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Assessing the Scaling Potential of Child Sexual Abuse Perpetration Prevention Interventions

Findings from a survey of the field

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This paper was prepared by MSI staff to contribute to the discussion and understanding of the important development challenges facing policymakers and practitioners.

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Acronyms

CSA Child Sexual Abuse

CSAM Child Sexual Abuse Material

MSI Management Systems International

SAT Scaling Assessment Tool

WHO World Health Organization

Introduction

Child sexual abuse is a global problem. Studies estimate that 1 in 9 children worldwide have been or are victims of child sexual abuse, enacting a terrible toll on children, families, and society. Notwithstanding its prevalence, child sexual abuse is commonly misunderstood. It is preventable, but will require a variety of solutions. Despite public misconceptions, evidence suggests that most sexual abuse is committed by individuals known to the child, rather than strangers, and that a high percentage is committed by other children. When child sexual abuse is committed by adults, the reasons are complex and nuanced; sexual attraction to children is sometimes, but not always, the primary motivation.

The good news is that child sexual abuse is preventable, but it will require a variety of solutions.

Prevention Global: Translating Knowledge to Action program, implemented by the Moore Center for the Prevention of Child Sexual Abuse at Johns Hopkins University (Moore Center), in partnership with the University of Ottawa's Institute for Mental Health Research at The Royal (The Royal), is an ambitious effort to systematically identify, evaluate, and catalogue the most promising interventions that have been developed to prevent child sexual abuse perpetration. Through this program, the Moore Center is:

1. Conducting scoping activities – Systematically reviewing the prevention landscape and identifying policies, programs, and strategies that are feasible, affordable, and scalable;
2. Evaluating effectiveness – Evaluating the most promising efforts with the strong potential for scale up to determine their effectiveness in preventing child sexual abuse perpetration; and
3. Cataloguing effective strategies – Developing an internationally trusted catalogue of proven perpetration prevention strategies to support their implementation and scale up.

Management Systems International (MSI) has supported the Translating Knowledge to Action program by assessing the scaling potential of 13 perpetration prevention interventions - identified by the research team - to help the team select a subset of interventions for deeper study. The assessments considered factors including the specific characteristics of the interventions, organizational characteristics, and relevant factors of the intervention's "home" context. The assessments relied on documentary analysis and key informant interviews with program implementers, through which MSI identified the most significant scaling challenges and opportunities for each intervention.

This paper is a synthesis of the key findings from the scaling assessments and includes conclusions and recommendations for efforts to scale child sexual abuse perpetration prevention programs more generally.

[1] Stoltenborgh M, van Ijzendoorn MH, Euser EM, Bakermans-Kranenburg MJ. A global perspective on child sexual abuse: meta-analysis of prevalence around the world. Child Maltreat. 2011 May;16(2):79-101. doi: 10.1177/1077559511403920. Epub 2011 Apr 21. PMID: 21511741

[2] Finkelhor D. Trends in Adverse Childhood Experiences (ACEs) in the United States. Child Abuse Negl. 2020 Oct;108:104641. doi: 10.1016/j.chiabu.2020.104641. Epub 2020 Jul 30. PMID: 32739600

Assessment Methodology

MSI has been working for more than two decades to develop tools and strategies to assess and accelerate the scaling of successful interventions.

MSI'S CORE TOOL

32 Item Scalabilty Assessment Tool (SAT)

14 Revisions since 2004

Used by

500+

Organizations

Among MSI's core tools is a 32-item Scalability Assessment Tool (SAT)[3] that has been used by more than 500 organizations and revised 14 times since 2004 to reflect emerging research and user insights on the factors that facilitate or hinder scaling.[4]

MSI has used the SAT to assess scaling potential across a range of thematic areas and contexts. However, MSI had not previously worked with programs focused on preventing the perpetration of child sexual abuse, which we recognized might feature specific and unique scaling considerations related to the stigmatized nature of the issue generally, and the population of adults sexual attracted to children, specifically. For this reason, MSI conducted a scan of the academic literature related to scaling interventions dealing with stigmatized populations (e.g., individuals suffering from mental health and addiction issues).[5] That review concluded that the SAT did not fully address the unique scaling considerations relating to stigmatization, so MSI added one category to the existing tool, composed of three programmatic features that would facilitate scaling interventions.

Model Category: Does the model facilitate the participation of stigmatized populations?

- Criteria 1: Model does not specifically target individuals subject to social stigma.
- Criteria 2: Model does not require participants seeking treatment to engage with mainstream institutions.
- Criteria 3: Model does not easily allow for confidentiality/anonymity of treatment group members.

The revised SAT is presented in Annex A to this paper.

Between September 2021 and September 2023, MSI used the revised SAT to assess 13 evidence-based perpetration prevention programs[6] selected by the research team. The assessments were based upon a review of publicly available literature, documents provided by program implementers, and key informant interviews with program staff. Interviewers provided confidentiality to program staff (on behalf of themselves and their programs) so that respondents could speak candidly about their implementation challenges. For this reason, the scaling discussion below will rarely reference specific programs – except in their general features to the extent these are publicly disseminated by the programs themselves.

MSI identified, as part of each assessment, intervention and contextual factors that were likely to facilitate or hinder scaling. The scaling team then carried out a synthesis of the assessments to develop cross-cutting findings and lessons about scaling perpetration prevention interventions more generally. Based upon this synthesis, the scaling team was able to divide interventions into four categories based upon characteristics that were deemed important as either

[3] The SAT is a 32-point checklist that identifies factors that are likely to affect the scalability of an intervention. The SAT was originally developed by MSI based on a review of the literature on the diffusion of innovation and scaling up. The tool is designed to:
· help to decide whether scaling up is a viable option;
· assess how relatively hard or easy that process will be; and
· identify ways to improve its scalability.

[4] Note: While widely acknowledged as a useful tool for assessing and improving scaling prospects, the tool's predictive power has not been the subject of rigorous third-party evaluation. It is also important to note that the SAT focuses only on the scalability of interventions. It presumes that efficacy will be judged using other methods and tools.

[5] The results of that review and an adapted version of the SAT are summarized in MSI's report of January 7, 2020.

[6] The 13 interventions assessed as part of this activity are listed in Annex B.

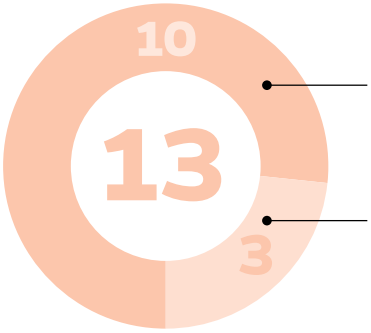
Characteristics of Interventions

There was a diverse mix of perpetration prevention programs (and interventions) that were part of the study, including (non-exclusively):

- Programs and interventions focused on preventing the onset of problematic sexual behaviors in children and promoting positive and healthy sexuality.
- Programs and interventions focused on mitigating and managing the risk of sexual abuse perpetration in the context of youth activities and sports programs.
- Programs and interventions focused on providing support to help-seeking adults who are concerned about their own thoughts and behaviors.

The programs were implemented across eight countries, mostly in North America and Europe – although a few programs operated in more than one country.

The programs are implemented by different organizations, most of which are associated with universities; however, a few are associated with foundations, government institutes, or hospitals.



10 of the 13 programs featured interventions supporting help-seeking adults with a sexual attraction to children.

3 of the assessed programs did not directly engage with people at elevated risk of perpetration,

Ten of the 13 programs featured interventions supporting help-seeking adults with a sexual attraction to children. Most of these programs included interventions to help people control their behaviors, to prevent child sexual abuse or viewing child sexual abuse material (CSAM). Other program goals included encouraging individuals to seek help in the first instance, raising awareness of CSA/CSAM and associated harms, and mobilizing stakeholders to take actions that protect children before they are harmed. Amongst these 10 programs:

- There was a breadth of types of engagement - from face-to-face structured therapy to remote counseling and provision of self-help materials online.
- All interventions provided support to adults whether or not they had committed any criminal sexual acts – provided they had not been arrested. A smaller number were open to individuals who had been arrested for criminal sexual offenses.[7]
- Several programs also provided support to friends and family worried about other adults whose behavior they found problematic. Some also provided information to professionals seeking information to help their clients at risk of offending.

An important consideration noted by numerous programs is the heterogeneity of the population of adults at risk of offending sexually against children. While some individuals are higher risk and have intensive needs, others are lower risk and require lower levels of engagement/intervention – which is an important consideration when considering the feasibility and advisability of scaling different types of interventions.

Three of the assessed programs did not directly engage with people at elevated risk of perpetration, including school and youth program-based interventions designed to prevent the onset of problem sexual behavior by:

- educating youth about child and/or peer sexual abuse and related norms, concepts, and laws and,
- reduce contextual risk factors that create opportunities for child sexual abuse.

[7] This in part reflects the priorities of the Global Perpetration Prevention program, which is focused on identifying effective primary and secondary (rather than tertiary) prevention interventions. "Primary prevention involves wide-scale initiatives aimed at the general public and implemented before the occurrence of sexual violence to prevent even initial incidents of child sexual abuse... Secondary prevention involves more targeted interventions for those at-risk of engaging in child sexual abuse, which address issues known to increase the risk of offending... Tertiary prevention is a reactionary approach after a sexual offence has occurred, which aims to prevent sexual recidivism." Laws, D. R. (2000). Sexual offending as a public health problem: A North American perspective. Journal of Sexual Aggression, 5, 30-44. doi:10.1080/13552600008413294.

Characteristics of Interventions

Categorization of Interventions

During the scaling assessments, the MSI team identified two factors that influenced scaling potential across all 13 interventions:

- whether the interventions targeted adults with a sexual attraction to children (or not); and
- the levels of time and money required to implement the intervention.

Based on these two factors, the assessment team was able to divide program interventions into four categories:

1. Structured therapy interventions: Individual and group therapy, delivered in person or virtually. [Adult-focused, Resource-intensive]
2. Remote counseling interventions: Online chat services and telephone helplines. [Adult-focused, Moderate resource requirements]
3. Interventions providing self-help materials and information resources: Resource websites and online self-paced modules. [Adult-focused, Low resource requirements]
4. Youth and school-based interventions: Youth-focused education and risk management interventions. [Not primarily focused on adults, Variable resource requirements]

Findings

The MSI team synthesized the findings from the scaling assessments to identify cross-cutting scaling challenges, constraints, and opportunities for child sexual abuse perpetration prevention programs. The team focused primarily on the characteristics of the interventions or the contexts in which they are delivered to identify scaling opportunities and challenges. The team did not incorporate factors into this synthesis that were unique to the implementing organizations – such as limited organizational capacity or funding.

There were a small number of general findings that applied to nearly all interventions, which we present at the outset. Thereafter, we present findings according to the four categories of interventions noted above (i.e., structured therapy, interventions providing remote counseling, interventions providing self-help materials and information resources, and youth and school-based interventions).

General Findings

Finding 1: Stigmatization, manifest in several ways, is the most significant challenge to scaling perpetration prevention interventions.

The stigmatization of the issue of child sexual abuse and child sexual abuse material hinders discussion of the issues, help-seeking for services and development of solutions. It manifests in several ways.

- First, adults with a sexual attraction to children and/or who have searched for child sexual abuse material are a highly stigmatized group, who often feel shame and embarrassment. They are rightfully concerned about disclosure to their family members and community, or professionals, which can be compounded by fear of mandatory reporting laws, law enforcement and censure from authorities. This makes them reluctant to seek help.
- Second, the stigmatization of child sexual abuse more generally hinders its discussion as an issue of public health that can be prevented.[8] Policymakers and the public are more comfortable addressing child sexual abuse as a criminal justice matter involving a small number of bad actors than as a public health issue affecting (in one way or another) a significant portion of the population.
- Third, cultural and religious sensitivities about discussing sexuality and children hinder efforts to implement solutions for younger populations, despite recent research that suggests that most child sexual abuse and many child sexual abuse material offenses are perpetrated by other children.
- Finally, there can be stigma attached to professionals who work with adults at risk of child sexual abuse and child sexual abuse material perpetration. Although there has been limited research on the impact of this "courtesy stigma",[9] it may result in reduced numbers of professionals providing health and social services for this group.

Finding 2: There are opportunities to collaborate with the private sector to increase awareness of perpetration prevention interventions, and possibly even to incentivize their adoption.

Several interventions that provide information and resources (in addition to other services) for adults at risk of child sexual abuse and child sexual abuse material perpetration have established relationships with social media providers such as Google and Meta (Facebook and Instagram). These social media companies provide links to support services for individuals seeking help for a sexual attraction to children, or who have been flagged for using search terms likely to return child sexual abuse material. Similar partnerships have been established between interventions and adult content websites such as Pornhub, which has also partnered as part of a deterrence campaign that provides warnings to individuals about the legal consequences of viewing child sexual abuse material.

However, there are likely more opportunities for collaboration with the private sector that have not been explored. Insurance companies, especially those that cover schools, religious institutions, youth clubs and sports programs, often provide abuse coverage as part of their insurance package.

It is worth exploring with these insurance companies whether it would be possible to incentivize the use of evidence-based sexual abuse risk mitigation interventions through lower coverage costs.

[8] The scaling team acknowledges that there is also a widely reported stigmatization of child sexual abuse survivors, which is not discussed in detail here – only because its influence on the scalability of perpetration prevention programs is not clear.

[9] Phillips R, Benoit C. Exploring stigma by association among front-line care providers serving sex workers. Healthc Policy. 2013 Oct;9(Spec Issue):139-51. PMID: 24289946; PMCID: PMC4750147.

Findings

Structured Therapy

Five programs included therapeutic interventions for adults at risk of child sexual abuse or child sexual abuse material perpetration. These were outpatient programs in all cases, and some programs were piloting remote therapy options – in part due to constraints posed by COVID-19. The therapies included both group and individual sessions led by psychological and counseling professionals. In each case, the therapy was conducted pursuant to a structured therapeutic plan tailored to the needs of the individual participants. Most of the therapy interventions integrated medical, psychological and pharmacological treatment options.

The goal of the therapy was to enable individuals to develop an ability to control their behavior in such a way that sexual offenses against children are avoided. The length of therapy varied by program, but most were weekly sessions (unless deemed high priority, some programs will do two sessions per week). The delivery of the sessions ranged from 8-12 weeks to one or two years.

Finding 3: Therapy is widely considered a credible approach to helping people manage their risk of child sexual abuse and child sexual abuse material perpetration.

While some of the therapeutic interventions within our sample had been subject to small studies that demonstrated efficacy, none were yet backed by rigorous and large-scale research demonstrating their effectiveness. However, the interventions were designed by experts and built on international research and best practices that show efficacy of therapy generally. Within the contexts in which they were currently delivered, these interventions were deemed credible.

Finding 4: Tailored therapeutic care for people at risk of child sexual abuse or child sexual abuse material perpetration is more expensive than other types of interventions.

Therapy provided to individuals on a one-to-one or group basis is costly. The most intensive intervention evaluated in this project shared that it costs approximately €10,000 per patient, per year, to implement its program. This is similar to the cost of intensive interventions for other high-risk groups (e.g., costs associated with acute suicidality).[10] Although this was high-end for structured therapy interventions, it remains true that structured therapy is more expensive than alternative approaches and would be cost-prohibitive for many potential beneficiaries, unless heavily subsidized by the state. It will be very difficult to scale programs with such high costs – although remote (i.e., online) therapy options are becoming more common and have a lower per person cost.

Finding 5: Tailored therapeutic care can probably only be scaled in a significant way if supported by changes in government policy.

Most therapy programs were funded in whole or part by philanthropic efforts and operated at small scale. In the case of the largest of the therapeutic programs, therapy was provided free of charge as part of a pilot project, funded through a national health service. This was pursuant to new legislation and regulations that established (and funded) the pilot program and mechanisms to ensure the anonymity of patients receiving this support. These policy changes were the result of over a decade of lobbying and would not be readily transferable.

Scaling structured therapeutic approaches in a new context would require a significant commitment of resources (not generally feasible through philanthropy) and changes in policy. This is not likely to be politically viable, in the short-term, in most countries.

Finding 6: In many contexts, there will not be enough trained mental health professionals to provide in-person structured therapy to the population of interest.

Delivering in-person therapy is time-intensive for

[10] Pilon et al., 2022. Economic burden of commercially insured patients with Major Depressive Disorder and acute suicidal ideation or behavior in the United States. The Journal of Clinical Psychiatry, 83(3), 21M14090. https://doi.org/10.4088/JCP.21m14090

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mental health professionals. In the contexts where this therapy is subsidized by the state, there are challenges finding sufficient qualified clinicians (i.e., psychologists, physicians, and sexologists) to treat individuals – even with just a small fraction of the population seeking treatment. This is because:

- there are only a limited number of clinicians with the specialized training to treat this population, and
- some mental health professionals have chosen not to work with this population.

An organization implementing this type of program will likely need to recruit and train mental health professionals to deliver this treatment and would need to build the internal capacity to manage the intervention at scale and/or partner with other institutions such as university research hospitals, therapy programs or clinics. One implication is that organizations will need a sustainable funding base to attract, hire and train the professionals needed to deliver these interventions.

Counseling Support

Several programs featured a telephone helpline that provided counseling support to individuals to manage their sexual thoughts, feelings or behaviors towards children. These services also generally extended this support to individuals concerned about another adult, young person, or child. The individuals seeking support could elect to remain anonymous and the level of support depended on the program – ranging from short-term counseling[11] (e.g., three 45-minute sessions) to providing information and referrals based on an individual's needs. Each of the helplines were staffed with trained specialists, although these were not necessarily individuals with previous experience or expertise in counseling or mental health. These programs also varied in other ways, such as the hours of operation and languages supported.

Three programs also featured alternative approaches to provide counseling support for individuals unable, unwilling or less inclined to use the telephone helpline. These included live chat and email. Individuals could post a question (option to ask anonymously) regarding their sexual interests (or those of another person) – and receive an answer after a short interval.

Finding 7: Remote counseling services are highly accessible to potential users, which will make them easier to scale.

Because these services are provided remotely, they are not bound to geographic limitations in the same way as in-person therapy and could provide a good support option for individuals living in rural and remote areas. In addition, the entry costs (in terms of time and money) and risks (in terms of publicly identifying oneself as at risk of child sexual abuse and child sexual abuse material perpetration) are lower for remote options. One successful remote counseling program receives approximately 15,700 contacts (via the helpline, email service, or live chat) per year from roughly 7,500 unique individuals concerned about their own behavior or the behavior of a family member or friend. Approximately 75 percent of these contacts took place through the confidential hotline, 18 percent through the anonymous email service, and 7 percent through the live chat.

Finding 8: Telephone helplines and online chat provide the option of anonymity for individuals, which is important to members of the treatment population.

Individuals seeking help can access these programs while preserving their anonymity, including by phone and chat. The organizations that deliver these programs have developed robust privacy standards and approaches - such as the helpline name not appearing on phone bills – to help ensure that counseling can be kept private, even from close family members. This allows the target population to feel more comfortable reaching out for support -

although some program implementation staff noted that even publicly stated commitments to privacy do not sufficiently allay concerns of a significant proportion of the target population.

[11] Relative to therapy, counseling is short-term, usually focuses on a specific issue given the time available, and is less dependent on building a therapeutic alliance and insight with the client. Fagan, A. (2023, April 12). Psychologist vs Therapist vs Counselor: What Are the Differences? Psychology Today. https://www.psychologytoday.com/us/basics/therapy/psychologist-vs-therapist-vs-counselor

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Finding 9: Remote counseling services are operationally easy to adapt and transfer.

These interventions are simple to deliver operationally, making them easier to scale and potentially transfer. None of the program components are technologically complex or would require significant adaptation to deliver to a significantly larger number of individuals. These programs do feature manuals and guides for call handlers, which would need to be translated and adapted to account for cultural and legal/regulatory differences. However, respondents noted that most helpline and online resources would require minimal adaptation if transferred within Europe, North America, Australia and New Zealand.

Finding 10: Remote counseling programs vary considerably in the qualifications required of counselors, which could have significant scaling implications.

The qualifications and experience that programs require for call handlers or telephone counselors vary considerably. For some interventions, the educational and professional qualifications for these positions are not particularly high, and the training required to become a call handler is not particularly long or intensive. For example, one intervention requires a masters-level education and program-sponsored training in:

- motivational interviewing,
- use of person-centered language and services,
- providing support for survivors of sexual abuse and their families, and
- safety planning to deter victimization and revictimization.

Other interventions require that counselors be trained mental health professionals, such as psychologists and social workers. Higher qualification requirements may result in challenges identifying the requisite number of appropriate staff and may raise the cost of the intervention.

Finding 11: There is low demand for remote counseling services, relative to the need.[12] This results from insufficient funding and high stigmatization of the population.

There is low demand for services that provide counseling to adults at-risk of child sexual abuse and child sexual abuse material perpetration. This stems from a lack of awareness of these programs and is related to the high level of stigmatization of the population. As one implementer explained, it is not socially acceptable to acknowledge a sexual attraction to minors, which makes it difficult to promote treatment and success stories as part of outreach efforts.

> *The high level of stigmatization distinguishes this population from other mental health issues requiring counseling (e.g., addiction), for which stigmatization has decreased over the last twenty years.*

Stigmatization hinders outreach and makes it difficult for organizations to convey that treatment is available and can be successful. Although highlighted here, this constraint also applies to awareness of the availability of self-help and information resources.

Self-Help and Information Resources

Six of the programs MSI reviewed made self-help materials available online for persons at risk of child sexual abuse or child sexual abuse material perpetration. The range of materials varied. Some interventions featured self-paced modules designed to help individuals with a sexual attraction to children manage their behavior. The modules varied in length from approximately 10 minutes to more than three hours of engagement. Some interventions had modules or transcripts of modules available in multiple languages.

Nearly all interventions featured a variety of other online, self-help material and information for individuals experiencing an attraction to children, or for concerned family or friends of such individuals. The types of resources depended on the specific program and included information on how to find professional support (including therapy), advice columns, tip sheets,

[12] Study suggests that the proportion of men with a sexual attraction to children is around 1% of the population. See Seto, M. C. (2018). Pedophilia and sexual offending against children: Theory, assessment, and intervention (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000107-000..

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guidebooks, links to existing online self-management tools and guidance, and information on prevention topics such as how to talk to a loved one who is crossing boundaries and how to report abuse.

Also included in this Self-Help category are deterrence campaigns, which disseminate information to potential users of child sexual abuse material of the legal consequences of their actions. These campaigns disseminate information through brochures and posters, in addition to online through collaborations with adult content websites to provide warnings in response to specific search terms.

Finding 12: Online resources and self-paced materials are operationally simple and inexpensive to deliver, which will make them easier to scale in a new context.

None of the program components for these interventions are complex. These interventions do not entail direct engagement with mental health professionals or staff, which can be costly and complicated to manage.

Most of the interventions providing information and training modules require low operating costs and would not need significant funding to begin the transition to scale.

The costs of expanding the number of modules or adapting the programs as they scale to different contexts vary based on the program, but for the most part consist only of modest upfront costs. The recurring costs of managing most of the programs' websites and/or online platforms with training modules is relatively low.

Finding 13: Relatively little adaptation would be required to scale these interventions to populations in new contexts.

The interventions provide online information and resources that are self-paced, making them easy to adapt, update, or expand based on new areas of need. The amount of adaptation that would be required to scale them to different contexts would likely be minimal, consisting primarily of adaptations for language, cultural sensitivities and country-specific legal/regulatory standards.

Finding 14: All the interventions with information and self-paced training modules can be accessed anonymously and confidentially, lowering the barriers to entry for users.

To ensure that individuals are not deterred from seeking help, these interventions try to mitigate feelings of stigmatization and ensure that materials are easily accessible by their targeted users. Websites provide resources with links to self-management tools and guidance that are available for users to access anonymously in the privacy of their home. This accessibility distinguishes these interventions that require either personal contact with therapists or counselors, or services that require providing personal information or completing questionnaires or assessments to access content, or which might be more clinical and overwhelming for individuals seeking help. Several of the programs have tracked the annual number of website visits and clicks to their materials and have data that indicate their resources are accessible and in relatively high demand.

One implementer noted that its online resources are accessed six times more frequently than its counseling services (telephone, email and chat combined).

Finding 15: Though the interventions are grounded in research and best practices, they have not been rigorously evaluated to demonstrate their efficacy.

The programs are broadly perceived to be credible and built on an evidence base of similar interventions that have been evaluated.

However, there is a dearth of rigorous study of these interventions with this target population and additional data on their efficacy could strengthen their scaling potential.

Youth and school-based interventions

MSI reviewed three programs that were either school-based or designed to be implemented as part of a youth sports activity, whether club or school based. These programs did not engage directly with adults at risk of child sexual abuse or child sexual abuse material perpetration.

Two of the programs had interventions aimed to prevent the onset of problem sexual behavior by teens against younger children and/or against peers by educating young people in appropriate behaviors,

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whereas two of the programs had interventions designed to identify, assess and mitigate risk factors that could lead to incidents of sexual (and other forms of) abuse. One program had both types of interventions.

Finding 16: Youth-focused interventions have received positive support and acceptance from key stakeholders.

Prevention interventions delivered to youth based on age or grade-level do not carry the same stigmatization concerns as programs dealing directly with those at risk of child sexual abuse or child sexual abuse material perpetration, making scaling up easier.

Teachers, school and sports team administrators, youth, and parents largely provide positive feedback about both the youth education and risk mitigation interventions. Preventing child sexual abuse continues to be a priority for schools, youth associations and youth sports clubs.

Finding 17: Programs that target youth could be integrated into schools and youth-serving community organizations.

Each of the three youth-focused prevention programs reviewed could theoretically be integrated into school curricula or activities of youth associations or youth sports clubs, which could allow these models to reach large numbers of youth. Each of the models requires minimal materials and follows a straightforward, multi-step process that can be completed at the school or youth association's preferred pace.

Finding 18: At least in schools within the United States, there are significant obstacles to integrating prevention programs targeting youth.

There are significant obstacles to recruiting U.S. schools to implement child sexual abuse primary prevention programs. Many schools are addressing learning loss resulting from the COVID-19 pandemic and will not devote additional time to non-academic activities. This is compounded by the fact that many schools are facing budget shortfalls, because of which they are understaffed and do not have teachers available to learn and deliver the curricula. There are also a variety of other issues – e.g., parental concern about discussing these issues, teacher nervousness about discussing these topics in class – that can make it difficult to recruit schools in the United States to implement these programs.

Finding 19: Scaling school-based interventions is likely to be more difficult in decentralized education systems such as the United States.

The process of scaling through decentralized education systems will be more challenging than scaling through centralized systems, as there will be adaptations and approvals required at multiple levels of government administration. For example, the U.S. educational system is administered through local school boards, which have significant authority to set policies and oversee the management of public schools within their jurisdiction. In these contexts, the process of scaling a school-based approach may vary according to local government unit. In addition, values and attitudes about topics of a sexual nature may vary between jurisdictions and will also need to be accommodated.

Finding 20: The heterogeneity of schools and youth serving organizations will require numerous and varied entry points for scaling.

Between and within countries, there can be great diversity amongst education and youth serving institutions and an emphasis on localization. Many education institutions and youth associations will have different levels of authority at the national and local levels.

As a result, scaling programs delivered in schools and youth associations will require understanding the different entry points for generating buy-in and obtaining approvals and financing. This may be time- and resource-intensive.

Finding 21: Scaling youth-focused prevention approaches will require more effective and intensive advocacy and marketing.

According to respondents, the focus for child sexual abuse interventions remains addressing victimization, although increasing attention is being paid to expanding child sexual abuse perpetrator prevention, as evidenced by increased U.S. Department of Justice funding opportunities for risk mitigation approaches.[13] Greater advocacy and marketing is critical to gain stakeholder

[13] The Sport Situational Prevention Approach assessed by MSI was developed and implemented under a Department of Justice grant through the US Center for Safe Sport.

Findings

buy-in from potential school systems or host organizations for implementing the interventions. More advocacy and awareness-raising about the extent of the problem and its significant consequences is needed.

Finding 22: There are private sector incentives to scale risk mitigation models.

In part driven by revival statutes that have lifted the statutes of limitations on claims, there have been many recent *civil suits* against schools, camps, and other groups working with children for child abuse stemming from negligent supervision.

This should create incentives for these organizations and their insurers to promote or mandate risk mitigation approaches that can reduce the incidence of child sexual abuse,

or at the very least, reduce the potential for liability resulting from negligence.

Conclusions

The past decade has seen an increase in the number of programs delivering child sexual abuse perpetration prevention interventions. Most of these interventions, including most of the interventions delivered by the 13 programs assessed as part of this study, are implemented by relatively small organizations with philanthropic funding. Based upon the Findings above, it will likely be very challenging for most of the interventions to scale beyond their current contexts, within the next five years.

- Structured therapeutic interventions are complex and require highly trained specialists to implement. They are also relatively expensive and would probably require policy changes and public funding to deliver at scale.
- Counseling interventions tend to be implemented by relatively small organizations which would need to build their organizational capacity to deliver at scale. These initiatives also tend to be funded by philanthropy and would need more funding of a sustainable nature.
- Both school-based interventions that were assessed were implemented in the United States, which poses scaling challenges because of the decentralized nature of its education system. That said, some school districts in the United States are very large,[14] so the interventions could be delivered to many more students through collaboration with only a few districts. The interventions also would probably scale more easily in centralized education systems.

Over the longer-term, the scaling obstacles facing these interventions could be overcome with greater support from policymakers, leading to more sustainable funding. This will require the perpetration prevention community and allies to take steps to lower the stigmatization associated with the issue of child sexual abuse generally, and of individuals at risk of child sexual abuse and child sexual abuse material perpetration seeking help, specifically, while at the same time maintaining stigma against perpetration behaviors.

The interventions that have the greatest potential to scale in the next several years would be those that are relatively easy to transfer and adapt, require only limited organizational capacity to deliver and either mitigate or avoid the issue of stigmatization – which is the greatest obstacle to scaling perpetration prevention interventions. These interventions include:

- self-help modules that can be disseminated online (e.g., Help Wanted | JHU, ReDirection | Protect Children (suojellaanlapsia.fi));
- online interventions designed to deter potential perpetrators from viewing child sexual abuse materials (e.g., Deterrence campaign to prevent online child sexual abuse - Stop It Now); and
- low-cost interventions designed to minimize the risk of sexual abuse by helping organization consider risk factors and risk mitigation approaches (e.g., SSPAImplementationGuide.pdf (uscenterforsafesport.org)).

[14] The four largest school districts in the United States (New York City, Los Angeles Unified, City of Chicago and Miami-Dade) had an enrollment of nearly 2 million children in 2021. U.S. Department of Education, National Center for Education Statistics, Common Core of Data (CCD), "Local Education Agency Universe Survey," 2021-22; "Local Education Agency (School District) Finance Survey (F33)," 2019-20; and unpublished Department of Education budget data. U.S. Department of Commerce, Census Bureau, Small Area Income and Poverty Estimates (SAIPE) Program, 2021 Poverty Estimates for School Districts.

Recommendations

Recommendation 1: Conduct more research on the effectiveness of the most scalable perpetration prevention models.

The study identified three perpetration prevention models that will be relatively

easier to scale – online self-help modules, online deterrence interventions and risk mitigation interventions.

These interventions are relatively easy to implement, can reach large numbers of people and largely avoid the issue of stigmatization. Unfortunately, there has not been much rigorous research on how effective these models are in preventing perpetration. Considering the scaling potential of these models, the perpetration prevention community should prioritize conducting rigorous studies of their effectiveness.

Recommendation 2: Investigate the potential of scaling youth-focused interventions in different jurisdictions.

In light of recent research that a high percentage of child sexual abuse is committed by other children, further consideration should be given to scaling youth-focused prevention models. If provided through schools,

youth-focused interventions have the potential to scale rapidly and reach large numbers of people.

There are significant obstacles to scaling through decentralized school systems, like that found in the United States. However, there could be the potential to scale these models in the more centralized systems found in other countries, through religious denominations or specific, large school districts within the United States.

Recommendation 3: Conduct a review of similar interventions to identify good practice models for scaling.

Across the portfolio of interventions that MSI reviewed, there was considerable experimentation, and many adaptations of similar interventions. This was true in structured therapy, counseling, and self-help interventions. While the experimentation and variation are normal at early stages of the scaling process, it might be worthwhile to look across similar interventions to identify the versions that have been most successful. This is pertinent in the context of practice, policy, and funding.

Identifying success around stimulating demand for services would be particularly worthwhile,

considering that this looks to be a constraint with even the best resourced interventions.

Recommendation 4: Researchers, implementers, and funders should prioritize advocacy efforts to treat child sexual abuse as a preventable public health issue, to increase acceptance of perpetration prevention as part of the solution, and to reduce stigmatization of help-seeking.

If people are unwilling to openly discuss the issue of child sexual abuse, and if individuals at risk of child sexual abuse and child sexual abuse material perpetration remain a highly stigmatized population, it will be difficult to scale many perpetration prevention programs. Nearly all these programs would benefit from a reduction in the level of stigmatization against help-seeking. It will be necessary to build coalitions (e.g., researchers, implementers, advocates, funders, the private sector) to publicly advocate for treating child sexual abuse and child sexual abuse material perpetration as preventable public health issue, and educate policymakers, public safety institutions and public health officials about the issue.

Recommendation 5: Identify programmatic ways to promote help-seeking and mitigate the impact of stigmatization on help-seeking for those at risk of perpetration.

Individuals at risk of child sexual abuse or child sexual abuse material perpetration may feel shame and embarrassment for their feelings, compounded by concern that their condition will become known to members of their family and community, leading to rejection and discrimination. To promote help-seeking and increase demand for their services, programs should consider programmatic ways to mitigate the impact of stigmatization, such as providing services remotely and guaranteeing (and prominently highlighting) where services can be provided anonymously.

One common approach used to promote scaling is to

Recommendations

bundle services to make the package of services more appealing to potential users. Combining services that address child sexual abuse with those that address other dangerous, but less stigmatized behaviors – i.e., various forms of addiction, self-harm or risky sexual behavior – may actually reduce the stigmatization associated with seeking help. There is some evidence within the portfolio of interventions that MSI reviewed to support this. One telephone intervention that provided referrals to any individual suffering from a paraphilia had broad public support and generated high demand, with 24 percent of callers reporting attraction to children as the basis for their call.

In addition, providing a continuum of treatment options within a single program - from treatment options with lower perceived risk (e.g., online self-help) to treatment options with higher perceived risk (e.g., in-person treatment) - may encourage individuals to take their first steps to seek help. Providing the user options according to their comfort level could mitigate the impact of stigmatization while also addressing other constraints, such as cost and accessibility.

Recommendation 6: The population of individuals at risk of child sexual abuse and child sexual abuse material perpetration is heterogeneous, so funders and implementers will need to make value-based judgements about their scaling priorities.

Program implementers regularly emphasized that the population of individuals at risk of child sexual abuse and child sexual abuse material perpetration is heterogeneous.

Despite popular misconceptions, a large percentage of cases of child sexual abuse is committed by minors,

it takes place in and out of families and it is not always driven by sexual attraction. Some individuals pose low levels of risk, which can be mitigated by deterrence, education, or self-help treatment interventions. These interventions tend to be low-cost, suitable for large populations and easier to scale. Other individuals pose higher levels of risk and may require more intensive therapeutic care, including pharmaceuticals. These interventions will be complex, costly, and require significant time and resources to scale. Whether the perpetration prevention community should prioritize scaling the former, the latter, or try to balance the two, is a value-based judgment for which there is no right answer.

Recommendation 7: The perpetration prevention community should engage the private sector, where feasible, to support its objectives.

Overcoming the challenges to scaling perpetration prevention interventions will be achieved by building a coalition of champions – including the private sector where possible. For some elements of the private sector, there is an alignment of interests with the perpetration prevention community. Social media companies, adult content websites and technology companies all have strong reasons – including reputational risk, potential liability, and threats of increased government scrutiny – to prevent the dissemination of child sexual abuse material or the use of their platforms to engage in child sexual abuse. Insurers of schools, religious institutions, youth and sports clubs have an interest in reducing potential costs associated with lawsuits arising from sexual abuse. There may be other areas where interests align with the private sector that have not been considered. Active outreach and engagement with the private sector around opportunities like these could create scaling opportunities – including opening up resources or generating incentives that help scale interventions.

Annex A: Scaling Assessment Tool

Model Categories		A	← Scaling up is easier	B	Scaling up is harder →	C
A. Is the intervention credible?	1		Robust evidence that the intervention works in diverse settings and for diverse target groups		Little or no robust evidence that the intervention works in diverse settings and for diverse target groups	
	2		Independent external evaluation		No independent external evaluation	
B. How strong is the support for change?	3		Supported by eminent individuals and institutions		Supported by few or no eminent individuals and institutions	
	4		Impact very visible to decision-makers and users, and easily associated with the intervention		Impact relatively invisible to decision-makers and users and/or not easily attributable to the intervention	
	5		Strong sense of urgency regarding the problem or need		Relative complacency	
	6		Strong and stable leadership coalition committed to change		Weak, divided, unstable, or deeply conservative leadership coalition	
	7		Addresses an issue that is high on the national policy agenda		Addresses an issue that is absent from or low on the national policy agenda	
	8		Addresses a need that is sharply felt by the potential target group(s)		Addresses a need that is not sharply felt by the potential target group(s)	
	9		Faces limited opposition		Faces strong opposition	
C. Does the model have relative advantage over existing practices?	10		Current situation widely considered inadequate		Current situation widely considered adequate	
	11		Superior effectiveness to other alternatives clearly established		Little or no objective evidence of superiority to other alternatives	
	12		Substantially lower cost than existing or alternative solutions		Higher cost than existing or alternative solutions	

[14] The four largest school districts in the United States (New York City, Los Angeles Unified, City of Chicago and Miami-Dade) had an enrollment of nearly 2 million children in 2021. U.S. Department of Education, National Center for Education Statistics, Common Core of Data (CCD), "Local Education Agency Universe Survey," 2021-22; "Local Education Agency (School District) Finance Survey (F33)," 2019-20; and unpublished Department of Education budget data. U.S. Department of Commerce, Census Bureau, Small Area Income and Poverty Estimates (SAIPE) Program, 2021 Poverty Estimates for School Districts.

Annex A: Scaling Assessment Tool

Model Categories		A	← Scaling up is easier	B	Scaling up is harder →	C
D. How easy is the model to transfer and adopt?	13		Homogeneous problem, target group and setting -- geography, language, economy, politics		Multiple, diverse contexts	
	14		Implementable with existing systems, infrastructure, and human resources		Requires significant new or additional systems, infrastructure, of human resources	
	15		Small departure from current practices		Large departure from current practices	
	16		Fully consistent with government policy		Requires substantial change in one or more government policies	
	17		Few decision-makers involved in authorizing or approving adoption		Many decision-makers involved in authorizing or approving adoption	
	18		Proposed changes are highly structured or highly technological		Heavily reliant on process, values, and/or flexibility	
	19		Low complexity or easily implemented component-by-component		High complexity and need for implementation as an integrated "package"	
	20		Compliance and quality of implementation easy to monitor		Compliance and quality of implementation difficult to monitor	
	21		Able to be tested on a limited scale		Unable to test without adoption on a large scale	
E. How good is the fit between the intervention and the originating or potential scaling organizations?	22		Strong prior collaboration between originating and potential scaling organization		No prior collaboration between originating and potential scaling organization	
	23		Scaling (or potential scaling) organization has operational capacity and financial resources to implement at scale		Scaling (or potential scaling) organization lacks systems, delivery agents, and/or resources to implement at scale	
	24		Scaling (or potential scaling) and intermediary organizations have experience scaling similar interventions		Scaling (or potential scaling) and intermediary organizations lack experience scaling similar interventions	
	25		Scaling (or potential scaling) organization has physical presence and strong network and credibility in relevant contexts		Scaling (or potential scaling) organization lacks footprint and credibility in relevant contexts	
	26		Intervention fully consistent with norms, incentives and leadership style of Scaling (or potential scaling) organization		Initiative conflicts with the norms, incentives and/or leadership style of Scaling (or potential scaling) organization	
	27		Demonstrable support for the intervention among staff of Scaling (or potential scaling) organization		Active resistance by staff of the Scaling (or potential scaling) organization	

Annex A: Scaling Assessment Tool

Model Categories		A	← Scaling up is easier	B	Scaling up is harder →	C
F. Is there a sustainable source of financing?	28		Budget implications clear, predictable and justifiable to those expected to bear the costs		Budget implications unclear, unpredictable and/or difficult to justify to those expected to bear the costs	
	29		Requires small commitment of funds to begin transition to scale		Requires large commitment of funds to begin transition to scale	
	30		External sponsors with long-term commitment to supporting the intervention		No external sponsors with long-term commitment to supporting the intervention	
	31		Full cost of implementation at scale able to be absorbed within government budget or covered from other sustainable sources		No realistic prospect for funding full cost of implementation at scale within government budget or from other sustainable sources	
G. Does the model facilitate the participation of stigmatized populations?	32		Intervention does not specifically target individuals subject to social stigma		Intervention targets/ focuses upon individuals subject to social stigma	
	33		Intervention does not require participants seeking treatment to engage with mainstream institutions		Intervention requires engagement of participants with mainstream institutions	
	34		Intervention allows for strong assurance of confidentiality/ anonymity on the part of treatment group members		Intervention does not easily allow for confidentiality /anonymity of treatment group members	

Annex B: Perpetration Prevention Programs

Help Wanted

Kein Täter Werden Prevention Network

Prevent It

PrevenTell

Project Paraphile

ReDirection

Responsible Behaviors for Young Children

Shifting Boundaries

Sport Situational Prevention Approach

Stand Strong Walk Tall

Stop It Now! (USA)

Stop It Now! UK and Ireland

Talking for Change

In Partnership with