY 2005-06 (3,488 COCSA-related calls in FY 2005-06; 3,261 calls in FY 2008-09).
- The number of alleged children with SBP consistently remains below the number of alleged COCSA victims (3,961 and 4,383 in FY 2008-09, respectively).
- COCSA alleged victims represented about 8 to 11 percent of all Abuse Report victims (these include those abused, neglected, threatened or harmed) over the last five years. Further, the percent of all COCSA referrals in which a victim was verified remained relatively constant between FY 2003-04 and FY 2006-07 (roughly 15-16% of all COCSA referrals).

Risk Factors and Characteristics of Children with Sexual Behavior Problems (SBP)

- The top three characteristics among all alleged children with SBP were: a history of physical/ emotional separation from a parent (38%), a history of instability in the family (30%), and a history of neglect (24%).
- Examining race differences, children with sexual behavior problems who were white, had a greater probability of having a history of sexual victimization compared to black children who engaged in child-on-child sexual abuse. Alternatively, blacks were significantly more likely to have a history of physical abuse, neglect, academic difficulties, and attribute blame to the victim, compared to white children engaging in these behaviors.
- Gender differences were also pronounced, with boys exhibiting an increased probability of having inadequate social skills, poor peer relationships, academic difficulties, and a history of impulse control problems, as compared to girls engaging in child-on-child sexual abuse. Girls, on the other hand, were much more likely to have a history of sexual victimization, neglect, and knowledge of advanced sexual practices compared to their male counterparts with sexual behavior problems.
- Younger alleged children with SBP (5 years and under) had an increased probability of having a history of instability in the home and a history of anxiety compared to older children who engaged in child-on-child sexual abuse. Older children (10 to 12 years) with sexual behavior problems tended to have an increased probability of having academic difficulties compared to their younger counterparts (aged 9 and younger).

Victim Risk Factors and Characteristics of Child-on-Child Sexual Abuse

- The top three characteristics among all alleged COCSA victims were: the alleged victim knew the alleged abuser (91%), the alleged victim was substantially younger than the abuser (27%), and more than one victim was involved (21%).
- White alleged COCSA victims had an increased probability of knowing the abuser, being bribed by the abuser, and being involved in elements of secrecy compared to black COCSA victims. Whereas, black alleged COCSA victims had a greater probability of being involved in incidents that were violent compared to white victims.
- Male victims had an increased probability of being substantially younger than their alleged abusers, being involved in a violent incident, and having elements involving secrecy compared to female victims.
- Younger alleged COCSA victims (5 and under) had an increased probability of knowing their abuser and being substantially younger than their abuser compared to older victims.
- Alleged COCSA victims, 6 through 12 years of age, had an increased probability of experiencing coercion compared to younger alleged COCSA victims (5 and younger).
- COCSA victims between the ages of 10 and 12 years of age had an increased probability of being a victim when there were multiple victims referenced and when there was a history of non-sexual aggravated assault, compared to younger victims.

Case Referral Process and Florida Abuse Hotline Calls

- Overall, there was no standard identification process for children with SBP and victims of COCSA. The State has been proactive in not identifying children with SBP under the age of 12 as verified perpetrators or offenders. As such, reports of children with SBP were not *founded* or *verified*, and in some cases there was no clear determination as to the initiator in the incident, only identifications of children in need of treatment.
- Survey and focus group data indicated that referrals for COCSA were most often received through the Florida Abuse Hotline.
- Both case file reviews and survey data suggested that fondling and sexual behavior experimentation were more common than more serious forms of abuse.
- Survey data found that COCSA incidents most often take place in the child's primary home. Respondents least often reported that the abuse occurred in a school or daycare.

Assessing Child-On-Child Sexual Abuse in Florida

- According to survey and focus group data, the most widely used assessment instrument was the Florida DCF Child-On-Child Sexual Abuse Assessment. The Juvenile Sex Offender Assessment Protocol-II was reported as the second most often used assessment.

- Respondents felt that the Child-On-Child Sexual Abuse Assessment should read "alleged victim" and "alleged offender" rather than "victim" and "offender," because the information has not been substantiated and the true victim and child with SBP cannot be identified until the case has been investigated.

Treatment Services for Children with Sexual Behavior Problems

- Survey data from treatment providers indicated that program goals, philosophy and approaches to treatment were relatively consistent with having a holistic service approach for children involved in COCSA cases.
- While Florida treatment providers offer a wide array of services to children involved in child-on-child sexual abuse, a comparison of the types of services received by victims and children with SBP showed little variation between how children engaging in these behaviors are treated compared to those who are victims.
- Most often treatment providers utilized individual counseling therapy followed by outpatient services for children engaging in or victimized by child-on-child sexual abuse.
- The majority of the treatment providers believed that treatments were tailored to the needs and problems of children with SBP and victims.
- Respondents reported that very young children and/or children with emotional or developmental problems are the most challenging to treat.
- Overwhelmingly, respondents felt that there were not enough services available for children engaging in these behaviors and, when available, the services were too expensive and too difficult to access.
- The majority of the respondents thought that victims were being served effectively through community resources.

Training and Service Barriers in Treating Children Involved in Child-On-Child Sexual Abuse

- Child protective investigators reported that they received a short pre-service training on child-on-child sexual abuse.
- Treatment providers who deal with COCSA cases frequently had more training and expertise in handling these cases than child protective investigators.
- Investigators reported that the pre-service training on child-on-child sexual abuse could be improved by having more in-depth trainings and by focusing on investigating COCSA. Additionally, they reported that booster trainings could help advance knowledge in this area.
- The majority of the respondents thought that there was no general agreement about what constitutes normal sexual behavior and that this needed to be clearly defined and disseminated.
- Overwhelmingly, treatment providers and investigative respondents indicated that there was a need for COCSA training across social service agencies and within the community.

The following recommendations are synthesized from the study results and offered to the Florida Department of Children and Families to facilitate effective service delivery to children involved in child-on-child sexual abuse:

- The number of Florida Hotline calls involving COCSA cases has generally declined. The current investigation found that COCSA is not a pandemic problem across Florida compared to other cases of abuse, neglect and abandonment. The dissemination of this report may help reduce fear and anxiety among child advocates about the number of COCSA cases being reported to the Department.
- The DCF information system should track whether COCSA cases are verified after the investigation is complete to differentiate confirmed from alleged cases. This does not mean that youth engaging in these behaviors should be labeled as sexual offenders. Rather, these cases could be recorded as a verified case of a child with sexual behavior problems. In addition, victims of COCSA should be investigated, verified, and this information should then been uniformly tracked in the DCF information system. Verification is essential as research has demonstrated that victims who are left untreated may become involved in future victimizations.
- Given empirical outcomes demonstrating low rates of future sexual offending by children with sexual behavior problems, as well as the documented need to address these problems early in the life course, it is recommended that the Department revisit issues related to age restrictions. Cases where the child with SBP is over the age of 12 are being directly referred to law enforcement and the local State Attorney's office. Investigations of these cases should be standardized across the State. Having multiple department investigations may not be the most effective way to gather and elicit information from alleged children with SBP, victims, and their families. Additionally, there are issues related to emotional maturity and cognitive functioning that dictate the need for exceptions to the rule. Finally, there is concern over those cases where the State Attorney's Office declines to prosecute, but the child is still in need of services to address their sexual behavior problems. These youth should be tracked to ensure that children engaging in behaviors that do not warrant prosecution but nonetheless may be indicative of sexual behavior problems, do not go untreated.
- Child protective investigators overwhelmingly asked for more training in investigating COCSA. Comprehensive training and booster sessions should be provided to DCF employees and providers to ensure effective identification, investigation and intervention in cases of COCSA.
- The main assessment used, the Florida DCF Child-On-Child Sexual Abuse Assessment, should be revised to accurately reflect the status of children *allegedly* engaging in child-on-child sexual abuse, as well as *alleged* victims of COCSA. DCF primarily handles children who are not prosecuted for sexual offending and who likely will not go onto to engage in such behavior. As such, it is recommended that children engaging in child-on-child sexual abuse should be referred to as children with sexual behavior problems (SBP), as opposed to offenders, perpetrators or abusers.
- Additional information should be solicited from CPIs (this is not identified yet) through focus groups and/or surveys to identify necessary changes to improve the Florida DCF Child-On-Child Abuse Assessment itself. Furthermore, the reliability and validity of the assessment instrument should be empirically verified.
- This investigation found that children who engage in child-on-child sexual abuse have a limited number of available treatment options. The Florida Department of Children and Families should

solicit additional funds to adequately address service gaps for these children. Treatments should be readily available through public options in addition to having an adequate number of services available through privately funded insurance.

- Individual counseling was the most reported treatment option for children involved in COCSA cases. The research suggests that this may not be enough. A number of evidence-based, cognitive behavioral interventions have been found to effective with this population including Trauma-Focused Cognitive Behavioral Therapy and Child Molester Treatments. In addition, Multi-Systemic Therapy (MST) and Parenting with Love and Limits (PLL) have demonstrated recent significant outcomes in reducing sexual behavior problems, delinquency, substance use, mental health symptoms, and out-of-home placements among youths who have engage in sexual offending. It is particularly critical that interventions include a strong family/caregiver component, as research indicates that cases with limited family/caregiver engagement have lower odds of successful outcomes than those engaging the caregivers in the treatment process.

- In order to appropriately serve children involved in COCSA cases, each circuit should document all available treatment options for these children so that this information is easily accessible and disseminated to appropriate referral agencies. Information regarding available treatment options also needs to be maintained in a web-based system so that it can be regularly updated. Availability of funding for these services as well as the acceptance of any specific insurance should be disseminated.

- Policies and protocols should be developed in Florida that clearly distinguish inappropriate sexual behavior from normal sexual behavior. All departments and agencies should be trained on these distinctions. Additionally, this information should be widely disseminated and made available to community members, schools, daycare centers and parents.

- Once the Department has had sufficient time to make appropriate changes, more research may be warranted in order to reassess the extent and nature of COCSA, characteristics and risk factors, the referral process, treatment outcomes, and barriers to training and service delivery.

PRIOR RESEARCH

In this section, an extensive literature review is presented on child-on-child sexual abuse characteristics and risk factors. This discussion includes characteristics and risk factors of children with sexual behavior problems in addition to research pertaining to sexual development and exploration, typologies, other contributing risk factors (prior sex abuse, environmental factors and personality disorder), and the risk of reoffending is explored. In addition to offender characteristics, the risk factors of victims of child-on-child sexual abuse are discussed in this section. The next section focuses on interventions for victims and offenders of child-on-child sexual abuse. This section includes: identification and assessments, assessment instruments, treatment interventions, and important aspects of treatment (comorbidity problems, parent and caregiver components, and treatment setting). After the review of the current research is discussed, the results of this investigation are presented.

Child-On-Child Sexual Abuse Characteristics and Risk Factors

Child-on-child sexual abuse involves children with sexual behavior problems and child victims. Children who engage in this type of abuse, as well as their victims, are diverse and not easily classified into typologies. Child-on-child sexual abuse may involve children of similar or divergent ages; may involve aggression, coercion or force; may involve harm or potential for harm; may occur frequently or infrequently; and may include minor or advanced sexual behaviors. As such, standard definitions of child-on-child sexual abuse are difficult to delineate and are variously used throughout the research literature resulting in differences in methodology and findings.

Depending upon local, state, and federal laws, children involved in this form of abuse may be considered a child with sexual behavior problems in need of child welfare services, may be legally defined as juvenile sex offenders or molesters, and/or may be permanently placed on a sex offender registry for involvement in such abuse.

Legal codifications based on age, as well as the nature of the sexual abuse, vary across jurisdictions and empirical studies. Most commonly, child molesters have been defined in the research as children who are more than five years older than their victim and who engage in any unwanted sexual acts with the victim (Browne and Finkelhor, 1986). Peer abusers are generally categorized as adolescent who sexually assault other peers who are within five years of their own age. In either of these types of cases, the child engaging in the sexual abuse may be legally processed, depending on jurisdictional laws and practices, by the juvenile or adult

criminal justice system as a sex offender. Likewise, the child may also receive services within the child welfare system. The latter setting and child-on-child sexual abuse are the focus of this review.

Characteristics and Risk Factors of Children with Sexual Behavior Problems

Children with sexual behavior problems (SBP) have been defined by Chaffin and his colleagues (2008) for the Association for the Treatment of Sexual Abusers (ATSA) as, "children ages 12 and younger who initiate behaviors involving sexual body parts (i.e., genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others" (p.200).

Childhood sexual behavior problems may involve behaviors that are self-focused or may involve other children. They may be relatively frequent or infrequent, may involve mutuality or coercion, or may occur during times of stress, anger, or frustration. Concern arises when sexual behavior problems involve substantial age or developmental inequalities between the perpetrator and the victim; more advanced sexual behaviors; use of aggression, force or coercion; and harm or potential for harm (Chaffin et al., 2008).

Children with significant sexual behavior problems should be distinguished from those who engage in sexual behaviors considered normal and age-appropriate. Several researchers have described differences between normal sexual development and inappropriate sexual behaviors (Beech, Craig and Browne, 2009; Phil, 2009; Chaffin et al., 2008).

Sexual Development and Exploration

Specifically, Rich (2009) states that sexual development and sex play are a normal and healthy process of progression into adulthood. Early in life, it is common for babies and toddlers to touch their own genitals. From ages 5 to 7 some sexual play may begin and this will last until puberty (8 or 9 years of age). Around age 10 to 12, youth begin to focus on social relationships within the family and school and they begin to experience sexual feelings. By adolescence, their body parts and sex organs are developing.

While some youth may engage in sexualized behaviors throughout their childhood, these behaviors become a concern when they are extensive, when they are unwanted by other children, when they suggest a preoccupation with non-consensual acts, and when they cannot stop their behavior once asked by a parent or guardian. There are likewise sexually reactive children, or those who have been exposed to inappropriate sexual activities and act out by virtue of their exposure.

Johnson (1999) lists signs of concern in children up to the age of 12. These include:

- Children should not be preoccupied with sexual play, and should not engage in many other forms of sexual play;
- Children should not engage in sexual play with much younger or much older children;
- Children should not have precocious knowledge of sex beyond their age;
- Children's sexual behaviors and interests should be similar to those of other same-age children;
- Children should not be "driven" to engage in sexual activities, and they should be able to stop when told to do so by an adult;
- Children's sexual play should not lead to complaints from or have a negative effect on other children, and should not cause physical or emotional discomfort to themselves or others;
- Children should not sexualize relationships, or see others as objects for sexual interactions;
- Children aged 4 and older should understand the rights and boundaries of other children in sexual play;
- Children should not experience fear, shame, or guilt in their sexual play;
- Children should not engage in adult-type sexual activities with other children;
- Children should not direct sexual behaviors toward older adolescents or adults;
- Children should not engage in sexual activities with animals;
- Children should not use sex to hurt others; and,
- Children should not use bribery, threats, or force to engage other children in sexual play.

Typologies

A number of typologies have been proposed for classifying youth who engage in risky sexual behavior (Berliner et al, 1986; Bonner et al., 1998; Graves et al., 1996; Hunter et al., 2003; Knight and Prentky, 1993; O'Brien and Bera, 1986; Weinrott, 1998; Worling, 2001). For example, Berliner and colleagues (1986) created a classification system of sexual problematic behaviors in children which outlines three types of sexually inappropriate behavior: precocious, inappropriate, and coercive sexual behaviors. Knight and Prentky (1993) included six categories of offenders including: rapists, child molesters, sexually reactive, fondlers, paraphilic offenders and unclassifiable. Paraphilic offenders are those who are sexually aroused by objects or situations that are not part of normative stimulation, and which can lead to distress or serious problems for the offender or those associated with the individual (APA DSM-IV, 1994). Most recently, Hunter and colleagues (2003)

identified three profiles in order to classify offenders over the life course: lifestyle persistent, adolescent onset/nonparaphilic, and early adolescent onset or paraphilic.

One problem noted with the use of these typologies is that they are often too complex and they are not mutually exclusive. In other words, categories or classifications may overlap extensively. For example, in Knight and Prentky's typology a fondler could also be considered sexually reactive. Studies have documented clusters of behaviors with distinct overlap, suggesting the lack of any clearly defined taxonomic subgroups (Bonner et al., 1999; Pithers et al., 1998; Chaffin et al., 2008).

As Chaffin and colleagues (2008) note, qualitatively different sexual behavior subtypes among children are not founded in the empirical research literature. Rather, children are found to have ranges of SBP in terms of severity and intensity. More intense ranges often include comorbid mental health, social and family problems (Hall, Mathews, Pearce, Sarlo-McGarvey, & Gavin, 1996; Chaffin et al., 2008).

Contributing Factors

Understanding and addressing the needs of children with sexual behavior problems requires ecological assessments of family, school, economic, social, and environmental contributing factors (Friedrick, Davies, Feher, & Wright, 2003; Friedrich et al., 2001). Research has consistently found that children who engage in sexual assaults of other children have themselves often been the victim of sexual abuse (Becker and Murphy, 1998). While past sexual victimization can increase the likelihood of sexually aggressive behavior, most children who are sexually abused do not engage in sexual offending. Furthermore, many children with sexual behavior problems present with no known history of sexual abuse. There are various pathways to childhood sexual behavior problems. Chaffin and his colleagues (2008) emphasize that "childhood SBP are sufficient to raise the question of sexual abuse but should not be considered sufficient, by themselves, to conclude that sexual abuse has occurred" (p.205).

Often however, caregivers, may erroneously conclude that child sexual behavior problems are caused by prior abuse and the absence of documented evidence of such abuse is itself indicative of serious problems. In such cases, they may continue to pursue such evidence to the detriment of the child. Sexual behavior, as is the case with any human behavior, arises from a number of complex and often intertwined causes (Chaffin et al., 2008). When evidence of prior sexual victimization is not definitive, the Association for the Treatment of Sexual Abusers Task Force recommends:

- Educating children about sexual abuse;

- Identifying who children might tell if they were abused;
- Identifying significant adults who can support this message; and
- Building support systems around the child (Chaffin et al., 2008).

In addition to prior sexual abuse, research has also identified family and environmental factors often found in the case histories of youth engaging in child-on-child sexual offending. For example, maltreatment and violence in the home, substandard parenting practices, neglect, exposure to sexually explicit media, and living in highly sexualized environments, are all contributing factors of child sex offending and sexual behavior problems that have been reported in the literature (Chaffin et al., 2008; Hunter and Figueredo, 2000; Maker, Kemmelmeier and Peterson, 2001; Small and Kerns 1993). Additionally, some personality characteristics such as: anxiety, aggression, depression, mental health, narcissism, pessimism, sexual dysfunction and self-sufficiency have been documented as common correlates of juvenile sexual offending (Hunter and Figueredo, 2000; Maker, Kemmelmeier and Peterson, 2001; Worling, 1995).

Patterns have also emerged within the literature concerning the various types of juvenile sex offenders in relation to their victims. Juvenile child molesters tend to be shy, socially awkward and have difficulties with peer relationships, while child peer sexual abuse offenders tend to be controlling, aggressive and have difficulty managing their anger (Richardson et al., 1988).

Additional factors may also distinguish children engaging in child-on-child sexual abuse including: age at time of first perpetration, number of victims, age of victim, gender of victim, relationship to victim, number of perpetrators, gender of perpetrators, fantasy prior to perpetration, and masturbation prior to perpetration (Hunter et al., 1993; Hunter, Hazelwood and Sledinger, 2000; Maker, Kemmelmeier and Peterson, 2001; Sperry and Gilbert, 2005; Worling, 1995).

Several personality traits have been identified as risk factors of child peer sex offending including: unpopular among peers, hostile, aggressive, low self esteem, adversarial sexual beliefs, rape-myth acceptance, and prior physical abuse as a child (Hunter et al., 1993; Hunter, Hazelwood and Sledinger, 2000; Maker, Kemmelmeier and Peterson, 2001; Sperry and Gilbert, 2005; Worling, 1995).

Youth who engage in sexually assaultive behaviors have frequently been diagnosed with other co-morbid behaviors such as:

- Defiant Disorder,
- Conduct Disorder,

- Substance abuse,
- Attention Deficit Hyperactivity Disorder (ADHD),
- Developmental disabilities,
- Learning disorders,
- Autism and Asperger's Syndrome,
- Bipolar disorders,
- Reactive Attachment Disorder,
- Posttraumatic Stress Disorder, and
- Biological deficits (see Schwartz, 2009, pp. 5-12 for a brief synopsis).

While children engaging in child-on-child sexual offending may be diagnosed with other non-sexual behavioral problems, it is important that risk assessments be comprehensive in order to provide services for youth that treat the cause of the behavior rather than merely the symptoms. For example, youth who act out may be diagnosed with Reactive Attachment Disorder because they have been a victim of sexual abuse. Establishing the chronological order of factors potentially contributing to childhood sexual behavior problems is an important component to effectively addressing child-on-child sexual abuse. These issues are discussed further within the assessment section of this review.

The co-morbid behaviors noted above are important to understanding factors that may be simultaneously involved in cases of child-on-child sexual abuse. Schwartz and colleagues (2006) recently outlined a distinct set of risk factors that may be helpful in identifying sexually aggressive youth. In their comprehensive analysis of 813 sexually abusive juveniles in Massachusetts, they found that common risks among juvenile sex offenders included a the mother's history of pregnancy and birth complications (25%), mother's history of alcohol abuse during pregnancy (15%), mother's history of drug abuse during pregnancy (20%), head trauma (14%), and an increased likelihood of attending special education classes. They also found that offenders were often characterized by instability within the home including: early age of placement in foster care (average age, 7 years), early placement in a residential facility (average age, 11 years), numerous home placements (5 times on average), and a large number of total changes in the living situation (10 times on average).

Like other studies, the Schwartz and colleagues documented that offenders themselves were likely to have suffered from prior abuse. Such abuse included neglect (93%), psychological abuse (49%), and sexual abuse (81% females, 63% males). Female offenders were more likely to be the victim of neglect, have an earlier age

at onset, and to have witnessed sexual deviance (42% females, 31% males) and domestic violence (84% females, 73% males), in comparison to their male counterparts. Girls were also more likely than boys to be abused for a longer duration and have a greater number of perpetrators (Schwartz et al., 2006: 70-71).

Risk to Re-Offend

It has been repeatedly documented through robust empirical evidence that children with sexual behavior problems and juvenile sex offenders have relatively low future sex offending rates (2% to 15%) (Chaffin, 2008; Chaffin et al., 2008; Carpentier, Silovsky, & Chaffin, 2006). While these findings may seem counterintuitive juxtaposed against adult sex offenders who report childhood onset of their sexual aggression, recent longitudinal studies suggest that childhood sexual behavioral problems and even juvenile sex offending does not significantly predispose one to engage in adult sex offenses (Carpentier et al., 2006; Zimring, Jennings, Piquero, & Hays, 2009).

Although relapse and recidivism among these populations is relatively rare, it is possible to identify risk factors that increase the likelihood for re-offending. Comprehensive meta-analytic studies have yielded a number of risk factors associated with recidivism among juvenile sex offenders. Roberts and colleagues (2002) identified two risk factor domains: sexual deviance and antisocial activity. These domains have also been used in other meta-analyses (See Hanson and Bussiére, 1998; McCann and Lussier, 2008).

McCann and Lussier (2008) conducted a meta-analysis and uncovered forty-eight risk factors associated with sexual deviance, antisocial activity and reoffending in juvenile sex offenders. Their meta-analysis included eighteen studies and a total of 3,189 sex offenders (McCann and Lussier, 2008:369). Risk factors were classified into the following categories: criminal history, index offense characteristics, victim characteristics, psychological/personality characteristics, behavioral factors, and cognitive emotional characteristics.

After excluding studies that were not inclusive of these categories, there were a total of fifteen risk factors derived from the five remaining studies (McCann and Lussier, 2008:369-371). Of those risk factors (15), seven were positively associated with sexual recidivism of juvenile offenders:

- Stranger victim,
- Child or adult victim (as opposed to peer victim),
- Threats/weapon used,
- Prior sexual offenses,

- Male victim,
- Intake age (older offenders), and
- Prior nonsexual offenses (McCann and Lussier, 2008: 374).

When looking at sexual reoffending over the life span, one longitudinal study completed by Zimring and colleagues (2009) offered an analysis based on repeat juvenile offenders through age 26. The researchers utilized data from the Second Philadelphia Birth Cohort, which involved 13,160 boys and 14,000 girls followed from birth through young adulthood (age 26). The study sought to examine sex offenders' history and involvement in sexual offending over the life course. Zimring and colleagues (2009)., identified four major findings from their analysis:

- Through the first eight years of adulthood, only one in 10 of the male and female juvenile sex offenders had a subsequent sex-related offense.
- The overwhelming majority (92%) of the males in the cohort who had an adult sex offending record had no prior juvenile sex offense.
- Males with no prior sex offenses but five or more juvenile police contacts, were twice as likely to commit a sex crime in adulthood, as a juvenile sex offender with less than five total juvenile police contacts.
- Being a juvenile sex offender did not significantly increase the odds of becoming an adult sex offender, nor did it significantly increase the frequency of juvenile sex offending.

The authors concluded that the growing evidence of a lack of continuity in sexual offending over the life course from adolescence to adulthood, calls into question current sex offender registration and notification laws as they apply to juvenile sex offenders. This is particularly important in light of the significant collateral consequences of sex offender registries such as labeling, loss of employment, harm to interpersonal relationships, and harassment (Zimring et al., 2009).

In summary, the literature on children who engage in child-on-child sexual abuse and juvenile sex offending suggests that they are subject to a wide range of negative personality traits, problem behaviors and have a history of instability within the family. Evidence to date suggests that there are differences among offender types (child molester versus child peer sexual offenders), as well as gender differences in the characteristics and risk factors of offenders. Recent meta-analysis research has identified important factors positively associated with sexual recidivism of juvenile offenders including: victims who were strangers, children, or males; use of threats and/or weapons, prior history of sexual offending; early age at intake; and a history of prior non-sexual criminal offending.

Victim Characteristics and Risk Factors

Victims are overwhelmingly more likely to be females (Hunter and Figueredo, 2000). Victims of juvenile sexual abuse over both the short term and long term often exhibit symptoms of depression, Post-Traumatic Stress Disorder (PTSD), and sexualized acting out behaviors (Browne and Finkelhor, 1986; Paolucci et al., 2001). Other short term effects include low self-esteem, anxiety, guilt, depression, anger and hostility (Bietchman et al, 1991; Browne and Finkelhor, 1986). Additionally, other indicators may include suicidal ideation, running away, truancy, alcohol and drug abuse, and sexual promiscuity (Bietchman et al, 1991). Long term effects of victimization can include self destructive behaviors, feelings of isolation, poor self-esteem, difficulty trusting others and re-victimization (Briere and Elliot, 1994; Browne and Finkelhor, 1986; Hunter and Figueredo, 2000).

In those studies that examine the difference between child molester victims and child peer sexual abuse victims, researchers found that child molester victims were more likely to have suffered from severe abuse experiences than those experienced by child peer victims (Sperry and Gilbert, 2005:896). Child molester victims were also more likely to be abused by family members or strangers and the incident was more likely to take place at school or at a relative's home; whereas child peer sexual abuse victims were more likely to be abused by a boyfriend or girlfriend, a cousin or a friend (Shaw et al., 2000; Sperry and Gilbert, 2005).

Other differences have been noted by Sperry and Gilbert (2005). They reported that victims of child peer sexual abuse often experienced less intrusive types of abuse (exposing sex organs, touching sexual organs, etc), and had higher levels of psychopathy, psychasthenia and schizophrenia (2005:899).

Carpenter and colleagues (2009) found that victims of child abuse were likely to score higher on Schizoid, Avoidant and Depression scales compared to their peer group. No differences were found however concerning race, sexual abuse history, history of child maltreatment, parent measures, perceptions of negativity and type of sexual abuse. Child peer sexual abuse victims were more likely however to have sexual concerns, sexual distress, and sexual preoccupations (Carpenter, Peed and Eastman, 2009; Shaw et al., 2000; Sperry and Gilbert, 2005). Overall, the primary conclusions from the studies were that victims are most often female and are likely to suffer from extensive mental health problems.

Interventions for Child-On-Child Sexual Abuse

This section discusses available assessments as well as treatment interventions for youth involved in child-on-child sexual abuse. Because offenders are often victims of sexual abuse, treatments and services inherently

coincide. Given that scientific inquiry into child sexual offending interventions is relatively new, some of the treatments outlined below may have been originally designed for adults and not fully validated for juvenile sex offenders or children with sexual behavior problems. The use and appropriateness of adult sex offender interventions will be discussed in more detail in the sections that follow.

Identification and Assessment

Comprehensive assessments of individuals are needed to facilitate treatment and intervention strategies. These include assessments of needs (psychological, social, cognitive and medical), family relationships, risk factors, and risk management possibilities (Righthand and Welch, 2001). It is important that parents and guardians are involved in the assessment and treatment process, to facilitate a more holistic approach and allow for the flexible modification of treatment schedules based on the youth and family's needs. Families and adolescents should be notified of confidentiality protocols and policies concerning the types of incidents that must be reported to authorities during the assessment process. Open dialogue is the key to uncovering youth/family risks and needs. The assessment is the cornerstone to effectively understanding family functioning and addressing child-on-child sexual abuse with appropriate services and interventions.

Given the diversity of causal factors, contributing factors, and variations in the severity and intensity of childhood sexual behavior problems, assessment should be ecologically focused and individualized. For most cases, it is not necessary to conduct broad-ranging assessments with extensive testing over numerous sessions as the needed assessment information can be collected from background materials, basic behavioral and psychological histories from parents or caregivers, basic assessment interviews with the child, and the administration of a few simple assessment instruments. In cases involving complicated diagnostic issues, more extensive assessments are warranted (Chaffin et al., 2008)

Chaffin and colleagues (2008) contend that assessment should focus most heavily on current and future contextual factors inside and outside the home. Such factors impact both the appropriateness of certain treatment interventions, as well as their effectiveness. These factors include the quality of the caregiver relationship; adult caregiver monitoring and supervision; presence of positive or negative role models and peers; discipline and limit-setting, and level of disciplinary consistency; child's response to corrective actions; exposure to and protection from potentially traumatic situations; sexual and/or violent stimulation in child's past and current environment; resilience factors or strengths that can be developed; and the social ecology of the extended family, neighborhood, school, and other influencing social environments (Chaffin et al., 2008, p. 203).

The authors likewise offer a number of key recommendations for assessing child sexual behavior problems and contributing factors:

- Obtain clear, chronological behavioral description of the sexual behaviors involved.
- Identify when behaviors began.
- Identify when behaviors occur. For example, do they occur during times when the child is stressed, depressed, frightened, or angry? Do they occur when the child is reminded of past sexual abuse or in response to certain environmental triggers, such as sexual stimuli, rough or tumble play? Do they occur only when opportunities present themselves, as opposed to planned events?
- Identify how frequently the behaviors occur.
- Identify whether the behaviors have progressed or changed over time, and if so, how they have progressed and changed.
- Identify whether key events in the child's life occurred at times when sexual behavior problems manifested.
- Use multiple information sources: parents/caregivers, other children, teachers, and potentially extended family.
- When assessing child-on-child sexual abuse, identify how the behaviors were initiated, the degree of mutuality, whether the behavior was planned or impulsive, and whether coercion, force or aggression to overcome resistance was involved (p. 204).

Assessment Instruments

An important part of an individualized, ecological approach to evaluating children for sexual behavior problems is the administration of age-appropriate assessment instruments. Psychological testing is useful for estimating the extent and nature of sexual behavior problems in children.

The research on assessment instruments includes studies of the validity and reliability of instruments in identifying childhood SBP and appropriate treatment, as well as in predicting subsequent relapse or recidivism. Saunders and colleagues (2004:28-34) set forth four primary domains which require assessment: 1) intellectual and neurological, 2) personality functioning and psycho-pathology, 3) behavioral deviance, and 4) sexual deviance. Risk assessment accuracy in predicting treatment and recidivism is critical to effectively addressing the needs of children who engage in sexual offending against other children. A number of studies have evaluated the accuracy of assessment measures. Those assessment instruments that have been evaluated are briefly here.

The **Child Sexual Behavior Inventory (CSBI)** (Friedrich, Beilke and Purcell, 1989; Friedrich, 1997) is a 38-item instrument completed by a parent or caregiver to determine the presence and intensity of a range of

sexual behaviors in children ages 2 to 12. The instrument measures the frequency of common and atypical behaviors, self-focused and other focused behaviors, sexual knowledge, and level of sexual interest. Recent items added to the instrument focus on whether the child's sexual offending is planned and whether it involves aggression. Age and gender norms have been identified and allow the assessor to discriminate between developmentally normal and atypical sexual behavior. In addition to being used to determine the presence of SBP, the CSBI is also useful for monitoring progress and tracking treatment progress.

The **Child Sexual Behavior Checklist (CSBCL-2nd Revision)** (Johnson & Friend, 1995) is appropriate for identifying SBP in children 12 years of age and younger. It can be completed by anyone who knows the child well, such as a parent/guardian or adult caregiver. The CSBCL examines 150 behaviors related to sexual behaviors and sexuality in children. It also assesses environmental factors that can increase problematic childhood SBP, asks details about such behaviors with other children, and lists characteristics associated with children's sexual behaviors (Chaffin et al., 2008; Johnson & Friend, 1995).

The **Weekly Behavior Report (WBR)** (Cohen & Mannarino, 1997b) is a relatively short instrument appropriate for use with young children and designed to track weekly changes in general and sexual behavior in children. The instrument is therefore useful for identification and for monitoring progress over time (Chaffin et al., 2008).

Parks and Bard (2006) conducted an evaluation of risk assessments to examine differences in recidivism risk factors and traits for three groups of male adolescent sexual offenders (N = 156): offenders who sexually assaulted children, offenders who sexually assaulted peers or adults, and mixed type offenders. The analysis utilized these typologies to test recidivism among sexual and nonsexual crimes. Data indicated that approximately 6% of the sample reoffended sexually and roughly 30% committed subsequent non-sexual offenses.

The researchers also examined risk assessment outcomes. Youth were assessed using the **Juvenile Sex Offender Assessment Protocol-II (JSOAP-II)** and the **Psychopathy Checklist: Youth Version (PCL:YV)**. They found that mixed type offenders produced higher risk scores than those who offended against children or adult/peers. Additionally, they found that the Impulsive/Antisocial Behavior scale of the JSOAP-II and the Interpersonal and Antisocial factors of the PCL:YV were significant predictors of sexual recidivism. The Behavioral and Antisocial factors of the PCL:YV were found to be significant predictors of nonsexual recidivism as well (Parks & Bard, 2006). Others have found that the JSOAP-II and the PCL:YV assessments are not predictive of adolescent violent recidivism for sex offenders (Viljoen et al., 2008; 2009).

Viljoen and colleagues (2008) included an examination of three different adolescent risk assessments: the **Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (J-SORRAT-II)**, the **Structured Assessment of Violence Risk in Youth (SAVRY)** and the **Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II)**. These assessments were used to predict violent behavior in 169 male youth who were admitted to a residential sex offender program. While none of these instruments predicted sexual violence, the SAVRY and J-SOAP-II predicted non-sexual violence. Additionally, the J-SOAP-II and the SAVRY were less effective in predicting reoffending in youth ages 15 and younger (Viljoen et al., 2008).

After the 2008 investigation, Viljoen and colleagues (2009) examined four other juvenile sex offender assessments including: the **Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR)**, the **Youth Level of Service/Case Management Inventory (YLS/CMI)**, the **Psychopathy Checklist: Youth Version (PCL:YV)**, and the **Static-99** to predict reoffending in a sample of 193 adolescents. Youth were followed for approximately 7 years after they were released from a residential sex offender treatment program. None of the instruments significantly predicted reoffending; however, the ERASOR nearly reached significance. Both the YLS/CMI and the PCL:YV predicted nonsexual violence, any violence, and any offending; however, the YLS/CMI demonstrated incremental validity compared to the PCL: YV. Additionally, the Static-99 did not predict sexual or nonsexual reoffending, despite empirical support for adult offenders.

Other assessments mentioned in the research literature include (for additional detail on these cited assessments, see Saunders (2004: 24-30)):

- Abel Assessment for Sexual Interest
- Minnesota Sex Offender Screening Tool,
- Multiphasic Sex Inventory
- Rosenberg Sexual Deviance Deception Assessment
- Sexual Interest and Deviancy Assessment
- Sexual Violence Risk-20 (SVR-20)
- The Sex Offense and Development Assessment.

The assessment is the foundation for the treatment process. Without accurate, inclusive, and refined assessments followed by reasonable treatment planning, interventions are likely to be misguided and ineffective (Saunders, 2004:30). Care should be taken in conducting assessments in a supportive

environment, free from pressure, accusatory language, or biased, suggestive, or leading questions (Chaffin et al., 2008).

Treatment Interventions

Research on the effectiveness of treatment interventions for juvenile sex offenders and children with sexual behavior problems has demonstrated positive outcomes for treatment approaches based upon cognitive-behavioral therapy (CBT). While sexual reoffense rates are relatively low for children with SBP and juvenile sex offenders, studies have documented program success in reducing recidivism among this population. Other research has indicated that program effectiveness is dependent in part on the type of intervention and type of sexual behavior problems. What has been noted in the research is that juvenile sex offenders are more likely than adults to respond positively to treatment and that they are also less likely to recidivate than adults (Association for the Treatment of Sexual Abusers, 2000; Worling and Curwin, 2000).

Juvenile sex offenders may come from any socio-demographic background and may present with a variety of different risk factors. It is therefore ill advised to ignore these differences when implementing treatment services. Recognizing that even within gender and race/ethnicity classifications, youths are not a homogeneous group, is critical to effectively addressing the unique criminogenic needs and risks of children with sexual behavior problems. Indeed, as with any interventions intended to curb deviant behavior, treatment effectiveness is dependent on the client's responsivity to treatment (Andrews and Gendreau, 1992).

The last decade has ushered in a new focus in child welfare and delinquency systems aimed at implementing evidence-based, or research-informed, practices. Meta-analytic techniques have allowed researchers to more effectively cull the literature and identify interventions which have been proven through rigorous empirical evaluation to reduce subsequent offending. One of the most significant findings from these studies is the efficacy of cognitive-behavioral interventions (Lipsey, 2009; Glick, 2009). These practices address offenders' cognitive functioning, behavioral motivations, cognitive skills and cognitive restructuring. Interventions are based on the premise that "it is your thoughts, feelings, beliefs and attitudes that control your behavior" (Glick, 2009: xiii). Correspondingly, treatment is designed to examine offenders' attitudes and values, and use cognitive restructuring and skills development to effect behavioral change (Glick, 2009).

A number of randomized trials have been conducting evaluating the efficacy of treatment interventions among children with sexual behavior problems. Bonner, Walker, & Berliner (1999) randomly assigned children with SBP to either a 12-session psychoeducational, cognitive behavioral group treatment program

(CBT) or 12-session play therapy group (involved teaching children simple sexual behavior and boundary rules, involving caregivers in monitoring and supervision activities, and teaching basic impulse control skills). The researchers documented short-term reductions in sexual and nonsexual behavior problems for both randomized cohorts (Bonner et al., 1999).

Long-term follow-up of sexual offense arrests and child welfare sexual abuse perpetration reports ten years after treatment produced outcomes significantly in favor of the CBT intervention (Carpentier, Silovsky, & Chaffin, 2006). Children randomized to CBT had significantly lower rates of sex offense arrests or sex abuse perpetration reports (2%) than children receiving play therapy (10%). Notably, the children receiving CBT were also compared to a clinical group of children diagnosed primarily with ADHD or behavior problems, and who had no known history of SBP. The children with sexual behavior problems who received CBT interventions had roughly the same rate of future sex offenses (2%) as the clinical comparison group (3%) (Carpentier et al., 2006). These results have led Chaffin and colleagues (2008:207) conclude that, "risk for future sexual offenses can be reduced to baseline levels with appropriate short-term treatment."

Pithers and Gray (1993) and Pithers, Gray, Busconi, & Houchens (1998) randomly assigned 115 children with SBP between the ages 6 and 12, and their families, to 32-sessions of either expressive therapy (education about sexual behavior rules, boundaries, emotional management, understanding the effects of sexual abuse, and teaching problem solving and social skills) or a relapse prevention-based program (focused on identifying relapse factors and building a prevention team. Both interventions were based on CBT models. The studies documented improvement in both groups and found that relapse prevention treatment was more effective in cases of serious traumatic stress symptoms (Pithers et al., 1998; Chaffin et al., 2008).

Others have compared CBT interventions for children with sexual behavior problems to nonspecific supportive therapy groups and found that the former was more effective in reducing SBP in children (Cohen and Mannarino, 1996, 1997a). A recent examination included controls for waitlist periods prior to treatment intervention and notably found that the sexual behavior problems tend to improve with time, and that rates of improvement increased when short-term psychoeducational CBT was introduced (Silovsky, Niec, Bard, & Hecht, 2007).

As discussed earlier, a common risk factor among juvenile sex offenders is a history of prior sexual abuse. Given that offenders have often been the victim of sexual abuse, many treatments work from a foundation of addressing both deviant behavior, as well as victimization and trauma.

Saunders and colleagues (2004) completed one of the most comprehensive analyses in regards to the various interventions available for offenders who have experienced prior physical and/or sexual abuse. They highlight two specific interventions which address offender behaviors: adolescent sex offender treatment and adult child molester treatment. Both treatments use cognitive behavioral and adjunctive therapies to help offenders develop motivation to change. In addition, replacement therapy is used to help change negative or risky thought patterns and promote prosocial behaviors (Saunders et al., 2004:93-98). Their analyses documented the importance of treatment that incorporates a multifaceted approach to behavior change, particularly given that most studies report higher rates of non-sexual rather than sexual recidivism. Some common practices among clinical practices include: involving families in the treatment, peer group therapy and other cognitive behavioral approaches such as Multi-Systemic Therapy (MST) (Burton et al., 1996, National Task Force, 1993; Swenson et al., 1998; Letourneau, 2009).

Saunders and colleagues (2004) analyze 24 different program types for adult and adolescent sex offenders and victims. Overall, two interventions (Trauma-Focused Cognitive Behavioral Treatment [CBT] and Adult Child Molester Therapy) received substantial empirical support and posed little risk to the client. These treatments can be utilized specifically with juvenile sex offenders and victims; however, process and outcome evaluations should be conducted to help ensure that juvenile sex offenders and victims are receiving adequate and client-centered services. Since this 2004 analysis, additional studies have documented the effectiveness of using Multi-Systemic Therapy (MST) in treating adolescent sex offenders. Using a factorial design with random assignment of youth to different treatment conditions, Letourneau and associates compared MST therapy to "treatment as usual for juvenile sex offenders" (hereafter TAU). TAU interventions included treatments with a cognitive behavioral orientation and focus on individual (youth-level) behavioral drivers. TAU interventions were delivered in weekly group treatment sessions for at least a year (Letourneau et al., 2009: 91). They used a sample of 127 youth and families who were recruited to the study based on referrals to a program. The research team found that youth who participated in MST reported significant reductions in sexual behavior problems, delinquency, substance use, mental health symptoms, and out of home placements.

Comorbidity Problems

Positive outcomes can be achieved for a broad range of children with sexual behavior problems using short-term, outpatient cognitive behavioral treatment approaches. Such results have been found for both aggressive and less aggressive sexual behaviors, as well as for both boys and girls. Research has found that

treatment modality (group versus individual sessions) is less critical to successful outcomes than the treatment approach (Chaffin et al., 2008).

Many youth with sexual behavior problems present with comorbidity. In these cases, blended CBT treatments designed to target sexual behavior and comorbid problems can be successful in reducing subsequent relapse. Children with serious traumatic stress symptoms should receive trauma-focused cognitive behavioral interventions that include added sexual behavior problem components. Chaffin and colleagues (2008) identify a broad array of well-supported models for addressing the needs of children with SBP and comorbidity including: Parent-Child Interaction Therapy (Brestan & Eyberg, 1998); The Incredible Years (Webster-Stratton, 2005); Barkley's Defiant Child Protocol (Barkley & Benton, 1998), or the Triple-P program (Sanders, Cann, and Markie-Dadds, 2003) (Chaffin et al., 2008: 209).

Treatment Components

Effective treatment interventions target the risks and needs of the child, and integrate the family or primary caregiver in the treatment process. Chaffin and colleagues (2008:211) set forth a number of treatment components for serving children with sexual behavior problems. They note that treatment should include:

- An understanding that children do not possess the requisite cognitive maturity or ability for emotion regulation necessary to achieve emotional or behavioral control through self-understanding.
- Teaching young children concrete rules about sexual behavior and physical boundaries such as, 'do not touch other children's private parts.'
- Demonstration for young children, as they learn better from modeling, practice and reinforcement of behaviors across settings.
- Identification and recognition of the inappropriateness of rule-violating sexual behaviors that occurred in the past.
- Age-appropriate sexual education.
- Coping and self-control strategies.
- Basic sexual abuse prevention and safety skills.
- Social skills.

Parent/Caregiver Treatment Components

The importance of integrating the child's parents and/or caregivers in the treatment process cannot be overstated. Treatment should teach parents, teachers, and caregivers practical behavior management and relationship improvement skills (Patterson, Reid, & Eddy, 2002) including how to: give clear behavioral directions to children, acknowledge positive child behaviors, use specific labeled praise for desired behavior, use time-outs with younger children, use logical and natural consequences with older children, and promote parental/caregiver consistency, warmth and sensitivity (Chaffin et al., 2008).

Chaffin and colleagues (2008) have identified a number of treatment interventions for parents and caregivers including:

- The development and implementation of a safety plan which includes a supervision and monitoring plan, communication with other adults (such as day care and extended family) about supervision needs, and modifications to the safety plan over time in accordance with improvements in behavior.
- Information about sexual development, normal sexual play and exploration, and how these differ from childhood sexual behavior problems.
- Strategies to encourage children to follow privacy and sexual behavior rules.
- Identification of factors that contribute to the development and maintenance of sexual behavior problems (e.g., an environment that is overly sexually stimulating for the child).
- Sex education and how to listen and talk with children about sexual matters.
- Parenting strategies for building positive relationships with children and addressing behavior problems including learning and practicing skills, redirection, giving clear directions, and consistent application of rules and discipline.
- Techniques for supporting children's use of self-control strategies they have learned.
- Information on relationship building and setting appropriate boundaries for physical affection with children.
- Strategies to guide children toward positive peer groups, which in turns can increase pro-social, protective factors for the child.

Treatment Setting

As has been documented through the research discussed here, positive outcomes can be achieved for many children with sexual behavior problems through the use of short-term, outpatient interventions that do not require removal of the child from the home setting. Great care should be taken in removing children from the home, as this can confound the child's problems and inhibit successful outcomes, as well as

effective caregiver integration in the treatment process. The selection of the treatment setting requires careful case-by-case assessment. While retaining children in the home should be the first priority, out-of-home placements may be necessary in those cases where retaining the child in the home may cause harm or significant distress to other members of the home, when reasonable efforts to restrict sexual behavior problems have not been successful, and when there is a lack of reasonable efforts to provide a healthy environment for the child and the sexual behavior problems persist. These should be the exception and not the norm, and removal should be short-term if at all possible (Chaffin et al., 2008).

In those circumstances where a child has sexually victimized another child in the same home and out-of-home placement is not deemed necessary, caregivers can:

- Have the child with sexual behavior problems stay near the caregiver, teacher or child care worker during nap times.
- Avoid leaving the child alone with other children in the bathroom or changing areas.
- Provide appropriate reinforcement for keeping hands to himself/herself.
- Educate teachers, staff, caregivers that "SBP are not uniquely difficult behaviors to correct and that most children with SBP will desist from the behavior given appropriate guidance, structure, and help" (Chaffin et al., 2008, p. 209). As Chaffin and colleagues (2008) note, this may help to prevent having the child excluded from these settings, which could cause additional disadvantage and risk.

Discussions and Summary Findings from the Literature Review

Empirical research on child-on-child sexual abuse is its early stages in comparison to studies of adult sexual offending. Analyses of adolescent sexual deviance suggests that there may be significant differences between youth and adult sex offenders in terms of risk factors, risk to re-offend, and the efficacy of treatment interventions. As such, it is critical that screening instruments and risk assessments be tailored to juveniles and adolescent development.

Treatment interventions based on cognitive-behavioral therapy demonstrate the greatest effectiveness to date in addressing the risks and needs of adolescents who engage in child-on-child sexual abuse. Future research should seek to validate individual treatment programs and assessments for adolescent sex offenders. All new and/or modified programs should be empirically assessed at implementation and outcomes should be examined to determine relative effectiveness in reducing subsequent offending.

Overall, the research literature to date has explored child-on-child sexual abuse in terms of characteristics and risk factors, assessment, and treatment interventions. A summary of each of these areas is presented below and citations referenced earlier apply accordingly.

Characteristics and Risk Factors of Children with Sexual Behavior Problems

- Children with sexual behavior problems are not a homogeneous group. Researchers have set forth the following general definitional age criteria for adolescent sex offenders:
- Child molesters: perpetrators who are more than 5 years older than their victim; and
- Peer offenders: perpetrators who are within five years of age of their victim.
- Various typologies have been proposed to classify youths who engage in risky sexual behavior; however, the categories often overlap and are overly complex, suggesting that ineffectiveness of taxonomic classification.
- Children with SBP may be subject to a wide range of negative personality traits, problem behaviors, and a history of family instability.
- Female adolescent sex offenders are quite different from their male counterparts, as they are more likely to be exposed to sexual abuse, have an earlier age at onset, and are more likely to have witnessed prior trauma.
- Risk factors identified in the research include: prior sexual abuse, exposure to domestic violence, association with negative peers, hostile and aggressive behavior, and mental health issues.
- Studies have identified a number of risk factors positively associated with the likelihood to reoffend among juvenile sex offenders including: 1) a child or adult victim, as opposed to a peer victim; 2) the use of threats or weapons in the commission of sex offense(s); 3) prior sex offenses; 4) a male victim, as opposed to a female victim; 5) older offender intake age; and 6) having prior non-sexual offenses.
- Children who engage in sexual offending are developmentally, cognitively and fundamentally distinct from adult sex offenders.

Victim Characteristics and Risk Factors

- There are few empirically sound studies which assess victim characteristics.
- Victims are most often female.
- Victims often exhibit symptoms of depression, Post-Traumatic Stress Disorder (PTSD), and sexual acting out behaviors.
- Other indicators of victimization may include suicidal ideation, running away, truancy, and substance abuse.

Identification and Assessment

- Evidence suggests that ecological assessments that consider the child's prior abuse history, environment, school, family, and social/economic factors are most effective in addressing the underlying issues and treatment needs of children with sexual behavior problems.
- A number of relatively easy-to-administer assessment instruments appropriate for children 12 years and younger were discussed including the Child Sexual Behavior Checklist (CSBCL), Child Sexual Behavior Inventory (CSBI) and the Weekly Behavior Report (WBR).
- The Impulsive/Antisocial Behavior scale of the JSOAP-II and the interpersonal and antisocial factors of the Psychopathy Checklist: Youth Version (PCL:YV) significantly predict future sexual recidivism.

Treatment Services

- Children with sexual behavior problems present with many similar risk factors to other serious youthful offenders, as such evidence-based practices for at-risk youth should be employed with this population.
- Treatment should be holistic and address the multiple ecological factors present.
- Cognitive-behavioral interventions have demonstrated success in relapse prevention and recidivism reduction.
- Trauma-Focused Cognitive Behavioral Therapy (CBT) and Adult Child Molester Treatments have received substantial support as effective treatment interventions for adolescent sex offenders.
- Multi-systemic Therapy (MST) has likewise demonstrated recent significant outcomes in reducing sexual behavior problems, delinquency, substance use, mental health symptoms, and out-of-home placements among youths who have engaged in sexual offending.

More generally, the field on child-on-child sexual abuse is growing in terms of empirical studies documenting offender and victim characteristics, as well as research on the efficacy of treatment interventions. This review highlights the need to conduct comprehensive and national reports of child-on-child sexual abuse. While reports of juvenile sex offending have increased substantially in recent years, the recent increase in statistics may not be due to an actual increase in the number of offenses per se but an increase in the number of reports to the police. Official statistics are necessary to determine trends in rates of offending and victimization.

METHODOLOGY

The aim of this paper is to assess seven research questions regarding child-on-child sexual abuse in the State of Florida:

1. What is the extent and nature of child-on-child sexual abuse in the Florida child welfare system?
2. What are the risk factors and characteristics of child-on-child sexual abuse (both victims and children with SBP)?
3. What are the needs of victims and children with SBP involved in child-on-child sexual abuse?
4. What treatment interventions and policies need to be in place to adequately serve this population?
5. Are services currently offered to this population in Florida meeting their needs?
6. What changes, if any, need to occur to facilitate effective service delivery to this population?
7. Are there any gaps and/or barriers to effective service delivery to this population?

In order to investigate the above research questions several methodologies were employed. Official data were gathered from the Florida Abuse Hotline Information System[3] (FAHIS) to assess the extent of child-on-child sexual abuse and to conduct a trend analysis of calls made to the Abuse Hotline from FY 2003-04 to FY 2008-09. Those who answer calls to the Hotline must gather certain information on the victim including: victim name, address or location, approximate age, race and sex; physical, mental or behavioral indications that the person is infirm or disabled; signs or indications of harm or injury, including a physical description; and, the relationship of the alleged child with SBP to the victim.

In order to supplement the Florida Abuse Hotline data and to assess characteristics and risk factors of victims and children with SBP, data were also collected from the Florida Safe Families Network (FSFN) database. FSFN collects data on various risk factors and characteristics of those who have been victims of abuse including intake, assessment, case management, resource management, eligibility and financial management functionality.

FSFN is a new data system which was launched in Fiscal Year 2007-08. Prior to the FSFN system, the HomeSafeNet database was used to manage information on child abuse. When assessing trends from FY 2007-08, it should be noted that the transition from HomeSafeNet to FSFN may have impacted the data

[3] More information on the Florida Abuse Hotline can be found at http://www.dcf.state.fl.us/abuse/.

presented for that year.[4] In addition, the new Child-on-Child Assessment was also implemented in conjunction with the transition. Backwards Stepwise Logistic Regression was utilized as the method of analysis to predict characteristics and risk factors of alleged[5] children with SBP (N=7,459) and risk factors of alleged victims (N= 8,896).

Backwards Stepwise Logistic Regression is a form of regression which is used when the dependent variable is binary and the independent variables are of any level of measurement. This type of regression is the preferred method of exploratory analyses, where the analysis begins with a full model and variables are deleted from the final model in an iterative progression. After the elimination of each variable, the fit of the model is tested to ensure that the model continues to effectively fit the data. When variables are no longer eliminated, the analysis is complete. This type of regression is necessary in this case to explore and predict the probability of victims and children with SBP having specific risk factors and characteristics. Because there was no comparison group available, only within group comparisons can be made. Thus, children with SBP were compared to other children with SBP and victims were compared to other victims.

In order to assess the various types of treatment currently utilized and whether there are any gaps and barriers in providing services to children with SBP and victims of child-on-child sexual abuse, a qualitative analysis was conducted. The qualitative analysis consisted of two parts. First, for exploratory purposes, two focus groups were conducted in Alachua County and Broward County. These counties were utilized because they had more specialized services for victims and children with SBP, and there were specific DCF task forces located there which were designated to mediate the problem of COCSA. Each focus group lasted approximately 2 1/2 hours. There were a total of 35 focus group participants. The Alachua County focus group included 16 participants and the Broward County focus group consisted of 19 participants. The focus groups involved a wide range of participants including: victim advocates, service providers and specialists, child protective investigators (CPIs), task force representatives, law enforcement personnel, and psychiatrists.

Second, case file reviews were conducted in those same counties in order to gather information about the prevalence and type of COCSA cases. Information on 41 cases of victims and children with SBP of COCSA were assessed in these areas. The type of information gathered during the file review included: client

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[4] More information concerning the transition from HomeSafeNet to FSFN can be found at http://www.dcf.state.fl.us/transition/docs/issues_fsfnhistorical.pdf

[5] It should be noted that unless specified, data on children with SBP involve only allegations, as opposed to verified or founded labels. Because the State has been proactive in not identifying children with SBP under the age of 12 as offenders or perpetrators, no outcomes are presented for verified or founded children with sexual behavior problems.

demographic information (sex, race, ethnicity, number of victims/children with SBP), case descriptions, assessments used, current prescriptions, family substance problems, having a history of delinquency or family delinquency, abuse history (sexual and physical), mental health, and treatment outcome. The qualitative data gathered from the focus groups and case file reviews are presented throughout the report as supplement to the quantitative data and analyses.

After the qualitative information was gathered, researchers additionally administered two online self-report surveys with treatment providers and CPIs involved in investigating or providing services to victims and children with SBP. The purpose of the online survey was to solicit feedback from around State and to supplement the information gathered in the focus groups. The Florida Department of Children and Families (DCF) was responsible for identifying survey participants. Respondents were asked about: 1) their relationship with DCF, 2) the frequency of referrals received, 3) child-on-child sexual abuse training, 4) identifying children with SBP and victims, 5) types of child-on-child sex abuse situations, 6) where child-on-child sexual abuse is most likely to occur, 7) assessments procedures used for screening cases of child-on-child sexual abuse, 8) policies and procedures in dealing with victims and children with SBP, 9) goals and philosophy to service victims and children with SBP, 10) types of treatments provided to victims and children with SBP, 11) the average length of the treatment, 12) gaps and barriers in providing treatment to child-on-child sexual abuse victims and children with SBP, and 13) ways that DCF can improve services to victims and children with SBP. The Department of Children and Families distributed the links to the appropriate Departments and treatment providers across the State. They also made several follow up contacts with participants who had not completed the surveys. The participants had two months to complete the surveys.

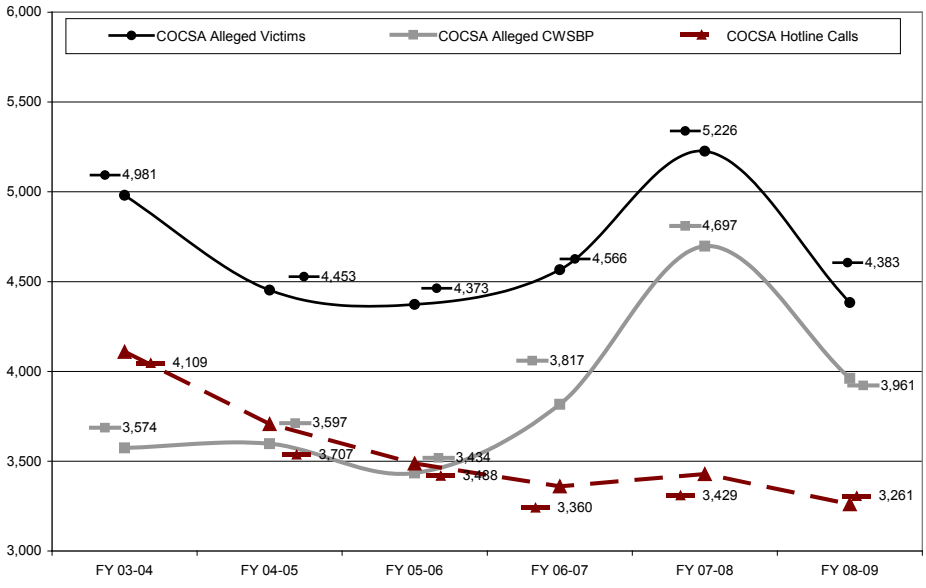
Before the results of the evaluation are discussed it is important to outline the frequency and types of respondents who participated in the survey. In total there were 237 respondents who participated in the online surveys. Child protective investigators represented 123 of the respondents, while treatment providers constituted 114 participants in the survey. Of the total number of respondents who took the investigator survey, 19% were administrators, 3% were case managers, and 79% identified themselves as CPIs. Among the participants in the treatment survey, 25% identified themselves as therapeutic administrators, 11% identified themselves as case managers, and 67% identified themselves as therapists. More than half (58%) of the respondents who participated in the provider survey indicated that their agency provided services to victims and children with SBP. The research findings are presented below.

RESULTS

The research findings are presented in the order followed throughout the report: the nature and extent of child-on-child sexual abuse in Florida, followed by characteristics and risk factors of alleged children with sexual behavior problems (SBP), alleged victim characteristics and risk factors, the referral process and calls to the Abuse Hotline, assessing child-on-child sexual abuse in Florida, treatment services for children with SBP and victims of child-on-child abuse, and training and service barriers in treating victims and children with SBP.

Extent and Nature of Child-on-Child Sexual Abuse

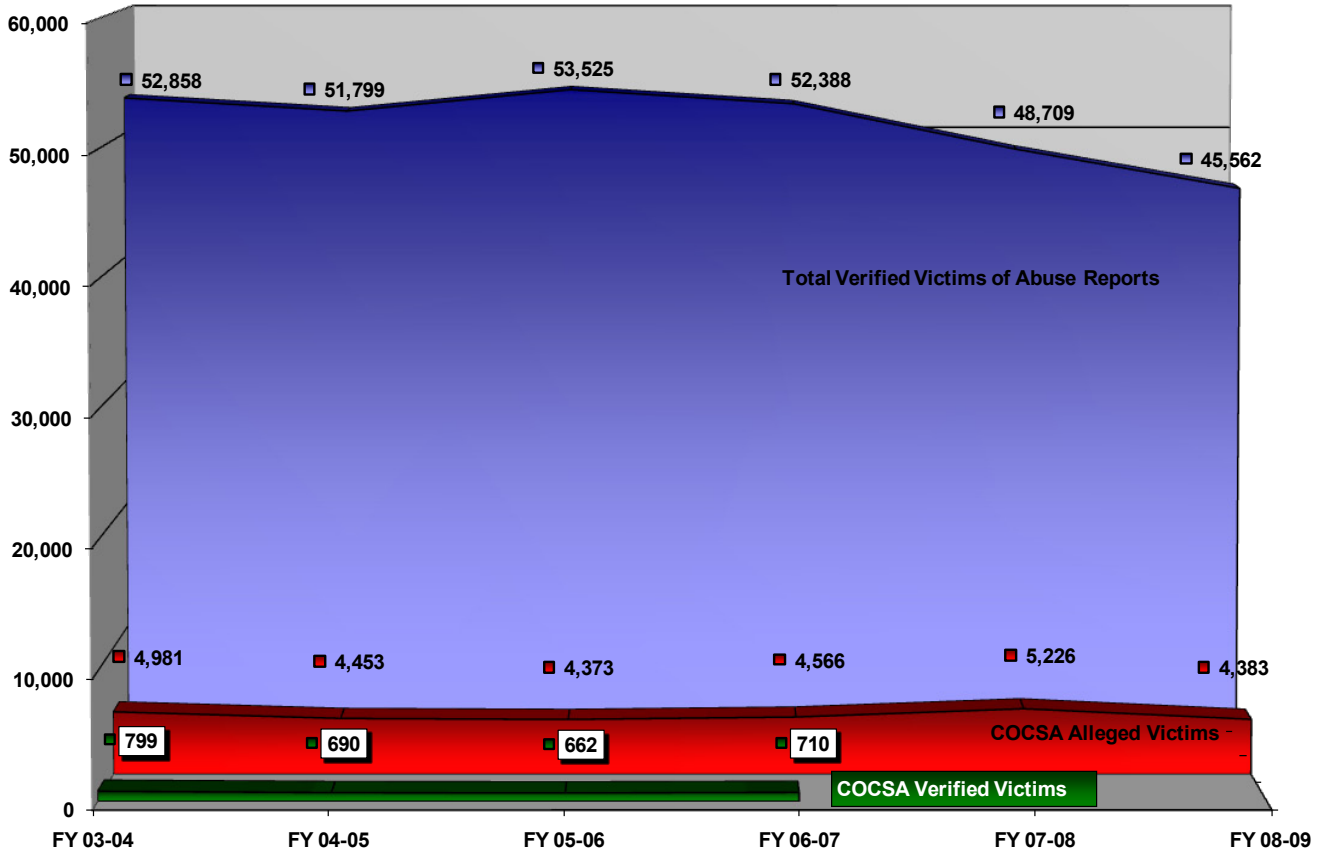
The following graph represents data on the number of COCSA Hotline Call reports and the number of COCSA alleged children with SBP and victims involved from FY 2003-04 to FY 2008-09. Although there are anomalies in the data presented as noted previously,[6] there are some clear trends that can be inferred from the graph. First, it shows that overall the number of COCSA alleged victims have declined by about 12 percent since FY 2003-04. Additionally, the data indicate that when calls are made to the Abuse Hotline more than half the time there is more than one victim reported. This was also true for children with SBP to a lesser extent. This implies that for every case reported to the hotline there is a good chance that the case will involve more than one victim and in some cases may involve more than one alleged child with SBP. This is not surprising given that some of the cases involve social



[6] In FY 2007-08 DCF-FS converted to a new child welfare information system, as well as changed polices and practices as they related to COCSA investigations. These combined events may have led to anomalies in the data counts for that year. Additionally, the last year may be slightly misrepresented since some of the cases may not have been entered in the system at the time the data were extracted.

institutions such as daycare facilities and schools. Moreover, when assessing the trend in reporting COCSA, calls to the Abuse Hotline decreased somewhat since FY 2005-06. Although the number of COCSA cases being reported to the Hotline declined, the number of alleged children with sexual behavior problems increased slightly. This may in part be due to referrals from other sources as well as potential data anomalies resulting from the data transfer from HomeSafeNet to FSFN, as noted previously.

There are some noted implications concerning the number of victims of child-on-child sexual abuse. The chart below highlights the total number of abused victims in the state including those who were abused, neglected, and subjected to some threatening harm (hereafter Abuse Report) as reported to the Florida Department of Children and Families between FY 2003-04 and FY 2008-09. The Abuse Report number is



compared to the total number of COCSA alleged victims and COCSA verified victims in order to provide a measure of perspective on COCSA as a statewide abuse issue. As can be seen, the COCSA alleged victims are a relatively small population of the greater Abuse Report victims as a whole; representing from 8 to 11 percent of the total Abuse Report victims. Further, the actual verified victims is proportionally less, representing only 15 to 16 percent of the alleged COCSA victims and only 1 to 2 percent of the total verified

Abuse Report victims. For example, in FY 2006-07 there were 52,388 cases of verified Abuse Report victims compared to 4,566 COCSA alleged victims, and only 710 cases of the alleged COCSA victims was verified. However, although the number of verified Abuse Report cases has been declining, the number of alleged COCSA victims has remained relatively stable.

Risk Factors & Characteristics of Children Engaging in Child-on-Child Sexual Abuse

In the literature review it was demonstrated that children with SBP are more likely to have certain characteristics and behavioral problems. The tables below utilize characteristics and risk factors and assess data for FY 2007-09 when COCSA assessment data were available. Seventeen risk factors were investigated by demographic characteristics including having: a history of sexual victimization, a history of physical abuse, a history of neglect, a history of family or domestic violence, a history of instability, a history of physical or emotional separation from a parent, having inadequate social skills and poor peer relations, knowledge of advanced sexual practice, been exposed or has had access to pornography, having academic difficulties, having reduced empathy, where the child with SBP blames the victim, a history of impulse control problems, a history of anxiety, a history of depression, a history of suicidal ideation, and having a history of substance abuse. The frequency of each risk factor is reported across the state by race, gender and age. Significant differences between children with SBP demographics are also presented.[7] Only those probabilities and ratios which were statistically significant ($p \leq .05$) are reported.

The table on the next page reports the frequency of alleged children with SBP who were given a COCSA assessment by gender and race during the combined fiscal years of 2007-08 and 2008-09. For purposes of brevity, alleged victims and alleged children with SBP are referred to generally in this section as victims and children with SBP. During this time, male children with SBP (N=5,771) were proportionately greater than female children with SBP (N=1,649) by 3:1. Additionally, there was a higher proportion of white children with SBP (N=4,504) compared to black children (N=2,486) by a ratio of 2:1, and other races (N=473) by a ratio of 10:1. The three most common characteristics for all alleged children with SBP were: a history of physical/emotional separation from a parent (38%), a history of instability in the family (30%), and a history of neglect (24%). Backward Wald Logistic Regression was used in order to explore which, if any, of the seventeen risk factors (noted in the table) were significantly associated with gender and race for the alleged

[7] See the Appendix for a more detailed review of frequencies on alleged COCSA children with sexual behavior problems by county in Florida.

children with SBP. The regression model results were used to calculate the probability the specific risk characteristics would be expected given demographic and all other characteristics being equal. The regression statistics and probabilities are presented following the descriptive table.

FYs 07-09: COCSA Assessment Data: Alleged Children With Sexual Behavior Problems

Alleged CWSBP by Gender/Race	Male	Female	Black youth	White youth	Other youth	Total
History of Sexual Victimization	889 (16%)	379 (23%)	373 (15%)	876 (20%)	21 (4%)	1,270 (17%)
History of Physical Abuse	688 (12%)	225 (14%)	388 (16%)	511 (11%)	14 (3%)	913 (12%)
History of Neglect	1,285 (22%)	476 (29%)	672 (27%)	1,064 (24%)	25 (5%)	1,761 (24%)
History of Family/ Domestic Violence	1,164 (21%)	378 (23%)	516 (21%)	1,006 (23%)	22 (5%)	1,544 (21%)
Alleged CWSBP's Family Has History of Instability	1,666 (29%)	546 (33%)	745 (30%)	1,423 (32%)	47 (10%)	2,215 (30%)
History of Physical/ Emotional Separation From a Parent	2,123 (37%)	642 (40%)	926 (38%)	1,768 (40%)	72 (16%)	2,766 (38%)
Inadequate Social Skills, Poor Peer Relationship	1,011 (18%)	222 (14%)	409 (17%)	782 (18%)	43 (9%)	1,234 (17%)
Knowledge of Advanced Sexual Practices	1,156 (21%)	412 (26%)	509 (21%)	1,014 (23%)	46 (10%)	1,569 (22%)
Been Exposed/ Access to Pornography	500 (10%)	135 (9%)	164 (7%)	451 (11%)	22 (5%)	637 (9%)
Academic Difficulties	1,215 (22%)	236 (15%)	598 (25%)	800 (19%)	53 (12%)	1,451 (20%)
Reduced Empathy	462 (8%)	113 (7%)	197 (8%)	357 (8%)	22 (5%)	576 (8%)
Alleged CWSBP Blames Victim	615 (11%)	201 (12%)	305 (13%)	479 (11%)	33 (7%)	817 (11%)
History of Impulse Control Problems	1,005 (18%)	220 (14%)	424 (18%)	768 (18%)	34 (7%)	1,226 (17%)
History of Anxiety	355 (7%)	78 (5%)	100 (4%)	318 (7%)	15 (3%)	433 (6%)
History of Depression	243 (4%)	71 (4%)	83 (4%)	228 (5%)	3 (1%)	314 (4%)
History of Suicidal Ideation	115 (2%)	36 (2%)	48 (2%)	102 (2%)	1 (0%)	151 (2%)
History of Substance Abuse	42 (1%)	9 (1%)	15 (1%)	33 (1%)	3 (1%)	51 (1%)
Total Number*	**5,771**	**1,649**	**2,486**	**4,504**	**473**	**7,459**

**Percentages are not necessarily based on the total number of youth as data for a specific trait may have been missing*
CWSBP=Child(ren) With Sexual Behavior Problems

Based on the regression model, there are some significant characteristics associated with gender. Of the seventeen different characteristics, females were significantly more likely to have a history of sexual victimization, a history of neglect and to be more knowledgeable of advanced sexual practices than were males. Males, on the other hand, tended to have a higher degree of inadequate social skills or poor peer relationships, academic difficulties and a history of impulse control problems, respectively. The table below presents the calculated probabilities for males and females for each particular trait. Female children with SBP had a 32% chance of having a history of sexual victimization compared to an 11% chance for males. One would, therefore, expect to see that about 1 out of every 3 female children with SBP would have this characteristic, versus 1 out of every 9 males. In addition to prior sexual victimization, other characteristic differences between males and females involved a history of neglect and academic difficulties. While females were significantly more likely to have a history of neglect (38% chance) compared to males (16% chance); males were more likely to have academic difficulties (31% chance) than females (10% chance).

Significant Characteristic Differences	Male youth Probability	Male youth Expected Population Ratio	Female youth Probability	Female youth Expected Population Ratio
History of Sexual Victimization	11%	1:9	32%	1:3
History of Neglect	16%	1:6	38%	1:3
Inadequate Social Skills, Poor Peer Relationship	21%	1:5	12%	1:9
Knowledge of Advanced Sexual Practices	18%	1:6	30%	1:3
Academic Difficulties	31%	1:3	10%	1:10
History of Impulse Control Problems	24%	1:4	10%	1:10

Cox & Snell - R^2 .020 Goodness Of Fit 5839.570
CWSBP=Child(ren) With Sexual Behavior Problems

There are some significant characteristics associated with race as well. Compared to black children with SBP, a higher percentage of white children with SBP had a history of sexual victimization, a family with a history of instability, inadequate social skills or poor peer relationships, exposure to or access to pornography, a history of anxiety, and a history of depression. On the other hand, blacks were more likely to present with a history of physical abuse, history of neglect, academic difficulties, and were more likely to attribute blame to the victim.

The probability differences between white and black alleged children with SBP are provided in the table below. Academic difficulties exhibited the largest characteristic difference between black and white children with SBP. While 1 out of every 8 white children with SBP would be expected to have these difficulties, blacks exhibited nearly 3 times the probability, with 1 out of every 3 children expected to have some academic difficulties. Blacks also had a higher probability of having a history of physical abuse (24% chance) than

Significant Characteristic Differences	Black youth Probability	Black youth Expected Population Ratio	White youth Probability	White youth Expected Population Ratio
History of Sexual Victimization	11%	1:9	26%	1:4
History of Physical Abuse	24%	1:4	7%	1:15
History of Neglect	32%	1:3	20%	1:5
CWSBP's Family Has History of Instability	26%	1:4	37%	1:3
Inadequate Social Skills, Poor Peer Relationship	15%	1:7	20%	1:5
Been Exposed/ Access To Pornography	5%	1:20	15%	1:7
Academic Difficulties	37%	1:3	12%	1:8
CWSBP Blames Victim	15%	1:7	9%	1:11
History of Anxiety	2%	1:51	14%	1:7
History of Depression	3%	1:36	7%	1:14

Cox & Snell - R^2 .029 Goodness Of Fit 5488.301
CWSBP=Child(ren) With Sexual Behavior Problems

whites (7% chance), representing a probability difference of 17%. The most notable difference between whites and blacks was the finding that whites were more likely to have experienced past sexual victimization. One out of every 4 white children with SBP had a history of sexual victimization, compared to 1 out every 9 black children with SBP.

In addition to examining characteristics by gender and race, correlations by age at the time of the assessment were also examined. The descriptive table below shows that alleged children with SBP (N= 3,495) ages 6 to 9 years were the most represented among the age groups, followed by those between the ages of 10 to 12 years (N=2,410).

FYs 07-09: COCSA Assessment Data: Alleged Children With Sexual Behavior Problems

Alleged CWSBP by Age at Report Date	5 and Under	6 to 9	10 to 12	Over 12	Total**
History of Sexual Victimization	162 (13%)	580 (17%)	483 (20%)	40 (18%)	1,265 (17%)
History of Physical Abuse	79 (6%)	416 (12%)	387 (16%)	29 (13%)	911 (12%)
History of Neglect	275 (22%)	821 (23%)	615 (26%)	45 (21%)	1,756 (24%)
History of Family/ Domestic Violence	268 (21%)	753 (22%)	481 (20%)	37 (18%)	1,539 (21%)
Alleged CWSBP's Family Has History of Instability	367 (29%)	1,026 (30%)	755 (32%)	60 (28%)	2,208 (30%)
History of Physical/ Emotional Separation From a Parent	406 (32%)	1,282 (37%)	989 (42%)	75 (35%)	2,752 (38%)
Inadequate Social Skills, Poor Peer Relationship	159 (13%)	536 (16%)	502 (21%)	35 (17%)	1,232 (17%)
Knowledge of Advanced Sexual Practices	205 (16%)	724 (21%)	579 (25%)	52 (25%)	1,560 (22%)
Been Exposed/ Access to Pornography	59 (5%)	279 (9%)	275 (13%)	20 (10%)	633 (9%)
Academic Difficulties	132 (11%)	643 (19%)	619 (27%)	54 (27%)	1,448 (21%)
Reduced Empathy	50 (4%)	240 (7%)	265 (12%)	18 (9%)	573 (8%)
Alleged CWSBP Blames Victim	93 (7%)	405 (12%)	297 (13%)	14 (7%)	809 (11%)
History of Impulse Control Problems	166 (13%)	543 (16%)	481 (21%)	34 (17%)	1,224 (17%)
History of Anxiety	33 (3%)	201 (6%)	186 (8%)	12 (6%)	432 (6%)
History of Depression	16 (1%)	125 (4%)	158 (7%)	14 (7%)	313 (4%)
History of Suicidal Ideation	6 (0%)	44 (1%)	92 (4%)	9 (5%)	151 (2%)
History of Substance Abuse	8 (1%)	19 (1%)	20 (1%)	4 (2%)	51 (1%)
Total Number*	**1,275**	**3,495**	**2,410**	**217**	**7,393**

**Percentages are not necessarily based on the total number of youth as data for a specific trait may have been missing*

***Dates of birth were not available for all youth.*

CWSBP=Child(ren) With Sexual Behavior Problems

Based on the results of the regression models that examined the significant characteristics associated with each of the three age groups (5 and under, 6 to 9, and 10 to 12), some notable differences were found. Of the seventeen characteristics assessed, alleged children with SBP who were 5 years old and younger at the time of the assessment, were significantly more likely to have a history of domestic violence and instability in the family than any other characteristic. Comparatively, children with SBP who were 6 to 9 years of age at the time of the assessment were most likely to demonstrate characteristics of blaming the victim and having a

history of domestic violence than any of the other characteristic. In comparison to younger children, older children with SBP (ages 10 to 12) were most likely to demonstrate academic difficulties, a history of physical abuse, a history of physical or emotional separation from a parent, exposure or access to pornography, reduced empathy, a history of depression, and a history of suicidal ideation. In examining differences in probabilities, the highest probability of any one characteristic among children 5 years and under was a history of instability in the family (34%). However, this probability is only slightly higher than that of youth ages 10 to 12 (29%). More notable was the difference in the characteristic of having a history of physical abuse. Alleged children with SBP who were 6 to 9 years had a much higher probability of a history of physical abuse (31%) than youth ages 5 years and under (3%) and, to lesser degree, youth who were 10 to 12 years (22%). Older children likewise had a much greater chance of being exposed to pornography than either of the other two age groups. It is estimated that 1 out of every 5 children with sexual behavior problems between the ages of 10 and 12 years, will have been exposed or had access to pornographic material. This compares to 1 out of 14 for children between the ages of 6 and 9 years, and 1 out of 33 for children under six years of age. A history of physical or emotional separation from a parent was the single greatest risk factor probability (45% chance) for children with SBP between the ages of 10 to 12 years.

	5 and Under[1]		6 Through 9[2]		10 Through 12[3]	
Significant Characteristic Differences	**Probability**	**Expected Population Ratio**	**Probability**	**Expected Population Ratio**	**Probability**	**Expected Population Ratio**
History of Physical Abuse	3%	1:39	31%	1:3	22%	1:4
History of Family/ Domestic Violence	26%	1:4	25%	1:4	15%	1:7
CWSBP's Family Has History of Instability	34%	1:3	n.s.	n.s.	29%	1:3
History of Physical/ Emotional Separation from a Parent	27%	1:4	n.s.	n.s.	45%	1:2
Been Exposed/ Access To Pornography	3%	1:33	7%	1:14	20%	1:5
Academic Difficulties	6%	1:17	5%	1:19	36%	1:3
Reduced Empathy	n.s.	n.s.	n.s.	n.s.	16%	1:6
History of Depression	0.5%	1:193	n.s.	n.s.	10%	1:10
History of Suicidal Ideation	n.s.	n.s.	1%	1:187	8%	1:13
CWSBP Blames Victim	4%	1:24	14%	1:7	n.s.	n.s.
History of Anxiety	2%	1:55	n.s.	n.s.	n.s.	n.s.

[1]Cox & Snell - R^2 .031 Goodness Of Fit 5643.576
[2]Cox & Snell - R^2 .005 Goodness Of Fit 5652.405
[3]Cox & Snell - R^2 .030 Goodness Of Fit 5651.616
n.s. = not significant
CWSBP=Child(ren) With Sexual Behavior Problems

Risk Factors and Characteristics of Victims of Child-on-Child Sexual Abuse

In the literature review it was demonstrated that COCSA victims are more likely to have certain characteristics and behavioral problems relative to children with SBP and to other children. The COCSA assessment identifies more distinctions in regards to the COCSA case rather than the individual risk factors of victims of COCSA. While this information is relevant in distinguishing one type of case from another, and to some degree the severity of the case, it does not provide the necessary data to identify those youth that are at greatest risk for victimization. That being noted, the tables that follow utilize these assessment outcomes and present the data collected on alleged victims between FY 2007-08 and FY 2008-09. The victim data were assessed by gender, race, and age and include: 1) alleged victim is substantially younger than the child with SBP, 2) alleged victim is known to the child with SBP, 3) alleged victim case included coercion, 4) alleged victim case included violence, 5) alleged victim case included bribes by the child with SBP, 6) elements of secrecy involved, 7) multiple alleged victims, 8) history of non-sexual aggravated assault, and 9) the number of prior incidents. Like children with SBP characteristics, the frequency of each factor is reported across the state by race, gender and age. Significant differences between the victim demographics are also presented.[8] Only those probabilities and population ratios which were statistically significant ($p \leq .05$) are reported.

The following table shows that there was a greater number of female alleged victims of COCSA (N=4,930) compared to males (N=3,925). Further there were more than twice the number of white alleged victims (N=5,667) compared to black alleged victims (N=2,611). Overall, the three most represented factors for the data collected on alleged COCSA victims were that the alleged victim is known to the child with SBP

FYs 07-09: COCSA Assessment Data: Alleged Victims

Alleged Victims by Gender/ Race	Male	Female	Black youth	White youth	Other youth	Total
Alleged Victim is Substantially Younger Than CWSBP	1,099 (28%)	1,276 (26%)	740 (28%)	1,523 (27%)	121 (20%)	2,384 (27%)
Alleged Victim is Known To CWSBP	3,547 (90%)	4,473 (91%)	2,331 (89%)	5,196 (92%)	523 (84%)	8,050 (90%)
Alleged Victim Included Coercion	367 (10%)	362 (8%)	201 (8%)	496 (9%)	34 (6%)	731 (9%)
Alleged Victim Case Included Violence	167 (4%)	138 (3%)	98 (4%)	188 (3%)	19 (3%)	305 (3%)
Alleged Victim Case Included Bribes by CWSBP	114 (3%)	98 (2%)	43 (2%)	161 (3%)	9 (2%)	213 (2%)
Elements of Secrecy Involved	836 (22%)	872 (18%)	453 (18%)	1,170 (21%)	94 (16%)	1,717 (20%)
Multiple Alleged Victims-Reference	832 (22%)	935 (20%)	506 (20%)	1,139 (21%)	135 (22%)	1,780 (21%)
History of Non-Sexual Aggravated Assault	120 (3%)	152 (3%)	93 (4%)	158 (3%)	24 (4%)	275 (3%)
Number of Incidents	817 (23%)	939 (21%)	473 (20%)	1,194 (23%)	98 (17%)	1,765 (21%)
Total Number*	**3,925**	**4,930**	**2,611**	**5,667**	**622**	**8,896**

**Percentages are not necessarily based on the total number of youth as data for a specific trait may have been missing*
CWSBP=Child(ren) With Sexual Behavior Problems

[8] See Appendix for a more detailed review of frequencies on alleged COCSA offender risk factors by county.

(90%), the alleged victim is substantially younger than the child with SBP (27%) and there were multiple alleged victims referenced (21%).

Although the regression model pseudo-R^2 is very low (r^2=.004), there are some indications of a few significant factors associated with gender. Of the nine different characteristics examined, male victims were significantly more likely than females to be younger than the alleged child with SBP, to have a case that included violence, and to have elements of secrecy involved. As the probability table below indicates, the largest difference was the probability of an alleged victim being substantially younger than the alleged child with SBP, where males have a 31% chance and females have a 24% chance of having a COCSA involving this scenario.

	Male youth		Female youth	
Significant Characteristic Differences	**Probability**	**Expected Population Ratio**	**Probability**	**Expected Population Ratio**
Alleged Victim is Substantially Younger than CWSBP	31%	1:3	24%	1:4
Alleged Victim Case Included Violence	6%	1:18	2%	1:48
Elements of Secrecy Involved	26%	1:4	15%	1:7

Cox & Snell - R^2 .004 Goodness Of Fit 7688.948
CWSBP=Child(ren) With Sexual Behavior Problems

As the table below indicates, four risk factors were associated with being a victim of COCSA in terms of race. Although the overall model is weak (r^2=.005), the probability differences were significant. White alleged COCSA victims had an increased probability of knowing the child with SBP (94%) compared to the probability of black victims (86%). Additionally, white victims had an increased probability of having cases that involved bribes by children with SBP (5%) and elements of secrecy (25%), compared to black victims (1% and 15%, respectively). Finally, black victims (5%) had an increased probability of being a victim when the case included violence compared to white alleged COCSA victims (2%).

	Black youth		White youth	
Significant Characteristic Differences	**Probability**	**Expected Population Ratio**	**Probability**	**Expected Population Ratio**
Alleged Victim is Known To CWSBP	86%	6:7	94%	15:16
Alleged Victim Case Included Violence	5%	1:19	2%	1:43
Alleged Victim Case Included Bribes by CWSBP	1%	1:83	5%	1:20
Elements of Secrecy Involved	15%	1:7	25%	1:4

Cox & Snell - R^2 .005 Goodness Of Fit 7205.406
CWSBP=Child(ren) With Sexual Behavior Problems

In addition to examining characteristics associated with the alleged victim's gender and race, associations by age at the time of the assessment were also examined. The descriptive table below shows that alleged COCSA victim ages 5 and under (N= 3,810) and 6 to 9 years (N= 3,946) were nearly equally represented in the sample; combined they represented 88% of the total 8,818 alleged victims.

FYs 07-09: COCSA Assessment Data: Alleged Victims

Alleged Victims by Age at Report Date	5 and Under	6 to 9	10 to 12	Over 12	Total**
Alleged Victim is Substantially Younger than CWSBP	1,560 (41%)	759 (19%)	49 (5%)	6 (5%)	2,374 (27%)
Alleged Victim is Known To CWSBP	3,484 (92%)	3,536 (90%)	855 (90%)	113 (92%)	7,988 (91%)
Alleged Victim Included Coercion	229 (6%)	400 (10%)	92 (10%)	5 (4%)	726 (9%)
Alleged Victim Case Included Violence	64 (2%)	179 (5%)	57 (6%)	3 (2%)	303 (4%)
Alleged Victim Case Included Bribes by CWSBP	54 (1%)	139 (4%)	18 (2%)	1 (1%)	212 (2%)
Elements of Secrecy Involved	635 (17%)	873 (23%)	179 (19%)	20 (16%)	1,707 (20%)
Multiple Alleged Victims-Reference	603 (16%)	884 (23%)	245 (27%)	32 (26%)	1,764 (21%)
History of Non-Sexual Aggravated Assault	84 (2%)	127 (3%)	52 (6%)	12 (10%)	275 (3%)
Number of Incidents	595 (17%)	911 (25%)	225 (25%)	27 (23%)	1,758 (21%)
Total Number*	**3,810**	**3,946**	**951**	**123**	**8,818**

**Percentages are not necessarily based on the total number of youth as data for a specific trait may have been missing*

***Dates of birth were not available for all youth.*

CWSBP=Child(ren) With Sexual Behavior Problems

The table below indicates that COCSA victims between the ages of 5 years and under, had a significantly greater probability of being substantially younger than the child with SBP (74%) compared to both older victim categories (10% and 1%, respectively). The younger victims also had a significantly higher probability of knowing the child with SBP compared to those victims 10 through 12 years. Alleged COCSA victims who were ages 6 through 12 had an increased probability of being a victim where the case included coercion (12%) compared to victims 5 years of age and younger (4%) as well as in cases involving elements of secrecy (28% vs. 13%). Conversely, older COCSA victims (10 through 12) had an increased probability of being a victim when there were multiple victims referenced (35%) and when there was a history of non-sexual aggravated assault (12%) compared to younger victims.

	5 and Under[1]		6 Through 9[2]		10 Through 12[3]	
Significant Characteristic Differences	**Probability**	**Expected Population Ratio**	**Probability**	**Expected Ratio**	**Probability**	**Expected Population Ratio**
Alleged Victim is Substantially Younger than CWSBP	74%	3:4	9%	1:10	1%	1:148
Alleged Victim is Known To CWSBP	93%	14:15	88%	7:1	6%	1:18
Alleged Victim Included Coercion	4%	1:23	12%	1:7	12%	1:7
Alleged Victim Case Included Violence	1%	1:129	8%	1:12	11%	1:8
Alleged Victim Case Included Bribes by CWSBP	1%	1:173	8%	1:12	1%	1:85
Elements of Secrecy Involved	13%	1:8	29%	1:3	n.s.	n.s.
Multiple Alleged Victims-Reference	11%	1:9	27%	1:3	35%	1:2
History of Non-Sexual Aggravated Assault	1.2%	1:86	n.s.	n.s.	13%	1:7
Number of Incidents	13%	1:7	29%	1:2	n.s.	n.s.

[1]Cox & Snell - R^2 .101 Goodness Of Fit 7570.356

[2]Cox & Snell - R^2 .044 Goodness Of Fit 7550.294

[3]Cox & Snell - R^2 .044 Goodness Of Fit 7444.180

n.s. = not significant

CWSBP=Child(ren) With Sexual Behavior Problems

Florida Abuse Hotline Referral Process and Calls

In order to understand the referral process for victims and children with SBP treatment providers and investigators were asked to identify where all possible referrals come from. Respondents were allowed to identify multiple referral sources. The table below illustrates that respondents receive referrals from a large variety of sources. Out of 140 respondents who answered this question, most are likely to receive referrals from the hotline (17.2%) followed by law enforcement (10.3%) and families (10.1%). The least reported referral source is public defenders (2.8%). Additionally, treatment providers stated that they often receive referrals through other community based agencies.

Referral Sources	Percent of Reported Responses
DCF Hotline	17%
Law Enforcement	10%
Family	10%
School	10%
Medical Practitioner	9%
Child Protection Team	8%
Judge	7%
Other Community Agencies	7%
State Attorney	6%
Daycare Center	6%
Department of Juvenile Justice	6%
Public Defender	3%
Total Number of Respondents	**140**

When asked about how a child with SBP is identified, CPIs indicated that this is usually determined through: the Hotline, by interviews with victims, and by which child exhibits inappropriate sexual behavior on the other child. One investigator explained the identification process for investigators. The respondent stated,

> *The Hotline codes the alleged offender as a "JS". Since the COC reports are special conditions reports, there is no finding of abuse, neglect or threatened harm. The COC assessment has specific questions that relate to offender behaviors, however, there is currently no specific place to identify if a child is truly an "offender" of COC. The information can be found in chronological notes and the assessment. There are limited resources available to have children who have been identified by a CPI as displaying offender behaviors or who have been identified as victimizing another child to be evaluated by a qualified professional to complete psycho-sexual evaluations or psychological evaluations. The CPI's complete interviews with the reported victim and the alleged JS are to obtain information to make assessments as well. Law Enforcement will take the lead in some investigations and will request CPI's not to interview the alleged JS due to the ongoing criminal investigation.*

The process used to identify victims is similar to the process used to identify offenders. One respondent indicates,

> *The Hotline codes the reported victim as a victim in the COC special conditions report. The CPI will complete interviews with all victims listed on the report and will complete referrals to the Child Protection Team who will complete a forensic interview on victim children who have disclosed information of being a victim of child on child sexual abuse. Law Enforcement may also be involved with the interview process with the reported victim. The COC assessment has specific questions relating to the reported victim. There are no*

findings of abuse, neglect or threatened harm in the COC assessment since it is not an investigation. The information identifying if the reported victim was actually a victim of child on child sexual abuse can be found through out the chronological notes and COC assessment.

Overall, there is no standard identification process for children with SBP and victims of COCSA. Reports of the aggressors are never truly founded and in some cases there are no clear identification of the child with SBP, there are only alleged children with SBP who are in need of treatment. In some cases, children with SBP are being identified as such because they are, "older, physically stronger, or have some sort of advantage over the other child. Also, if one child used force, coercion, threat, or manipulation to initiate the sexual activity, that child might be identified as an offending child." Victims are also identified through the Abuse Hotline.

A question was asked to assess specific types of child-on-child sexual abuse cases and the frequency of such cases. In this question survey participants were asked how often they or their program serves/investigates child-on-child sex abuse involving a variety of situations. Of the 140 respondents who answered this question, the most common cases received were classified as fondling, experimental and precocious behavior. Less common were cases involved coercion and penetration. Only rarely were cases involving violent sexual abuse received.

The case files revealed the same type of pattern as the online survey. From the total number of cases reviewed (N=41), fondling (66%) was the most reported type of incident followed by experimental (29%); consensual, coercion, and violence (17%). Both case file reviews and self-report data indicated that the majority of reported cases were for less serious types of COCSA.

				% In Which the Incident Indicated:				
Case Location	Alleged CWSBP or Victim	Number of Cases	Avg. Age at Incident	Violence	Coercion	Consentual	Fondling	Experimental
Alachua	Offender	10	8	30%	30%	20%	60%	30%
Alachua	Victim	10	5	10%	20%	30%	70%	40%
Broward	Offender	11	9	18%	9%	9%	64%	27%
Broward	Victim	10	5	10%	10%	10%	70%	20%
Total	**Offender**	**21**	**8**	**24%**	**19%**	**14%**	**62%**	**29%**
Total	**Victim**	**20**	**5**	**10%**	**15%**	**20%**	**70%**	**30%**
Total		**41**	**7**	**17%**	**17%**	**17%**	**66%**	**29%**

A question was asked to assess the frequency by which the respondents receive COCSA referrals and where these incidents most likely occurred. Respondents were allowed to identify multiple COCSA locations. Out of the total number of respondents answering this question, 137 individuals provided responses. The

respondents reported that child-on-child sexual abuse most often takes place in the child's primary home. Respondents least often reported that the abuse occurred in a school or daycare. However over a quarter of the respondents reported receiving school and daycare related cases often or very often.

The next set of questions addressed common characteristics of victims and children with SBP that the respondents have worked with including characteristics in regards to: family, mental health, cognitive and educational, having a history of non-sexual delinquency offenses, having a history of traumatic experiences. The most reported characteristics of children with SBP and victims included: having a history of sexual and/or physical abuse in the home, having a lack of supervision and lack of structure in the home, coming from a single parent home, being exposed to pornography or sexual material and families with low income. These same characteristics were also common in the literature review.

The survey also asked specific questions regarding the role of the Florida Abuse Hotline in regards to COCSA. Of the 177 respondents who reported whether they had ever made a call to the DCF Abuse Hotline in reference to a COCSA report, 46% said that they had. Of those who had made calls, respondents were asked to determine whether adequate feedback was given concerning the reported case. The results were varied. Specific comments included:

> *Abuse report was initiated and the children were referred to services within the agency. There was no feedback from the hotline counselor.*
>
> *Yes and no, recently a CPI in my unit made a call about COC sexual abuse and the hotline made the call into two new sexual abuse cases when the allegations were clearly COC sexual abuse with 4 yr olds involved.*
>
> *They accepted the report but I was not informed of the results.*
>
> *There are times when I felt it was child on child sexual abuse and the hotline would not accept the report. Then our unit would receive a report that appeared to be minimal in comparison to the one reported.*
>
> *Reports were accepted and forwarded to the local Sherriff's office and I was provided with adequate feedback.*
>
> *Actually it was disappointing, since they could [not] take some referrals in spite of knowing that the child is at risk. At times they have used the excuse that it is not under their jurisdiction and sometimes an adequate follow through is not completed.*
>
> *In most cases, reports are accepted and investigated or they are transferred to local law enforcement.*

Offender was placed in treatment. Hotline counselor gave no feedback other than to acknowledge that the report had been received and would be acted upon

Report was taken on more than half of the occasions and adequate feedback given by the counselor.

In some cases, the caller did not receive feedback, while in others the caller did. Because of the lack of standardization among whether the callers receive feedback, DCF should determine whether feedback is essential in COCSA cases. Appropriate policies and protocols for COCSA cases should be set forth based on this investigation.

Assessing Child-On-Child Sexual Abuse in Florida

Respondents were queried about all possible assessments they use when investigating child-on-child sexual abuse. The table below indicates the percentage of assessments that are used across the State of Florida.

Assessment Instruments	% of Reported Responses
Florida DCF Child on Child Sexual Abuse Assessment	89.5%
Abel Assessment for Sexual Interest (AASI)	2.6%
Clinical Polygraph	2.6%
Estimate of Risk of Adolescent Sexual Offence Recidivism (ERASOR)	6.6%
Global Assessment Instrument for Juvenile Sex Offenders (GAIJSO)	1.3%
Hare Psychopathy Checklist (PCL) – Revised	1.3%
Juvenile Sex Offender Assessment Protocol (J-SOAP – II)	9.2%
Juvenile Sex Offender Assessment Protocol (J-SOAP)	5.3%
Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (J-SORRAT-I	1.3%
Minnesota Sex Offender Screening Tool - Revised (MnSOST – R)	3.9%
Multiphasic Sex Inventory	1.3%
Psychopathy Checklist: Youth Version (PCL:YV)	1.3%
Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR)	1.3%
Risk Matrix 2000	1.3%
Sex Offender Risk Appraisal Guide (SORAG)	1.3%
Sex Offender Screening and Risk Assessment (SOSRA)	1.3%
Sexual Interest and Deviancy Assessment	2.6%
STATIC–2002	1.3%
STATIC–99	1.3%
Youth Level of Service/Case Management Inventory (YLS/CMI)	1.3%
Total Number of Respondents	*76*

The most used assessment was the Florida DCF Child-On-Child Abuse Assessment (89.5%). While all CPIs were familiar with the assessment, the majority of the treatment providers (73.7%) were not familiar. Of those who were familiar with the assessment, about 70 percent of the providers felt that the instrument was sufficient to determine if an additional assessment is needed. Information was also gathered from the Child Protective Investigators concerning whether there was a need to improve the instrument. Overall, there were a few key issues with the instrument that are highlighted below. Specific comments include:

The assessment reads as if the perpetration has actually happened. The assessment labels the youth as offenders and victims before the assessment is even completed.

The assessment tool should provide additional coverage of the offender child's family history and environment.

Include more narrative section to describe specific behaviors and risks.

Weed out experimental behavior in young children, where there is no penetration, just showing/touching. Law enforcement has to get involved on more serious cases with older teens.

Provide training for what is considered sexual abuse among children verse kids experimenting.

Fix it so CPI's have the ability to expand on their answers.

The assessment appears adequate for the task; the breakdown appears to be in the treatment and prevention end.

There needs to be a section that allows for the response to be no evidence of sexual abuse and therefore no services are necessary.

These quotes highlight a few areas suggested for change. It was recommended that the assessment should read "alleged victim" and "alleged offender" rather than "victim" and "offender" because the information has not been substantiated and the true victim and offender cannot be identified until the case has been investigated. The child protective investigators also highlighted other deficits in the COC assessment which included sections of missing information for children with SBP. However, because this type of information varied from person to person, if more changes are needed to the assessment, DCF should conduct focus groups specifically with CPIs to obtain more information about the exact changes needed to improve the Florida DCF Child-On-Child Abuse Assessment.

The second most used assessment was the Juvenile Sex Offender Assessment Protocol-II (9.2%). This assessment was highlighted in the literature review as receiving some empirical support. Treatment providers should continue to use validated instruments in assessing risk and needs of COCSA victims and children with SBP.

Treatment Services for Children Involved in Child-On-Child Sexual Abuse

The State of Florida offers a wide array of services to victims and children with SBP. While there is no concrete list of providers, the online survey investigated the various types of treatment offered within the State. Treatment providers were asked to describe their program goals, philosophy and approach to treatment. Slightly over a quarter (26.3%) of the treatment providers answered the question. Some noted comments include:

Our goals are to support the victimized child, stabilize the family and child, and provide necessary and appropriate counseling services to the child along with supportive counseling to the family. The program strives to reduce the negative impact of the victimization on the child via counseling and a strong education/prevention component in which formation is provided to the child on body safety and safe boundaries.

Our program goals are to provide in-home short term treatment for children and families.

Services for Cases of Child-On-Child Sexual Abuse	Percent of Services for CWSBP	Percent of Services for Victims
Individual Therapy	**90.5%**	**79.2%**
Outpatient	81.0%	70.8%
Family Therapy or Counseling	76.2%	66.7%
Assessment and Evaluation	61.9%	50.0%
Group Therapy	57.1%	41.7%
Cognitive Restructuring	52.4%	58.3%
CBT for Children with Sexual Behavior Problems	47.6%	50.0%
Social Skills Training	47.6%	45.8%
Crisis Counseling	42.9%	54.2%
Family Focused, Child Centered Treatment	38.1%	41.7%
Relapse Prevention	38.1%	16.7%
Trauma-Focused Play Therapy	33.3%	50.0%
Sex Education	33.3%	45.8%
Behavioral Parent Training	33.3%	33.3%
Pharmacological Treatment	28.6%	33.3%
Attachment-Trauma Therapy	28.6%	29.2%
Cognitive Processing Therapy (CPT)	28.6%	25.0%
Parent-Child Interaction Therapy	28.6%	16.7%
Adolescent Sex Offender Therapy	28.6%	12.5%
Dynamic Play Children with Sexual Behavior Problems	23.8%	20.8%
Brief Strategic Family Therapy (BSFT)	19.0%	8.3%
Parent-Child Education/Physical Abuse	14.3%	16.7%
Inpatient	14.3%	4.2%
Multisystemic Therapy (MST)	14.3%	4.2%
Child/Parent Physical Abuse CBT	9.5%	12.5%
Corrective Attachment Therapy	9.5%	12.5%
Eye Movement Desensitization & Reprocessing (EMDR)	9.5%	12.5%
Family Resolution Therapy	9.5%	8.3%
Milieu Therapy	9.5%	4.2%
Treatment of Dissociative Symptomatology	9.5%	4.2%
Physical Abuse Family Therapy	4.8%	8.3%
Intensive Family Preservation	4.8%	4.2%
Research	4.8%	0.0%
Trauma-Focused Integrative-Eclectic Therapy	0.0%	8.3%
Therapeutic Child Development Program	0.0%	4.2%
Functional Family Therapy (FFT)	0.0%	0.0%
Parents Anonymous	0.0%	0.0%
Parents United	0.0%	0.0%
Resilient Peer Training Intervention	0.0%	0.0%
Surgical Treatment	0.0%	0.0%
Total Number of Respondents	*21.00*	*24.00*

CWSBP=Child(ren) With Sexual Behavior Problems

The program philosophy and approach to treatment is to use a directed play therapy for the victim that incorporates a lot of recognized educational and therapeutic materials, therapeutic games and creative therapeutic materials. The child learns that the abuse was not their fault and they learn important information aimed to prevent any further abuse.

Our Mission is to provide the highest quality behavioral healthcare services which are affordable and accessible to the individuals and families served

We treat all children 17 and younger who have experienced trauma or who display sexual behavior problems We work from a family systems model, providing play therapy, individual/family therapy, group, psychiatric services, case management, and medication case management. We are linked to the Sexual Abuse Intervention Network and are members of Association for the Treatment of Sexual Abuser, following that organizations ethics and guidelines

Our philosophy and approach to treatment is family centered and based on positive youth development. Goals are to prevent youth from entering DCF and DJJ systems and to reunite them with their families when appropriate.

We use a team approach to treat each child's unique needs; we assist in meeting their emotional, behavioral, and educational needs through matching them with appropriate foster and adoptive parents, supportive mental health counseling with qualified therapists, and referrals to appropriate community resources.

Treatment providers who responded indicated that they believed that the program goals, philosophy and approach to treatment illustrated a holistic approach to treating youth who have sexual behavior problems and victims of COCSA. Some programs said they target the risks and needs of the child and integrate the family or primary caregiver in the treatment process. These are all important aspects of treating victims and children with SBP that were outlined in the literature review. A closer investigation of the programs may be needed in order to evaluate whether the programs are truly implementing services based on a holistic approach, whether they are assessing the risk of reoffending and the risk of victims becoming revictimized later in life.

Only a small percentage of the treatment providers identified what type of treatment, services or support they or their program provided to children with SBP (18.4%) and to victims of COCSA (21.1%). Caution should be made in drawing conclusions because of the small percentage providing answers to this question. The responses indicated that the providers who responded offer a variety of treatment interventions for children with SBP and victims. A comparison of the various types of services provided by treatment providers who serve both children with SBP and victims shows little variation between how a child with SBP

is treated compared to the victim. Most often treatment providers reported utilizing individual counseling therapy for children with SBP (90.5%) and victims (79.2%), followed by outpatient treatment services for children with SBP (81.0%) and victims (70.8%), and family therapy and counseling for children with SBP (76.2%) and victims (66.7%). Additionally family therapy or counseling, assessment and evaluation, group therapy, Cognitive Restructuring, CBT for Children with Sexual Behavior Problems, social skills training and crisis counseling were offered often by providers treating children with SBP. Those same services were most offered victims by providers in addition to family focused child centered treatment, Trauma-Focused Play Therapy and sex education. No providers reported using Functional Family Therapy (FFT), Parents Anonymous, Parents United, Resilient Peer Training Intervention or surgical treatment.

The average length of treatment for children with SBP and victims was reported to be about 6 to 9 months in duration. The reported average number of hours per week that a child with SBP or victim spends on treatment ranges from one to three hours.

The next set of questions focused on the most challenging behaviors to care for and investigate. Child protective investigators stated that victim and children with SBP are the most difficult cases to investigate when the they involve: very young children, children who have emotional or developmental problems, acts that are consensual, more serious sex abuse cases, parents who are uncooperative, and when the victim and offender share the same home. Specific comments included:

> *Cases in which the act is consensual as both the offender and the victim tend to hide all evidence and/or not cooperate. Any time the family is in denial things are more challenging.*
>
> *When the report involves non-verbal children or children who have emotional or developmental problems such as autism.*
>
> *The most challenging cases are when the victim and offender live in the same home. There is often not a better solution than to have the parents closely supervise the children in those situations that do not call for law enforcement.*
>
> *When the offender child is of an age that law enforcement may make an arrest on. The CPI is unable to conduct an interview with the offender without cooperation from law enforcement.*
>
> *Non cooperative parents who don't want to believe the allegations.*
>
> *Penetration cases because often times children fear getting into trouble. Sometimes they have been molested or some form of incest has happened which is the contributing factor of the abuse.*

When the children live together it is much more difficult for a caregiver to restrict access.

When the parents are not supportive and they deny the fact that their child needs help.

Providers stated that most difficult child-on-child sexual abuse cases to treat are the cases where: the family is non-supportive and unstructured, there are non-verbal youth involved, there is poor attendance to treatment because it is voluntary, there are self-blame and self-esteem issues, there are anger management issues, the child is in foster care, and those children who are in denial. Specific comments included:

It is difficult to reframe victim and offenders thinking into understanding that this is a violation of someone's personal boundaries if they have been taught from a young age that it was ok for someone to do it to them; therefore it must be ok for them to do it to someone else.

It is most challenging to treat offenders who have a history of multiple offenses. Patterns of anti-social behaviors are most challenging.

For offenders, developing empathy, addressing anger management and any unresolved victimizations.

It is most challenging to treat children with parents and caregivers who are in denial of the act.

For victims, understanding that what happened was not their fault.

Trauma, resulting from social stigma attached to the incident.

Typically, the development of trust is a significant issue for victims of sexual abuse. This requires time and therapeutic "patience."

Feelings of guilt, anger and issues related to self-esteem and empowerment.

Children in foster care who move a lot and who change placements frequently.

Believing they are to blame for the abuse because they deeply believe that they are at fault.

The next set of questions asked respondents about whether children with SBP are being served effectively through the available community resources. Out of the total number of respondents who answered this question (N=83), 53 percent thought that children with SBP were not being served effectively through the available community resources. Respondents were also asked why they felt this way.

Overall, there were numerous issues that respondents felt needed to be improved for children with SBP including: an increase in funding and resources for children with SBP, better counseling services, education

classes for parents, better in-home family services, a need to mandate services for offenders, more available treatments for those who use Medicaid, more realistic safety plans, and transportation to and from services. Overwhelmingly, respondents felt that there were not enough services available for children with SBP and, when available, the services were too expensive and too difficult to get to. Specific comments included:

> *More resources are necessary. The nearest treatment is located sixty miles from here. Many families do not follow through because it is too difficult to get there.*
>
> *There are limited services and they are costly. It is difficult for the offender to get there. Evaluations are often not completed timely on offender children when they are referred.*
>
> *We have minimal services. If there is something for the children, it is located far away. Few of our families can afford these services because they are too expensive and Medicaid isn't accepted.*
>
> *For offenders who must leave their home, there are inadequate placement options.*
>
> *There are not enough services and people do not know what services are available.*
>
> *There are inadequate resources to thoroughly address the needs of offenders and there are not enough prevention dollars for prevention programs.*
>
> *In my experience, many children are simply not ready to talk about or emotionally deal with their issues. They divert attention with irrelevant discussion, outlier behavior, and other co-occurring mental health disorders.*
>
> *The community agency that serves many youthful offenders is a fabulous program; however, they have insufficient funding to serve all those in need.*
>
> *Engaging the families as to why services are necessary. Better communication between the parties and agencies in working with the offenders and the families.*

Respondents were asked whether victims are being served effectively through the available community resources. Out of the total number of respondents who answered this question (N=81), 65 percent of respondents thought that victims were being served effectively through community resources. Overall, respondents thought that victims were receiving adequate services compared to children with SBP. Specific comments included:

> *There are plenty of resources available; many are free of charge or sliding scale fee for those who can't afford regular costs.*
>
> *There has always been more focus on the victim than the offender and many more programs offered to them.*

The battered women's shelter does child sexual abuse counseling and it is free for the children, but they do not accept offenders.

There are several providers in the area both public and private. There are also programs to assist in paying for the services.

The therapists seem to be able to deal with the victims more effectively than the offenders.

There are multiple counseling options available and private individual therapists who can get reimbursed through victim's compensation.

I believe once families are identified, they are being served.

Victims have more services offered to them. The families need to take advantage of it.

We are the premier providers in this area and we have had great feedback from the community about the effectiveness of our program, as well as other programs nearby.

This agency has provided quality services for victims/families for more than 30 years.

Even though the majority of respondents were satisfied with services that were available to victims, those respondents who did not think that victims are being served effectively stated:

There is a lack of resources to assist families and to counsel individuals who have Medicaid.

There is such a long waiting lists for victims to get in to see a therapist.

There are not enough skilled professionals for treatment.

Our agency provides fantastic services and we believe they are effective. However, we are insufficiently funded to serve all those referred in a timely manner. Right now we have a 3 to 5 month waiting list!

In summary, due to the limited number of respondents to the questions in this section caution should be taken in generalizing the results. Treatment providers did report that their philosophy to treatment is a holistic approach to treating children with SBP and victims of COCSA. Providers also reported that they tailor the programs to the child with SBP and victim risks and needs. Additionally, the type of treatment for victims and children with SBP are similar with most the most common service being individual therapy. Providers also reported that the most challenging to treat children with SBP and victims were most often young and non-verbal. Additionally, the majority of respondents thought that children with SBP were not receiving the treatment that they needed in the community due to a lack of funding, a lack of available

resources, and transportation issues. Conversely, respondents reported that victims were getting the services they needed in the community.

Training and Service Barriers in Treatment

In order to assess the gaps and service barriers in treating victims and children with SBP, several questions were asked to the treatment providers and investigators. First, investigator and treatment providers were asked to discuss the training that they have received in COCSA. Second, respondents were queried about what the Department could do to better service victims and children with SBP.

The requirements for training vary from CPIs to those who provide treatment for children with SBP and victims of child-on-child sexual abuse. Child protective investigators are required to attend pre-service trainings in regards to investigating child-on-child sexual abuse. Thus, all CPIs should have completed the required training before entering the field. Additionally, 36 percent of the investigators reported receiving additional training on child-on-child sexual abuse. Many of those who received training reported that they had received, on average, about 10 to 20 additional hours of training. Many investigators (N=44) also reported that the pre-service training could be improved. Specific comments included:

> *Include more during the pre-service training; provide staff with refresher courses during the re-certification process. Include more interactive trainings with experts in the field.*
>
> *I don't think DCF has had much of this training for a CPI. There is a lot on sexual abuse, but just a short session on COC.*
>
> *Trainings should focus on what services are available in the community for both offender and victim children. Safety planning should be creative. Not every child offender is the same and not every victim is the same. Trainings tend to put both victims and offenders into one category and that is not what we experience in the field.*
>
> *We need more or at least some training. We spend so much time learning about "customer service, HIPPA, etc." and not much time on this issue at all. We have had basic child sexual abuse training, but I believe that the part that focused on child on child was probably less than 10 minutes. I would like more information on child on child.*
>
> *To begin with, there should be a training given more regularly, like "Ethics" which is every two years. Interviewing a child regarding being spanked by mom or dad is very different than when it is a COC report-- no matter how the child is assured that he/she isn't in any trouble, most children do not like to reveal what they did.*
>
> *Up to date and current techniques need to be offered on a regular basis by professional on the front lines of this abuse and neglect issue*

It needs to better prepare CPIs. What I have learned has been a result of my Supervisor and co-workers who have been with the department for over 10 years. The training did not prepare me for child on child cases.

Treatment providers were also asked questions in regards to training that they have received on child-on-child sexual abuse. Of those who answered the question (N=53), approximately 66 percent reported having received training on child-on-child sexual abuse. Treatment providers were further questioned about the types of in-service trainings that may be beneficial to those providing services to offenders and victims of child-on-child sexual abuse. They stated:

I am a member of SAIN (Sexual Abuse Intervention Network). This network is joined by mental health professionals dealing with sexual abuse. As a result, current laws, not just local but national, treatment trends are discussed including ways to improve services to this population. I would highly recommend that any professional working with this population become familiar with this organization.

The Kempe Center curriculum provides primary, secondary, and tertiary prevention of sexually abusive behaviors in childhood and adolescence.

Orange CAC annual Conference in addition to ongoing community and professional training provided through Howard Phillips Center Sexual trauma recovery center are beneficial trainings.

The License Board of Pinellas Florida and The Children's Home has training that might be beneficial to professionals providing treatment to VICTIMS/OFFENDERS and families.

I completed one through Meridian with Robert Edelman from the Village Counseling Center.

The National Center on Sexual Behavior of Youth

Cross Country Education sometimes offers such seminars. they are typically offered in Melbourne or Orlando, but cost $159 per person for early registration.

Overall, both investigators and treatment providers stated that more training on child-on-child sexual abuse was warranted. It was also clear that there was no interagency agreement about what constitutes normal sexual behavior. Of those investigators who answered the question (N=49), 69 percent indicated that there was not a clear agreement between agencies about what constitutes normal sexual behavior. Those investigators who thought this stated that more training was needed in addition to the short pre-service training. Respondents also indicated that referral sources could also benefit from training on identifying cases of child-on-child sexual abuse (76%) and on what constitutes normal adolescent sexual behaviors (81%). Specific comments included:

It is based on the age of the child but an exact definition of normal is not made and is left up to the interpretation of the people involved.

There needs to be more training on this subject. Most of the CPIs understand there are guidelines about normal childhood behaviors and experimentation.

There is a wide scope of what is considered normal and what is considered inappropriate sexual behavior.

It is not clear. We use common sense but I have not seen any kind of specific lay out to define it.

It does not seem to be clearly defined.

Respondents were asked how the Department of Children and Families could better educate investigators, community providers and families about child-on-child sexual abuse. Respondents pointed to more training throughout all agencies, communities and schools. Specifics comments included,

More training is needed about what constitutes normal and abnormal sexual behaviors. Specifically, information should be provided to us in our area about how to educate others.

Training is needed for providers who make reports on normal adolescent behaviors. Training needs to be across the board so Child Protection Teams, law enforcement, DCF, and providers are all on the same page.

Brochures and literature should be consistent throughout the state and sent to CPIs, schools, daycares, and foster parents including what to look for and what behaviors should be reported.

Hold frequent trainings conducted by experts in the field. In our circuit, we have a specialized unit that handles these cases which provides consistency in their handling and expertise.

Provide more outreach and encourage providers to talk more about normal child hood exploration and how to talk to kids about this.

Educational resources and dollars for community providers like our agency to conduct trainings.

More community activities making families aware of what is available and holding special assemblies at schools to make the kids aware of what is available to them.

Legislation is needed that treats all children as children regarding sexual behavior problems. There should not be a cut-off after age 12. The state has gone overboard in labeling children as sexual predators, and legislators need education about the differences between adult and child sexual offenders. Studies have been done that show the effectiveness of

quality treatment programs, but we continue to put our funding into restriction rather than treatment and prevention.

The majority of the child protective investigators have received a short pre-service training on child-on-child sexual abuse. Those treatment providers who deal with these cases more frequently have more training and expertise on child-on-child sexual abuse than do investigative staff reporting. The majority of respondents highlighted specific training needs across Departments and agencies including those involved in the referral process. Respondents also pointed to an internal agency difficulty in identifying what is normal and inappropriate sexual behavior by children. Policies, protocols and appropriate trainings which address these deficits should be the focus of the Florida Department of Children and Families.

SUMMARY FINDINGS AND RECOMMENDATIONS

The findings from the Florida Child-on-Child Sexual Abuse Assessment for children with sexual behavior problems and child victims have significant policy implications. The literature review demonstrated that the use of community-based and family-focused interventions for youth who engage in sexual offending is supported (Letourneau et al., 2009; Saunders et al., 2004). The use of cognitive-behavioral treatment approaches is likewise supported by these studies, as is the documentation of similarities in risk factors between adolescent sex offending and other types of serious antisocial offending. Decreased attachment to family and school, as well as association with deviant peers, are relevant risk factors for adolescent sex offenders and delinquent youth in general (Ronis and Borduin, 2007). As such, interventions should target "multiple ecological systems" impacting the lives of youth involved in sexual deviance (Letourneau et al., 2009:99).

Public fear of and disdain for child victimization and sex offenses is pronounced. In recent years, states and the federal government have moved to implement public sex offender registration and notification for not only adult sex offenders but also children who commit sexual offenses. In many ways, despite empirical evidence to the contrary, there is a presumption that children with SBP are intransigent, compulsive and incurable. With recent legislation such as the Adam Walsh Act, public policy is increasingly stigmatizing and isolating young sex offenders far more than adult criminals and at ages as young as 14 years (stigmatizing and labels which will remain with the child for their entire lives) (Zimring, 2004). Yet, research findings have consistently demonstrated relatively low risk levels for sexual reoffending among children found to have sexual behavior problems or who have sexually offended (Carpentier et al., 2006). This has led some to conclude that 'public policies for these youth have been fundamentally driven by misperceptions, resulting in a set of well-intentioned but ultimately flawed policies and practices that are unlikely to deliver either child protection or juvenile justice benefits' (Chaffin, 2008:110)

The findings from the Child-On-Child Sexual Abuse Needs Assessment were similar to the findings from the literature review. The summary findings in each of the following areas is presented below: the extent and nature of child-on-child sexual abuse, alleged children with SBP risk factors and characteristics, alleged victim risk factors and characteristics, referrals and calls to the Florida Abuse Hotline, assessing child-on-child sexual abuse in Florida, treatment services for children with SBP and victims of child-on-child sexual abuse, training and service barriers in treating children with SBP and victims of child-on-child sexual abuse.

Extent and Nature of Child-on-Child Sexual Abuse in the Florida Child Welfare System

- The number of COCSA alleged victims and verified victims remained relatively stable between fiscal year (FY) 2003-04 and FY 2006-07. In FY 2003-04, the total number of alleged victims was 4,981 and in FY 2006-07 this figure was 4,566. There were a total of 799 verified victims in FY 2003-04 and 710 in FY 2006-07.
- When assessing the trends in reporting COCSA, calls to the Florida Abuse Hotline have moderately decreased since FY 2005-06 (3,488 COCSA-related calls in FY 2005-06; 3,261 calls in FY 2008-09).
- The number of alleged children with SBP consistently remains below the number of alleged COCSA victims (3,961 and 4,383 in FY 2008-09, respectively).
- COCSA alleged victims represented about 8 to 11 percent of all Abuse Report victims (these include those abused, neglected, threatened or harmed) over the last five years. Further, the percent of all COCSA referrals in which a victim was verified remained relatively constant between FY 2003-04 and FY 2006-07 (roughly 15-16% of all COCSA referrals).

Risk Factors and Characteristics of Children with Sexual Behavior Problems (SBP)

- The top three characteristics among all alleged children with SBP were: a history of physical/ emotional separation from a parent (38%), a history of instability in the family (30%), and a history of neglect (24%).
- Examining race differences, children with sexual behavior problems who were white, had a greater probability of having a history of sexual victimization compared to black children who engaged in child-on-child sexual abuse. Alternatively, blacks were significantly more likely to have a history of physical abuse, neglect, academic difficulties, and attribute blame to the victim, compared to white children engaging in these behaviors.
- Gender differences were also pronounced, with boys exhibiting an increased probability of having inadequate social skills, poor peer relationships, academic difficulties, and a history of impulse control problems, as compared to girls engaging in child-on-child sexual abuse. Girls, on the other hand, were much more likely to have a history of sexual victimization, neglect, and knowledge of advanced sexual practices compared to their male counterparts with sexual behavior problems.
- Younger alleged children with SBP (5 years and under) had an increased probability of having a history of instability in the home and a history of anxiety compared to older children who engaged in child-on-child sexual abuse. Older children (10 to 12 years) with sexual behavior problems tended to have an increased probability of having academic difficulties compared to their younger counterparts (aged 9 and younger).

Victim Risk Factors and Characteristics of Child-on-Child Sexual Abuse

- The top three characteristics among all alleged COCSA victims were: the alleged victim knew the alleged abuser (91%), the alleged victim was substantially younger than the abuser (27%), and more than one victim was involved (21%).

- White alleged COCSA victims had an increased probability of knowing the abuser, being bribed by the abuser, and being involved in elements of secrecy compared to black COCSA victims. Whereas, black alleged COCSA victims had a greater probability of being involved in incidents that were violent compared to white victims.
- Male victims had an increased probability of being substantially younger than their alleged abusers, being involved in a violent incident, and having elements involving secrecy compared to female victims.
- Younger alleged COCSA victims (5 and under) had an increased probability of knowing their abuser and being substantially younger than their abuser compared to older victims.
- Alleged COCSA victims, 6 through 12 years of age, had an increased probability of experiencing coercion compared to younger alleged COCSA victims (5 and younger).
- COCSA victims between the ages of 10 and 12 years of age had an increased probability of being a victim when there were multiple victims referenced and when there was a history of non-sexual aggravated assault, compared to younger victims.

Case Referral Process and Florida Abuse Hotline Calls

- Overall, there was no standard identification process for children with SBP and victims of COCSA. The State has been proactive in not identifying children with SBP under the age of 12 as verified perpetrators or offenders. As such, reports of children with SBP were not *founded* or *verified*, and in some cases there was no clear determination as to the initiator in the incident, only identifications of children in need of treatment.
- Survey and focus group data indicated that referrals for COCSA were most often received through the Florida Abuse Hotline.
- Both case file reviews and survey data suggested that fondling and sexual behavior experimentation were more common than more serious forms of abuse.
- Survey data found that COCSA incidents most often take place in the child's primary home. Respondents least often reported that the abuse occurred in a school or daycare.

Assessing Child-On-Child Sexual Abuse in Florida

- According to survey and focus group data, the most widely used assessment instrument was the Florida DCF Child-On-Child Sexual Abuse Assessment. The Juvenile Sex Offender Assessment Protocol-II was reported as the second most often used assessment.
- Respondents felt that the Child-On-Child Sexual Abuse Assessment should read "alleged victim" and "alleged offender" rather than "victim" and "offender," because the information has not been substantiated and the true victim and child with SBP cannot be identified until the case has been investigated.

Treatment Services for Children with Sexual Behavior Problems

- Survey data from treatment providers indicated that program goals, philosophy and approaches to treatment were relatively consistent with having a holistic service approach for children involved in COCSA cases.
- While Florida treatment providers offer a wide array of services to children involved in child-on-child sexual abuse, a comparison of the types of services received by victims and children with SBP showed little variation between how children engaging in these behaviors are treated compared to those who are victims.
- Most often treatment providers utilized individual counseling therapy followed by outpatient services for children engaging in or victimized by child-on-child sexual abuse.
- The majority of the treatment providers believed that treatments were tailored to the needs and problems of children with SBP and victims.
- Respondents reported that very young children and/or children with emotional or developmental problems are the most challenging to treat.
- Overwhelmingly, respondents felt that there were not enough services available for children engaging in these behaviors and, when available, the services were too expensive and too difficult to access.
- The majority of the respondents thought that victims were being served effectively through community resources.

Training and Service Barriers in Treating Children Involved in Child-On-Child Sexual Abuse

- Child protective investigators reported that they received a short pre-service training on child-on-child sexual abuse.
- Treatment providers who deal with COCSA cases frequently had more training and expertise in handling these cases than child protective investigators.
- Investigators reported that the pre-service training on child-on-child sexual abuse could be improved by having more in-depth trainings and by focusing on investigating COCSA. Additionally, they reported that booster trainings could help advance knowledge in this area.
- The majority of the respondents thought that there was no general agreement about what constitutes normal sexual behavior and that this needed to be clearly defined and disseminated.
- Overwhelmingly, treatment providers and investigative respondents indicated that there was a need for COCSA training across social service agencies and within the community.

Recommendations

The following recommendations are synthesized from the study results and offered to the Florida Department of Children and Families to facilitate effective service delivery to children involved in child-on-child sexual abuse:

1. The number of Florida Hotline calls involving COCSA cases has generally declined. The current investigation found that COCSA is not a pandemic problem across Florida compared to other cases of abuse, neglect and abandonment. The dissemination of this report may help reduce fear and anxiety among child advocates about the number of COCSA cases being reported to the Department.
2. The DCF information system should track whether COCSA cases are verified after the investigation is complete to differentiate confirmed from alleged cases. This does not mean that youth engaging in these behaviors should be labeled as sexual offenders. Rather, these cases could be recorded as a verified case of a child with sexual behavior problems. In addition, victims of COCSA should be investigated, verified, and this information should then been uniformly tracked in the DCF information system. Verification is essential as research has demonstrated that victims who are left untreated may become involved in future victimizations.
3. Given empirical outcomes demonstrating low rates of future sexual offending by children with sexual behavior problems, as well as the documented need to address these problems early in the life course, it is recommended that the Department revisit issues related to age restrictions. Cases where the child with SBP is over the age of 12 are being directly referred to law enforcement and the local State Attorney's office. Investigations of these cases should be standardized across the State. Having multiple department investigations may not be the most effective way to gather and elicit information from alleged children with SBP, victims, and their families. Additionally, there are issues related to emotional maturity and cognitive functioning that dictate the need for exceptions to the rule. Finally, there is concern over those cases where the State Attorney's Office declines to prosecute, but the child is still in need of services to address their sexual behavior problems. These youth should be tracked to ensure that children engaging in behaviors that do not warrant prosecution but nonetheless may be indicative of sexual behavior problems, do not go untreated.

4. Child protective investigators overwhelmingly asked for more training in investigating COCSA. Comprehensive training and booster sessions should be provided to DCF employees and providers to ensure effective identification, investigation and intervention in cases of COCSA.
5. The main assessment used, the Florida DCF Child-On-Child Sexual Abuse Assessment, should be revised to accurately reflect the status of children *allegedly* engaging in child-on-child sexual abuse, as well as *alleged* victims of COCSA. DCF primarily handles children who are not prosecuted for sexual offending and who likely will not go onto to engage in such behavior. As such, it is recommended that children engaging in child-on-child sexual abuse should be referred to as children with sexual behavior problems (SBP), as opposed to offenders, perpetrators or abusers.
6. Additional information should be solicited from CPIs (this is not identified yet) through focus groups and/or surveys to identify necessary changes to improve the Florida DCF Child-On-Child Abuse Assessment itself. Furthermore, the reliability and validity of the assessment instrument should be empirically verified.
7. This investigation found that children who engage in child-on-child sexual abuse have a limited number of available treatment options. The Florida Department of Children and Families should solicit additional funds to adequately address service gaps for these children. Treatments should be readily available through public options in addition to having an adequate number of services available through privately funded insurance.
8. Individual counseling was the most reported treatment option for children involved in COCSA cases. The research suggests that this may not be enough. A number of evidence-based, cognitive behavioral interventions have been found to effective with this population including Trauma-Focused Cognitive Behavioral Therapy and Child Molester Treatments. In addition, Multi-Systemic Therapy (MST) and Parenting with Love and Limits (PLL) have demonstrated recent significant outcomes in reducing sexual behavior problems, delinquency, substance use, mental health symptoms, and out-of-home placements among youths who have engage in sexual offending. It is particularly critical that interventions include a strong family/caregiver component, as research indicates that cases with limited family/caregiver engagement have lower odds of successful outcomes than those engaging the caregivers in the treatment process.
9. In order to appropriately serve children involved in COCSA cases, each circuit should document all available treatment options for these children so that this information is easily accessible and disseminated to appropriate referral agencies. Information regarding available treatment options

also needs to be maintained in a web-based system so that it can be regularly updated. Availability of funding for these services as well as the acceptance of any specific insurance should be disseminated.

10. Policies and protocols should be developed in Florida that clearly distinguish inappropriate sexual behavior from normal sexual behavior. All departments and agencies should be trained on these distinctions. Additionally, this information should be widely disseminated and made available to community members, schools, daycares and parents.
11. Once the Department has had sufficient time to make appropriate changes, more research may be warranted in order to reassess the extent and nature of COCSA, characteristics and risk factors, the referral process, treatment outcomes, and barriers to training and service delivery.

The Florida Department of Children and Families commitment to investigating and servicing children with SBP and victims of child-on-child sexual abuse represents a fundamental change in utilizing evidence-based practices in Florida. System level transformations of this nature require detailed planning, direction and continual monitoring and support to ensure that true change is accomplished. True sustained change also requires continual support and feedback from those providers and investigators in the field. In order to effectively integrate new policies on COCSA, all organizational levels should be knowledgeable of the policy, procedures and overall vision in effective service delivery for children with SBP and victims of child-on-child sexual abuse. Refinement of current COCSA policies and procedures will, if implemented effectively, cut costs and produce long-term dividends for the Department, the community and children with SBP and victims served. The Florida Department of Children and Families will be able to contribute greatly to the emerging evidence that supports the specialized treatment approach of children with SBP and victims of child-on-child sexual abuse.

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APPENDIX

Child-on-Child Sexual Abuse Cases by County

Alleged Offenders by County	Total Number*	History Of Sexual Victimization	History Of Physical Abuse	History Of Neglect	History Of Family/ Domestic Violence	Alleged Offender's Family Has History Of Instability	History Of Physical/ Emotional Separation From a Parent	Inadequate Social Skills, Poor Peer Relationship	Knowledge Of Advanced Sexual Practices	Been Exposed/ Access To Pornography	Academic Difficulties	Reduced Empathy	Alleged Offender Blames Victim	History Of Impulse Control Problems	History Of Anxiety	History Of Depression	History Of Suicidal Ideation	History Of Substance Abuse
Alachua	132	26 (20%)	15 (12%)	24 (18%)	19 (15%)	41 (31%)	45 (35%)	19 (15%)	37 (30%)	12 (11%)	19 (16%)	4 (3%)	3 (3%)	20 (17%)	3 (3%)	6 (5%)	1 (1%)	0 (0%)
Baker	13	2 (15%)	3 (23%)	2 (15%)	4 (31%)	6 (46%)	6 (46%)	3 (23%)	0 (0%)	0 (0%)	5 (42%)	1 (8%)	3 (23%)	4 (31%)	3 (23%)	0 (0%)	0 (0%)	0 (0%)
Bay	99	28 (28%)	17 (17%)	27 (28%)	32 (33%)	37 (37%)	43 (43%)	25 (26%)	24 (26%)	5 (5%)	18 (19%)	6 (6%)	8 (8%)	21 (22%)	4 (4%)	5 (5%)	1 (1%)	3 (3%)
Bradford	11	0 (0%)	0 (0%)	0 (0%)	1 (9%)	2 (18%)	1 (10%)	2 (18%)	1 (9%)	0 (0%)	1 (10%)	1 (9%)	3 (27%)	2 (18%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Brevard	242	53 (22%)	46 (19%)	70 (29%)	72 (30%)	91 (38%)	117 (49%)	63 (26%)	70 (30%)	29 (13%)	80 (33%)	23 (10%)	28 (12%)	49 (21%)	16 (7%)	16 (7%)	9 (4%)	2 (1%)
Broward	588	83 (14%)	73 (12%)	141 (24%)	81 (14%)	145 (25%)	186 (32%)	103 (18%)	137 (24%)	59 (11%)	130 (23%)	42 (8%)	75 (13%)	90 (16%)	22 (4%)	15 (3%)	11 (2%)	8 (1%)
Calhoun	5	0 (0%)	0 (0%)	1 (20%)	1 (20%)	2 (40%)	3 (60%)	2 (40%)	2 (40%)	1 (20%)	0 (0%)	1 (20%)	1 (20%)	0 (0%)	1 (20%)	0 (0%)	0 (0%)	0 (0%)
Charlotte	54	11 (21%)	7 (13%)	14 (27%)	10 (20%)	19 (37%)	21 (40%)	9 (17%)	4 (8%)	9 (19%)	15 (29%)	6 (12%)	7 (14%)	8 (15%)	6 (12%)	4 (7%)	1 (2%)	0 (0%)
Citrus	45	16 (36%)	3 (7%)	11 (24%)	8 (18%)	25 (58%)	25 (58%)	9 (22%)	10 (24%)	4 (11%)	7 (17%)	2 (5%)	1 (2%)	8 (20%)	4 (10%)	1 (3%)	0 (0%)	1 (2%)
Clay	97	21 (22%)	11 (12%)	22 (23%)	25 (26%)	33 (34%)	36 (38%)	24 (26%)	22 (25%)	15 (18%)	21 (23%)	15 (16%)	12 (13%)	24 (27%)	9 (10%)	7 (8%)	2 (2%)	0 (0%)
Collier	67	6 (10%)	8 (12%)	11 (16%)	7 (11%)	11 (18%)	21 (35%)	10 (17%)	6 (10%)	5 (9%)	9 (15%)	0 (0%)	2 (3%)	5 (9%)	1 (2%)	1 (2%)	1 (2%)	0 (0%)
Columbia	39	8 (24%)	8 (21%)	11 (28%)	17 (46%)	17 (45%)	16 (43%)	5 (13%)	8 (25%)	2 (6%)	9 (26%)	4 (12%)	4 (13%)	5 (15%)	2 (6%)	3 (10%)	2 (6%)	0 (0%)
Desoto	26	8 (32%)	10 (38%)	12 (46%)	13 (52%)	11 (48%)	15 (60%)	2 (8%)	8 (36%)	8 (32%)	6 (25%)	3 (13%)	0 (0%)	2 (9%)	1 (4%)	3 (13%)	2 (8%)	0 (0%)
Dixie	9	1 (11%)	2 (22%)	3 (33%)	4 (44%)	3 (33%)	2 (22%)	0 (0%)	0 (0%)	0 (0%)	1 (11%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Duval	433	65 (15%)	51 (12%)	112 (26%)	85 (20%)	114 (27%)	154 (36%)	78 (18%)	93 (22%)	37 (9%)	89 (21%)	36 (9%)	48 (11%)	72 (18%)	34 (8%)	20 (5%)	3 (1%)	0 (0%)
Escambia	183	31 (17%)	21 (12%)	45 (25%)	37 (21%)	58 (32%)	59 (33%)	26 (14%)	41 (23%)	11 (6%)	30 (17%)	7 (4%)	19 (11%)	19 (11%)	5 (3%)	6 (3%)	6 (3%)	1 (1%)
Flagler	43	4 (10%)	6 (14%)	6 (14%)	10 (24%)	12 (28%)	14 (33%)	4 (10%)	7 (18%)	2 (5%)	5 (13%)	7 (18%)	6 (15%)	4 (10%)	3 (7%)	1 (3%)	0 (0%)	0 (0%)
Franklin	6	0 (0%)	1 (17%)	2 (33%)	2 (33%)	3 (50%)	3 (50%)	0 (0%)	1 (17%)	0 (0%)	1 (17%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (17%)
Gadsden	19	5 (29%)	1 (6%)	9 (50%)	7 (41%)	11 (58%)	9 (50%)	2 (11%)	4 (22%)	1 (6%)	5 (31%)	1 (6%)	0 (0%)	0 (0%)	1 (6%)	0 (0%)	0 (0%)	0 (0%)
Gilchrist	9	1 (13%)	1 (11%)	5 (56%)	2 (25%)	5 (56%)	6 (67%)	2 (22%)	2 (22%)	0 (0%)	5 (56%)	2 (22%)	2 (22%)	3 (33%)	1 (13%)	1 (13%)	1 (13%)	0 (0%)
Glades	2	0 (0%)	0 (0%)	0 (0%)	2 (100%)	1 (50%)	1 (50%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Gulf	6	1 (17%)	0 (0%)	4 (67%)	4 (67%)	5 (83%)	6 (100%)	4 (67%)	3 (75%)	0 (0%)	0 (0%)	0 (0%)	1 (17%)	2 (33%)	2 (33%)	0 (0%)	0 (0%)	0 (0%)
Hamilton	11	4 (36%)	1 (9%)	1 (9%)	0 (0%)	2 (18%)	7 (64%)	1 (9%)	2 (20%)	0 (0%)	1 (10%)	1 (10%)	3 (30%)	2 (18%)	1 (10%)	0 (0%)	0 (0%)	0 (0%)
Hardee	8	0 (0%)	0 (0%)	2 (25%)	2 (25%)	1 (13%)	2 (25%)	1 (13%)	2 (33%)	1 (17%)	2 (29%)	1 (17%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Hendry	17	3 (19%)	1 (7%)	4 (27%)	1 (7%)	7 (50%)	8 (50%)	1 (6%)	2 (13%)	1 (7%)	3 (20%)	1 (6%)	3 (18%)	1 (6%)	1 (6%)	0 (0%)	0 (0%)	0 (0%)
Hernando	65	9 (15%)	5 (8%)	14 (22%)	19 (30%)	25 (38%)	29 (45%)	14 (23%)	16 (25%)	7 (12%)	18 (31%)	7 (11%)	9 (14%)	19 (30%)	5 (8%)	5 (9%)	3 (5%)	1 (2%)
Highlands	50	6 (12%)	3 (6%)	10 (20%)	15 (31%)	13 (27%)	18 (38%)	9 (18%)	9 (20%)	5 (11%)	5 (11%)	4 (9%)	2 (4%)	9 (19%)	3 (6%)	5 (11%)	1 (2%)	0 (0%)
Hillsborough	493	94 (19%)	85 (17%)	130 (26%)	99 (21%)	146 (30%)	184 (39%)	58 (12%)	105 (22%)	37 (9%)	76 (17%)	34 (7%)	56 (12%)	68 (15%)	28 (6%)	13 (3%)	13 (3%)	4 (1%)
Holmes	18	3 (17%)	2 (11%)	5 (28%)	5 (28%)	6 (33%)	7 (39%)	0 (0%)	4 (22%)	0 (0%)	2 (11%)	0 (0%)	0 (0%)	2 (11%)	1 (6%)	1 (6%)	0 (0%)	0 (0%)
Indian River	58	9 (16%)	7 (13%)	20 (34%)	8 (14%)	21 (38%)	32 (56%)	12 (21%)	12 (21%)	5 (10%)	8 (15%)	5 (9%)	9 (16%)	6 (11%)	3 (5%)	2 (4%)	0 (0%)	0 (0%)
Jackson	42	7 (17%)	5 (12%)	11 (26%)	11 (27%)	12 (29%)	15 (36%)	3 (7%)	9 (22%)	2 (5%)	8 (19%)	5 (12%)	1 (2%)	8 (20%)	0 (0%)	2 (5%)	0 (0%)	0 (0%)
Jefferson	5	1 (25%)	0 (0%)	1 (20%)	2 (40%)	1 (20%)	2 (40%)	2 (40%)	0 (0%)	0 (0%)	2 (40%)	0 (0%)	1 (25%)	2 (40%)	1 (25%)	1 (25%)	1 (20%)	0 (0%)
Lake	101	19 (19%)	19 (19%)	24 (24%)	24 (25%)	31 (31%)	50 (50%)	13 (13%)	30 (30%)	15 (16%)	16 (17%)	4 (4%)	14 (15%)	8 (9%)	2 (2%)	2 (2%)	1 (1%)	2 (2%)
Lee	226	16 (7%)	24 (11%)	29 (13%)	31 (15%)	56 (25%)	77 (34%)	19 (9%)	34 (16%)	18 (9%)	30 (14%)	15 (7%)	11 (5%)	25 (12%)	9 (4%)	4 (2%)	4 (2%)	2 (1%)
Leon	88	13 (15%)	15 (17%)	21 (24%)	21 (24%)	22 (25%)	23 (26%)	11 (13%)	18 (21%)	4 (5%)	19 (23%)	7 (8%)	11 (13%)	17 (20%)	6 (7%)	3 (3%)	1 (1%)	2 (2%)
Levy	34	7 (21%)	2 (6%)	8 (24%)	6 (18%)	10 (30%)	11 (33%)	9 (27%)	7 (21%)	1 (3%)	10 (30%)	7 (21%)	5 (15%)	6 (18%)	2 (6%)	1 (3%)	2 (6%)	0 (0%)
Liberty	8	2 (25%)	1 (13%)	1 (14%)	2 (29%)	3 (43%)	4 (57%)	0 (0%)	1 (17%)	0 (0%)	2 (25%)	1 (13%)	0 (0%)	0 (0%)	1 (13%)	0 (0%)	0 (0%)	0 (0%)
Madison	3	0 (0%)	1 (33%)	1 (33%)	0 (0%)	0 (0%)	1 (33%)	0 (0%)	0 (0%)	0 (0%)	1 (50%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Manatee	163	30 (19%)	18 (11%)	41 (25%)	38 (23%)	54 (33%)	60 (37%)	24 (15%)	33 (21%)	11 (7%)	28 (18%)	13 (8%)	28 (18%)	32 (21%)	17 (11%)	14 (9%)	6 (4%)	1 (1%)
Marion	259	45 (18%)	36 (14%)	58 (22%)	68 (26%)	88 (35%)	100 (40%)	49 (20%)	55 (22%)	18 (8%)	54 (22%)	18 (7%)	18 (7%)	62 (25%)	19 (8%)	12 (5%)	8 (3%)	3 (1%)
Martin	48	7 (15%)	7 (15%)	7 (15%)	6 (13%)	18 (39%)	18 (38%)	6 (13%)	10 (22%)	5 (12%)	7 (16%)	5 (11%)	10 (22%)	10 (22%)	3 (7%)	4 (9%)	0 (0%)	1 (2%)
Miami-Dade	414	41 (10%)	28 (7%)	59 (14%)	37 (9%)	80 (19%)	119 (29%)	50 (12%)	62 (16%)	30 (8%)	72 (19%)	19 (5%)	31 (8%)	46 (12%)	10 (3%)	5 (1%)	3 (1%)	0 (0%)
Monroe	15	2 (13%)	1 (7%)	7 (47%)	5 (33%)	6 (40%)	4 (27%)	2 (13%)	2 (13%)	1 (8%)	3 (20%)	0 (0%)	1 (7%)	3 (20%)	1 (7%)	0 (0%)	0 (0%)	0 (0%)
Nassau	30	2 (7%)	0 (0%)	6 (20%)	5 (18%)	10 (34%)	8 (29%)	2 (7%)	4 (14%)	3 (12%)	6 (21%)	2 (7%)	2 (7%)	3 (11%)	1 (4%)	1 (4%)	1 (4%)	0 (0%)
Okaloosa	74	18 (27%)	10 (14%)	35 (48%)	17 (24%)	39 (53%)	49 (67%)	18 (25%)	30 (41%)	14 (22%)	20 (29%)	9 (13%)	6 (8%)	18 (26%)	5 (7%)	2 (3%)	0 (0%)	0 (0%)
Okeechobee	27	3 (11%)	1 (4%)	5 (19%)	3 (11%)	6 (22%)	7 (26%)	1 (4%)	6 (22%)	1 (4%)	4 (16%)	1 (4%)	3 (11%)	2 (7%)	0 (0%)	1 (4%)	0 (0%)	0 (0%)
Orange	585	102 (18%)	75 (13%)	113 (19%)	117 (20%)	133 (23%)	187 (33%)	90 (16%)	107 (19%)	48 (9%)	127 (23%)	42 (7%)	53 (9%)	88 (16%)	15 (3%)	16 (3%)	12 (2%)	3 (1%)
Osceola	176	26 (15%)	17 (10%)	32 (18%)	39 (23%)	42 (26%)	57 (35%)	29 (18%)	22 (14%)	11 (8%)	26 (17%)	13 (8%)	23 (14%)	27 (17%)	9 (6%)	6 (4%)	1 (1%)	1 (1%)
Palm Beach	406	62 (16%)	46 (11%)	88 (22%)	83 (21%)	106 (27%)	110 (28%)	64 (16%)	61 (16%)	33 (9%)	74 (19%)	13 (3%)	44 (11%)	58 (15%)	24 (6%)	15 (4%)	4 (1%)	2 (1%)
Pasco	211	31 (15%)	17 (8%)	52 (25%)	48 (23%)	73 (35%)	82 (40%)	48 (23%)	35 (17%)	18 (9%)	34 (17%)	17 (8%)	32 (15%)	45 (22%)	14 (7%)	8 (4%)	4 (2%)	1 (0%)
Pinellas	481	98 (21%)	69 (14%)	136 (28%)	127 (27%)	158 (33%)	210 (44%)	103 (22%)	120 (25%)	59 (13%)	102 (22%)	67 (14%)	87 (18%)	102 (22%)	30 (6%)	24 (5%)	12 (3%)	3 (1%)
Polk	296	59 (21%)	25 (9%)	89 (30%)	59 (20%)	85 (29%)	112 (38%)	32 (11%)	73 (27%)	22 (8%)	39 (14%)	16 (6%)	24 (8%)	30 (11%)	16 (6%)	15 (5%)	6 (2%)	3 (1%)
Putnam	49	8 (16%)	9 (19%)	8 (16%)	12 (27%)	12 (27%)	15 (33%)	5 (10%)	12 (27%)	4 (10%)	7 (15%)	4 (9%)	3 (6%)	4 (11%)	1 (3%)	4 (10%)	1 (2%)	0 (0%)
Santa Rosa	77	18 (24%)	11 (14%)	32 (42%)	15 (20%)	25 (33%)	31 (42%)	13 (18%)	20 (29%)	8 (12%)	16 (23%)	6 (8%)	8 (11%)	19 (27%)	3 (4%)	4 (6%)	0 (0%)	0 (0%)
Sarasota	177	24 (14%)	17 (10%)	32 (18%)	31 (18%)	51 (29%)	61 (36%)	35 (20%)	36 (21%)	9 (6%)	42 (24%)	11 (6%)	18 (11%)	31 (18%)	16 (10%)	8 (5%)	1 (1%)	1 (1%)
Seminole	148	18 (13%)	11 (8%)	23 (16%)	31 (21%)	28 (19%)	45 (31%)	14 (10%)	22 (15%)	6 (4%)	17 (12%)	8 (6%)	15 (10%)	19 (13%)	11 (8%)	4 (3%)	4 (3%)	0 (0%)
St Johns	61	16 (28%)	8 (14%)	12 (20%)	16 (27%)	24 (40%)	31 (52%)	17 (29%)	22 (36%)	3 (5%)	16 (27%)	10 (17%)	9 (16%)	15 (26%)	7 (12%)	4 (7%)	1 (2%)	1 (2%)
St Lucie	120	25 (22%)	15 (13%)	32 (27%)	30 (25%)	43 (36%)	59 (50%)	30 (25%)	20 (17%)	8 (7%)	31 (27%)	16 (15%)	19 (17%)	32 (29%)	18 (16%)	18 (16%)	6 (5%)	2 (2%)
Sumter	11	2 (20%)	1 (10%)	4 (36%)	4 (36%)	5 (45%)	5 (45%)	3 (27%)	1 (13%)	1 (17%)	2 (18%)	0 (0%)	2 (18%)	2 (22%)	0 (0%)	2 (22%)	1 (10%)	0 (0%)
Suwannee	20	3 (15%)	2 (10%)	6 (30%)	5 (25%)	7 (35%)	9 (45%)	2 (10%)	5 (25%)	0 (0%)	5 (25%)	2 (10%)	3 (15%)	5 (25%)	1 (5%)	0 (0%)	0 (0%)	0 (0%)
Taylor	19	4 (21%)	0 (0%)	4 (21%)	4 (21%)	10 (53%)	13 (68%)	3 (16%)	3 (18%)	3 (19%)	5 (28%)	2 (11%)	1 (5%)	3 (16%)	2 (11%)	0 (0%)	0 (0%)	0 (0%)
Union	10	2 (20%)	0 (0%)	3 (33%)	0 (0%)	7 (78%)	6 (67%)	1 (11%)	3 (30%)	1 (11%)	4 (44%)	1 (11%)	0 (0%)	3 (33%)	2 (22%)	0 (0%)	0 (0%)	0 (0%)
Volusia	219	41 (19%)	26 (12%)	43 (20%)	40 (19%)	76 (35%)	84 (39%)	38 (18%)	51 (24%)	17 (8%)	37 (18%)	25 (12%)	26 (12%)	49 (23%)	19 (9%)	16 (8%)	10 (5%)	2 (1%)
Wakulla	17	7 (41%)	2 (12%)	5 (29%)	6 (38%)	4 (24%)	5 (31%)	4 (29%)	6 (40%)	3 (21%)	2 (14%)	2 (13%)	1 (7%)	2 (13%)	1 (7%)	2 (13%)	2 (13%)	0 (0%)
Walton	21	7 (35%)	3 (14%)	7 (33%)	5 (24%)	10 (50%)	10 (48%)	3 (15%)	6 (30%)	1 (6%)	8 (40%)	1 (5%)	2 (10%)	5 (25%)	5 (25%)	1 (5%)	2 (10%)	0 (0%)
Washington	18	6 (35%)	3 (18%)	8 (47%)	4 (24%)	7 (44%)	10 (63%)	3 (18%)	11 (61%)	3 (19%)	4 (25%)	0 (0%)	0 (0%)	0 (0%)	2 (13%)	0 (0%)	0 (0%)	0 (0%)
Total	**7,459**	**1270 (17%)**	**913 (12%)**	**1761 (24%)**	**1544 (21%)**	**2215 (30%)**	**2766 (38%)**	**1234 (17%)**	**1569 (22%)**	**637 (9%)**	**1451 (20%)**	**576 (8%)**	**817 (11%)**	**1226 (17%)**	**433 (6%)**	**314 (4%)**	**151 (2%)**	**51 (1%)**

Alleged Victims by County	Total Number*	Alleged Victim Is Substantially Younger Than Offender	Alleged Victim Is Known To Offender	Alleged Victim Included Coercion	Alleged Victim Case Included Violence	Alleged Victim Case Included Bribes By Offender	Elements Of Secrecy Involved	Multiple Alleged Victims-Reference	History Of Non-Sexual Aggravated Assault	Number Of Incidents
Alachua	159	37 (24%)	136 (86%)	12 (8%)	5 (3%)	7 (5%)	36 (24%)	41 (28%)	5 (3%)	30 (21%)
Baker	14	3 (21%)	12 (86%)	1 (7%)	0 (0%)	0 (0%)	3 (21%)	2 (14%)	0 (0%)	0 (0%)
Bay	120	27 (23%)	107 (91%)	14 (12%)	3 (3%)	8 (7%)	31 (26%)	35 (30%)	4 (3%)	26 (23%)
Bradford	13	4 (31%)	10 (77%)	2 (15%)	0 (0%)	0 (0%)	1 (8%)	4 (31%)	3 (23%)	3 (27%)
Brevard	281	79 (28%)	268 (95%)	26 (9%)	7 (3%)	3 (1%)	70 (25%)	63 (23%)	12 (4%)	58 (22%)
Broward	684	183 (27%)	612 (90%)	48 (7%)	21 (3%)	15 (2%)	156 (23%)	118 (18%)	20 (3%)	127 (20%)
Calhoun	5	0 (0%)	5 (100%)	0 (0%)	0 (0%)	0 (0%)	1 (20%)	1 (20%)	0 (0%)	2 (40%)
Charlotte	71	20 (28%)	65 (92%)	7 (11%)	2 (3%)	2 (3%)	17 (25%)	9 (13%)	3 (4%)	14 (23%)
Citrus	46	19 (41%)	44 (96%)	5 (12%)	1 (2%)	1 (2%)	16 (36%)	8 (18%)	2 (4%)	10 (22%)
Clay	115	42 (37%)	100 (87%)	17 (16%)	7 (6%)	2 (2%)	24 (22%)	24 (22%)	1 (1%)	21 (21%)
Collier	79	26 (33%)	66 (85%)	4 (6%)	1 (1%)	2 (3%)	16 (22%)	13 (18%)	2 (3%)	11 (17%)
Columbia	45	20 (44%)	40 (89%)	2 (5%)	0 (0%)	0 (0%)	7 (17%)	11 (28%)	2 (4%)	8 (20%)
Desoto	36	8 (22%)	24 (67%)	0 (0%)	0 (0%)	0 (0%)	8 (26%)	4 (12%)	0 (0%)	4 (13%)
Dixie	11	3 (27%)	9 (82%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (9%)	0 (0%)	0 (0%)
Duval	500	162 (32%)	447 (90%)	37 (8%)	15 (3%)	18 (4%)	80 (16%)	99 (21%)	16 (3%)	116 (25%)
Escambia	200	58 (29%)	189 (95%)	16 (8%)	9 (5%)	4 (2%)	42 (21%)	40 (21%)	5 (3%)	45 (23%)
Flagler	48	12 (25%)	44 (92%)	3 (6%)	2 (4%)	0 (0%)	12 (25%)	10 (22%)	0 (0%)	8 (18%)
Franklin	6	3 (50%)	6 (100%)	1 (17%)	0 (0%)	0 (0%)	1 (17%)	1 (17%)	0 (0%)	1 (17%)
Gadsden	18	10 (56%)	17 (94%)	1 (6%)	0 (0%)	0 (0%)	1 (6%)	0 (0%)	1 (6%)	1 (6%)
Gilchrist	9	3 (33%)	9 (100%)	2 (22%)	1 (11%)	1 (11%)	3 (33%)	1 (11%)	0 (0%)	2 (22%)
Glades	8	0 (0%)	7 (88%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	6 (75%)	0 (0%)	0 (0%)
Gulf	8	1 (13%)	7 (88%)	0 (0%)	0 (0%)	0 (0%)	2 (25%)	2 (25%)	0 (0%)	1 (13%)
Hamilton	12	7 (58%)	11 (92%)	3 (25%)	0 (0%)	0 (0%)	7 (58%)	0 (0%)	0 (0%)	3 (25%)
Hardee	9	4 (44%)	9 (100%)	1 (11%)	0 (0%)	0 (0%)	2 (29%)	2 (22%)	0 (0%)	2 (22%)
Hendry	19	8 (42%)	19 (100%)	0 (0%)	0 (0%)	4 (22%)	3 (16%)	3 (16%)	0 (0%)	2 (15%)
Hernando	79	32 (41%)	76 (97%)	3 (4%)	2 (3%)	1 (1%)	13 (18%)	19 (26%)	6 (8%)	17 (24%)
Highlands	52	10 (19%)	47 (90%)	2 (4%)	1 (2%)	0 (0%)	13 (26%)	2 (4%)	1 (2%)	5 (11%)
Hillsborough	583	137 (23%)	546 (94%)	36 (6%)	19 (3%)	14 (2%)	93 (16%)	96 (17%)	15 (3%)	105 (20%)
Holmes	21	7 (33%)	21 (100%)	2 (10%)	0 (0%)	0 (0%)	2 (10%)	4 (19%)	0 (0%)	7 (33%)
Indian River	63	19 (30%)	59 (95%)	9 (15%)	1 (2%)	2 (3%)	9 (15%)	6 (10%)	0 (0%)	16 (27%)
Jackson	53	20 (38%)	48 (91%)	3 (6%)	0 (0%)	0 (0%)	8 (15%)	13 (25%)	0 (0%)	12 (26%)
Jefferson	6	1 (17%)	5 (83%)	3 (50%)	1 (17%)	0 (0%)	2 (33%)	2 (33%)	1 (17%)	3 (50%)
Lake	126	31 (25%)	119 (94%)	11 (9%)	7 (6%)	2 (2%)	19 (16%)	18 (15%)	2 (2%)	29 (25%)
Lee	272	74 (27%)	252 (93%)	28 (11%)	10 (4%)	10 (4%)	40 (15%)	43 (17%)	6 (2%)	44 (19%)
Leon	115	34 (30%)	110 (96%)	7 (7%)	7 (6%)	2 (2%)	21 (20%)	28 (25%)	10 (9%)	24 (24%)
Levy	34	10 (30%)	31 (91%)	1 (3%)	1 (3%)	0 (0%)	3 (9%)	3 (9%)	0 (0%)	5 (15%)
Liberty	13	5 (38%)	11 (85%)	0 (0%)	0 (0%)	0 (0%)	2 (15%)	5 (42%)	1 (8%)	5 (42%)
Madison	3	1 (33%)	3 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (50%)
Manatee	212	49 (23%)	200 (94%)	20 (10%)	10 (5%)	8 (4%)	38 (18%)	61 (29%)	4 (2%)	55 (27%)
Marion	325	70 (22%)	285 (88%)	20 (6%)	10 (3%)	4 (1%)	45 (15%)	79 (25%)	6 (2%)	64 (22%)
Martin	59	16 (28%)	55 (93%)	3 (5%)	2 (3%)	1 (2%)	9 (15%)	7 (12%)	0 (0%)	12 (20%)
Miami-Dade	516	133 (26%)	447 (87%)	46 (9%)	25 (5%)	9 (2%)	67 (13%)	101 (20%)	44 (9%)	75 (17%)
Monroe	20	5 (25%)	20 (100%)	1 (5%)	1 (5%)	0 (0%)	2 (12%)	0 (0%)	0 (0%)	2 (11%)
Nassau	34	7 (21%)	28 (82%)	2 (6%)	0 (0%)	0 (0%)	6 (19%)	7 (22%)	0 (0%)	6 (20%)
Okaloosa	89	24 (28%)	84 (94%)	10 (11%)	1 (1%)	2 (2%)	35 (40%)	16 (18%)	3 (3%)	24 (28%)
Okeechobee	30	7 (23%)	25 (86%)	0 (0%)	0 (0%)	0 (0%)	1 (3%)	5 (17%)	0 (0%)	4 (15%)
Orange	694	160 (23%)	599 (86%)	46 (7%)	31 (5%)	9 (1%)	104 (15%)	136 (20%)	27 (4%)	130 (20%)
Osceola	223	48 (22%)	204 (91%)	17 (8%)	8 (4%)	5 (2%)	38 (18%)	49 (23%)	4 (2%)	39 (19%)
Palm Beach	458	113 (25%)	412 (90%)	36 (8%)	9 (2%)	13 (3%)	102 (23%)	63 (14%)	11 (2%)	74 (17%)
Pasco	252	72 (29%)	229 (91%)	15 (6%)	5 (2%)	9 (4%)	63 (25%)	50 (20%)	2 (1%)	39 (17%)
Pinellas	573	117 (20%)	536 (94%)	70 (12%)	30 (5%)	12 (2%)	139 (25%)	156 (28%)	19 (3%)	158 (28%)
Polk	359	132 (37%)	324 (90%)	17 (5%)	8 (2%)	8 (2%)	53 (15%)	72 (21%)	11 (3%)	74 (23%)
Putnam	56	20 (36%)	49 (89%)	6 (12%)	8 (15%)	2 (4%)	12 (23%)	11 (22%)	1 (2%)	9 (18%)
Santa Rosa	82	27 (33%)	77 (94%)	4 (5%)	0 (0%)	0 (0%)	17 (22%)	19 (25%)	1 (1%)	16 (22%)
Sarasota	197	35 (18%)	179 (92%)	13 (7%)	5 (3%)	4 (2%)	28 (15%)	34 (18%)	4 (2%)	29 (16%)
Seminole	182	46 (25%)	157 (86%)	19 (11%)	9 (5%)	11 (6%)	42 (24%)	44 (25%)	3 (2%)	34 (19%)
St Johns	67	21 (31%)	62 (93%)	5 (7%)	3 (4%)	4 (6%)	21 (31%)	15 (23%)	1 (1%)	18 (28%)
St Lucie	145	36 (25%)	134 (92%)	10 (7%)	4 (3%)	3 (2%)	31 (22%)	24 (18%)	3 (2%)	39 (30%)
Sumter	14	10 (71%)	14 (100%)	0 (0%)	0 (0%)	0 (0%)	1 (7%)	0 (0%)	0 (0%)	2 (17%)
Suwannee	20	6 (30%)	17 (85%)	0 (0%)	0 (0%)	2 (11%)	5 (26%)	1 (5%)	0 (0%)	2 (11%)
Taylor	27	7 (26%)	23 (85%)	3 (11%)	0 (0%)	0 (0%)	3 (11%)	8 (30%)	1 (4%)	8 (30%)
Union	12	4 (33%)	9 (75%)	1 (10%)	1 (9%)	0 (0%)	0 (0%)	2 (18%)	1 (10%)	2 (20%)
Volusia	258	73 (29%)	224 (87%)	55 (22%)	8 (3%)	9 (4%)	69 (27%)	62 (25%)	9 (4%)	66 (28%)
Wakulla	23	8 (35%)	18 (78%)	3 (14%)	1 (4%)	0 (0%)	4 (18%)	6 (27%)	1 (5%)	8 (36%)
Walton	28	13 (46%)	28 (100%)	0 (0%)	1 (4%)	0 (0%)	12 (46%)	6 (24%)	1 (4%)	5 (24%)
Washington	22	5 (24%)	20 (95%)	2 (10%)	2 (10%)	0 (0%)	6 (29%)	9 (41%)	0 (0%)	3 (15%)
Total	**8,896**	**2384 (27%)**	**8050 (90%)**	**731 (9%)**	**305 (3%)**	**213 (2%)**	**1717 (20%)**	**1780 (21%)**	**275 (3%)**	**1765 (21%)**

**Percentages are not necessarily based on the total number of youth as data for a specific trait may have been missing*