HB4086 CHILDREN EXHIBITING COMPLEX SEXUAL BEHAVIOR (CECSB) COMMITTEE

TOWARD A COORDINATED STATEWIDE RESPONSE TO COMPLEX SEXUAL BEHAVIOR IN CHILDREN

August 31, 2025

This report is being written and submitted by Just Build Village Then, LLC, contracted partners of Oregon Department of Human Service. Expert contributions and recommendations have been provided by members of the HB4086 Children Exhibiting Complex Sexual Behaviors (CECSB) Committee, as well as families and community members that have been impacted by complex and problematic sexual behaviors.

Table of Contents

Part I: Executive Summary

The Oregon Legislature established a committee under House Bill 4086 to review the state's response to reports of child abuse and to provide recommendations for system improvement. To carry out this task, HB4086 created two legislative study committees to review the following:

1. Child Welfare Jurisdiction Committee – focus on scope of mandatory child abuse and neglect investigations, definitions of abuse/neglect, best practices in multidisciplinary responses, and due process.
2. Problematic Sexual Behavior (PSB) which became the CECSB - Children Exhibiting Complex Sexual Behavior (CSB) Committee – focus on current service array for children exhibiting CSB and their families/caregivers, identification of gaps in services, review of best practices, and analysis of solutions to improve access to support, treatment, and resources available.

This report reflects the work of the CECSB committee and its four workgroups over the past year, as well as feedback solicited through community surveys, caregiver listening sessions, and community forums. This legislative report presents a roadmap to improve outcomes for children and families while enhancing public safety and equity.

Terminology: CSB vs PSB

Throughout its work, the committee discussed the distinction between Complex Sexual Behavior (CSB) and Problematic Sexual Behavior (PSB) to reflect both clinical, holistic, and systemic perspectives. While no nationally recognized definition is available, the following represents how these two terms have been used within the CECSB committee:

- **Problematic Sexual Behavior** – The term "problematic sexual behavior" (PSB) is commonly used in clinical and child-serving settings to describe patterns that may require therapeutic intervention. The Association for the Treatment and Prevention of Sexual Abuse (ATSA)—formerly the Association for the Treatment of Sexual Abusers—released its 2nd Edition of Children with Sexual Behavior Problems in 2023, adopting person-first language and updating its definition. ATSA now defines PSB in the following way:
    - "Children with sexual behavior problems are defined as those aged 12 and younger who initiate sexualized behaviors that are developmentally inappropriate or potentially harmful to themselves or others".[1]

For consistency, this report will use the term CSB, while acknowledging that PSB may appear in reference to clinical models (e.g., PSB-CBT being Problematic Sexual Behaviors with a focus on Cognitive Behavioral therapy).

This update also reflects the increasing role of technology and social media in children's sexualized behaviors, which is why prior ATSA definitions which referenced specific physical acts in the prior definition were updated. While ATSA's definition is influential, it is not universally adopted. Other states, national organizations, and the U.S. military extend the age range up to 18 when defining

[1] Association for the Treatment and Prevention of Sexual Abuse. (2023). *Children with sexual behavior problems* (2nd ed.). https://members.atsa.com/ap/CloudFile/Download/PdKaxOQp

PSB and sometimes frame PSB more broadly.[2] The National Children's Alliance, for example, partners with the National Center on the Sexual Behavior of Youth (NCSBY), which provides a more flexible definition to guide multidisciplinary teams.[3] According to the NCSBY Website, "There is no clear line that separates normative from problematic sexual behavior. Sexual behavior in childhood and adolescence falls on a continuum, from normative, to cautionary, to harmful." NCSBY further describes how problematic sexual behaviors include a wide range of behaviors.

It is important to note that statutory and clinical definitions are not fully aligned. For example, HB 4086 directed this committee to examine services for children "under 12 years of age," while ATSA's clinical definition specifies "12 and under." Meanwhile, OYA's jurisdiction covers youth ages 12–24 who commit crimes before 18. This inconsistency means that the status of 12-year-olds can shift depending on the framework. For purposes of this report, the committee has attempted to use terminology consistently while acknowledging these definitional differences.

- **Complex Sexual Behavior** – In consideration of the varying definitions for PSB, the term Complex Sexual Behavior or CSB was intentionally chosen as the title of this committee to align with the NCSBY framework that all sexual behavior falls on a continuum. In addition, the phrase CSB also reflects the broader, systemic complexity involved in these cases—including trauma histories, family dynamics, and multi-agency involvement.

Purpose of the CECSB Committee

- Examine current state and local responses to all children exhibiting CSB/PSB, and identify resources made available to their families and caregivers. A special call within this was to identify which of those services and resources are available to children 12 years of age and under.
- Identify gaps and inconsistencies in services, interventions, and legal responses to children exhibiting CSB/PSB.
- Determine the national best practices on trauma-informed multidisciplinary responses to children exhibiting CSB/PSB.
- Analyze solutions to identify and provide support, treatment and resources for children exhibiting CSB/PSB and for their families and caregivers.
- Recommend policy, legislative, and funding strategies to strengthen Oregon's systemic responses to CSB/PSB.
- Align the response system with trauma-informed and developmentally appropriate best practices.

This report reflects significant areas of agreement among committee members, but does not imply unanimous endorsement of all conclusions and recommendations.

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[2] Military OneSource. (2022). *Problematic sexual behavior in children and youth*. U.S. Department of Defense. https://www.militaryonesource.mil/parenting/children-youth-teens/problematic-sexual-behavior-in-children-and-youth/

[3] National Center on the Sexual Behavior of Youth (2025). Professionals/Overview and Definitions/Problematic Sexual Behavior. https://www.ncsby.org/professionals

North Star

To prevent harm and promote healing of children exhibiting complex sexual behaviors, their families, and communities through a coordinated, trauma-informed response — so all children grow up with safety, dignity, and belonging.

This North Star was co-created by the Committee through a facilitated process with expert facilitators, ensuring shared ownership and alignment across members.

Key Insights

This comparison highlights the relative costs and outcomes of different response pathways. Foster care placements and juvenile justice incarceration carry high annual costs per child, often accompanied by significant disruption and trauma, while offering limited long-term effectiveness. By contrast, evidence-based CSB/PSB treatments such as MST-PSB, TF-CBT, and PSB-CBT cost substantially less per child, even when accounting for training and start-up expenses. More importantly, these approaches yield better outcomes: reduced recidivism, improved family stability, and less reliance on costly system interventions.

Investing in treatment-first pathways is therefore both a fiscally responsible strategy and a trauma-informed approach that aligns with Oregon's goals of reducing harm and strengthening communities.

Response	Estimated Cost per Child per Year	Outcomes
Foster Care Placement	Foster Care Placement: $11,500–$12,300 (base payments only)[4] Residential Treatment Placement: $30,000–$50,000+[5]	High disruption, recurring trauma[6]
Juvenile Justice Incarceration	Approaches $100,000 per youth per year.[7]	Limited effectiveness of incarceration, long-term system costs[8]

[4] Oregon Department of Human Services. *Foster Care Maintenance Rates.* Updated July 2024. https://www.oregon.gov/odhs/providers-partners/foster-care/pages/rates.aspx

[5] American Addiction Centers. *Residential Treatment Costs: How Much Does Inpatient Rehab Cost?* 2023. https://amfmtreatment.com/cost/residential/

[6] Oregon-specific data show that placement instability is a norm in foster care: about **41%** of Oregon foster youth have had three or more placements, and foster students are significantly more likely to face frequent school changes, special education classification, and housing instability — all stressors closely associated with recurring trauma. Street Roots. (2021, October 13). *Lack of placement stability for Oregon foster youth.* Street Roots News. https://www.streetroots.org/news/2021/10/13/placement-stability

[7] Oregon Public Broadcasting. (2021, February 15). Oregon ranks among top states for youth incarceration costs. OPB. https://www.opb.org/news/article/oregon-incarceration-youth-rank-united-states/

[8] Mendel, Richard. The Sentencing Project. (2023). Why Youth Incarceration Fails: An Updated Review of the Evidence https://www.sentencingproject.org/reports/why-youth-incarceration-fails-an-updated-review-of-the-evidence/

Evidence-Based CSB Treatment (MST-PSB, TF-CBT, PSB-CBT)	$6,000–$10,000 annually per child.[9] Plus start-up costs for provider training and certification (from $50,000–$150,000 per site depending on model and staffing[10]	Lower recidivism, family stability, reduced system involvement[11]

Prioritizing the implementation of evidence-based and evidence-informed clinical models (e.g., TF-CBT, PSB-CBT, PBT, MST-PSB)[12] and robust multidisciplinary team (MDT) approaches is crucial for effective intervention and healing, as validated by the "HB 4086 Children and Adolescents Exhibiting Complex Sexual Behavior: A review of services, interventions, and system responses" report completed by Just Build Village Then (JBVT) in April 2025, herein referenced as the "HB 4086 Informative Report." In addition, Oregon counties are required under ORS 147.401 to maintain Sexual Assault Response Teams (SARTs), coordinated through the District Attorney's office, to develop and adopt protocols for responding to adolescent and adult sexual assault. Given their statutory role and overlap with adolescent cases, SARTs should be considered key partners in this work alongside Oregon's Child Abuse Multidisciplinary Teams, or MDTs.

Child Abuse Multidisciplinary Teams

A "Child Abuse Multidisciplinary Team (MDT)" is a county-based investigative and assessment team established by Oregon statute (ORS 418.747, originally enacted in 1989). The law requires the district attorney in each county to convene a team for the purpose of investigating and coordinating the response to child abuse cases. Membership must include, but is not limited to: law enforcement personnel, Department of Human Services child protective service workers, school officials, local health department staff, county mental health personnel with child/family experience, child abuse intervention center staff (if available), and juvenile department representatives, along with others specially trained in child abuse, child sexual abuse, and child rape investigations.[13]

Nationally recognized CSB/PSB clinician and CECSB Committee Guest Speaker, Geoff Sidoli, amplifies that identifying and providing ongoing support to quality therapists is as important if not more than the type of intervention utilized. Quality therapists are both skilled in their clinical modality, reflective in their practice, and build relationships through warm, empathetic, non-judgmental, and genuine client

[9] Coalition for Evidence-Based Policy. (2019). Multisystemic therapy (MST). Evidence-Based Programs. https://evidencebasedprograms.org/programs/multisystemic-therapy/

[10] MST-PSB start-up fee: $11,000 for first team, $8,000 for subsequent teams. https://www.blueprintsprograms.org/programs/849999999/multisystemic-therapy-problem-sexual-behavior-mst-psb/?utm_source=chatgpt.com

[11] Borduin, C. M., Letourneau, E. J., Henggeler, S. W., McCart, M. R., Chapman, J. E., & Sheidow, A. J. (2021). *A Randomized Clinical Trial of Multisystemic Therapy With Juvenile Sexual Offenders: Effects on Sexual and Nonsexual Recidivism at a 24.9-Year Follow-Up.* Journal of Consulting and Clinical Psychology, 89(5), 365–376. https://doi.org/10.1037/ccp0000649

[12] TF-CBT = Trauma Focused Cognitive Behavioral Therapy; PSB-CBT = Problematic Sexual Behavior Cognitive Behavioral Therapy, PBT = Phase Based Treatment, and MST-PSB = Multi-Systemic Therapy for Problematic Sexual Behavior.

[13] Oregon Legislature. (2025). ORS 418.747: County teams for investigation; duties; training; method of investigation; designated medical professional. Oregon Revised Statutes. https://oregon.public.law/statutes/ors_418.747

engagement.[14] Throughout this HB4086 CECSB Committee report, recommendations are grounded in developmental science, emphasizing interventions matched to the child's stage of growth and learning rather than strict age cutoffs.

Key Findings

Feedback from HB4086 CECSB committee members, families impacted by CSB/PSB, and community surveys noted systemic barriers, inconsistent messaging, and missed opportunities for early intervention for children under the age of 13 exhibiting CSB/PSB. Families and providers noted the need for clearer processes, accessible services without punitive consequences, and coordinated, cross-agency engagement. A summary of these findings include:

- Current responses are inconsistent and fragmented, with varying interpretations of statutory roles across agencies and jurisdictions.
- Mandated reporting practices are unclear, particularly for peer-on-peer incidents, leading to overreporting or inappropriate legal involvement.
- Services and workforce capacity are insufficient, particularly in rural and underserved communities.
- Coordination among agencies is limited, creating confusion for families and professionals navigating the system.
- Psychosocial education around understanding, supporting, and discussing sexual development is lacking both across communities and provider settings
- Equity gaps persist, disproportionately affecting children of color and those in child welfare or juvenile justice systems.

While the report reflects substantial areas of agreement, not all committee members—particularly representatives from juvenile justice agencies (county juvenile departments and OYA)—support all conclusions and recommendations. These members have expressed concerns regarding age scope, system roles, oversight structures, and statutory implications. Their perspectives are summarized in Appendix IX.

[14] Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (Eds.) (2010), The heart and soul of change—Delivering what works in therapy (2nd ed.). Washington DC: American Psychological Association.

Highlights from April 2025 caregivers of "initiating children" listening session, August 7th community session, and *Designing a New Response System HB4086 sub-committee workgroup*:

- **What We Heard:** Families receive mixed messages, children miss timely access to services, prevention opportunities are lost, and barriers persist for youth, families, and providers doing their best.
- **What We're Proposing:** Build multidisciplinary local capacity; create a statewide Task Force to steward this work; clarify responsibilities and thresholds for intervention.
    - **Specialized Roles:** Dedicated navigators/outreach workers; specialized positions in child welfare and other agencies to respond when system intervention is needed.
    - **Flexible Pathways:** Develop non-punitive, easily accessible service pathways that don't require formal system involvement.
- **Why This Matters:** Effective responses exist but need to be delivered consistently, sustainably, and equitably across Oregon.

Caregiver Voices

"We kept being told our son was going to be scheduled for therapy, but weeks went by with no call back. Meanwhile, he was deteriorating and isolating himself in the basement."

"Child Welfare tried to say the abuse wasn't legitimate. Family reunification was such a priority that they disregarded my child's behaviors, safety concerns, and needs."

"We had to do our own research to even find specialized therapy. Child Welfare just referred us back to our regular therapist who wasn't trained for this."

"The system was so slow that by the time services were offered, my son had already reoffended—first at summer camp, then again at home. We kept asking for help, but were told to call Juvenile Justice."

"The Children's Center did a thorough assessment, but then Juvenile Justice did a long, drawn-out series of assessments that was more hurtful than helpful. It retraumatized our son."

"Why do parents have to go through the juvenile justice system to get services? It doesn't make sense that the state has to charge children with felonies before help is available."

* Note: This is a small sample of a handful of caregivers that spoke to the Committee about their concerns and recommendations for change. While this does not reflect all caregivers of CSB/PSB youth nor the actions of every child welfare and juvenile justice employee, it does speak to themes within the system and community to be addressed through iterations of the HB4086 work.

Recommendations (See Section IV for full recommendation table)

As part of its work, the committee identified five priority recommendations that should be elevated for legislative consideration. These represent the most urgent and foundational system-building steps.

At the same time, the committee generated a broader set of recommendations across prevention, treatment, legal alignment, workforce, and system governance. The table below provides a summary of these recommendations, organized by timing and feasibility. Some actions are achievable in the near term with current resources, while others require new investments, statutory changes, or further deliberation to reach consensus.

Category	Key Recommendations
Committee Elevated Priorities	**R1.** Establish a statewide response pathway with clear protocols. **R2.** Invest in services and workforce (evidence-based treatment, training, supports). **R3.** Define and standardize CSB/PSB terminology in statute/policy. **R4.** Clarify mandated reporting expectations through statutory amendments and training. **R5.** Create an Implementation Task Force and a phased roadmap with clear accountability.
Early Wins	**R6.** Support referral/treatment pathways that avoid "child abuser" labels for young children. **R7.** Launch education and training campaigns within 12 months. **R8.** Expand Sexual Incident Response Committees (SIRC) in schools/early learning. **R9.** Strengthen provider supports (reflective supervision, peer networks). **R10.** Expand use of family navigators to connect families with services.
Strategic Investments for Scale	**R11.** Expand statewide access to evidence-based treatment models (TF-CBT, MST-PSB, PSB-CBT, PBT). **R12.** Legislative mandate for braided funding across systems. **R13.** Secure Medicaid reimbursement and enforce insurance compliance. **R14.** Develop MDT-supported judicial guidance and trauma-informed judicial training. **R15.** Expand trauma-informed models in rural/underserved areas. **R16.** Build workforce pipeline through training, certification, and higher ed partnerships.

Areas for Continued Deliberation	**R17.** Determine oversight structure (OHA vs. SOC Advisory Council). **R18.** Clarify age scope (12 and under vs. up to 18). **R19.** Consider statutory exemption for children from "perpetrator" classification. **R20.** Explore creative funding models (e.g., Pay for Success, insurance incentives).

Note: These recommendations reflect strong areas of committee alignment, but not unanimous endorsement. Some items are included as discussion points for future exploration and do not represent formal consensus.

Path Forward: Implementation Roadmap

Implementation Considerations: Many of the recommendations in this report are intentionally broad. They represent system-level strategies that may require action from multiple partners, including the Oregon Legislature, state and local government agencies, county systems, schools, and community-based providers. In most cases, further scoping and implementation planning will be needed to identify specific agency leads, assign responsibilities, and determine resourcing.

The committee recommends a phased approach to building Oregon's coordinated CSB/PSB response system:

Phase 1 (0–12 months):

- Establish a Task Force composed of youth and families with cross-agency representation that serves as an interagency workgroup, review and finalize statutory proposals, and begin community training pilots (R5).
- Review and finalize statutory proposals in alignment with mandated reporting and judicial consistency (R4, R14).
- Launch initial community training pilots and public awareness campaigns (R7, R9).
- Consider creation of an Advisory Board/Steering Committee of CSB/PSB-impacted youth to inform Task Force activities (Discussion Idea – R19).
- Ensure community members serving on committees are compensated for their expertise and time (R15, R18).

While HB 4086 did not finalize an oversight body, it is proposed that the Oregon Health Authority (OHA) serve as the steward of the CSB/PSB Task Force. In addition to its mission of ensuring that all people and communities can achieve optimal physical, mental, and social well-being, OHA is uniquely positioned to lead this work because it:

- Oversees the state's Behavioral Health Division, which provides access to mental health and addiction services and supports for both children and adults.
- Administers Medicaid (Oregon Health Plan), which is a primary funding stream for children's behavioral health services.
- Collaborates with counties, other state agencies, providers, advocates, and families to coordinate care across systems.

There was additional dialogue within the committee to designate a separate Advisory Board/Steering Committee composed of CSB/PSB impacted youth that the Task Force would report to. During Phase 1 of the next iteration of HB4086, this concept should be further deliberated and decided upon. Additionally, whether on the Advisory/Steering Committee or Task Force, community members should receive compensation for their time and commitment in these spaces.

Phase 2 (1–2 years):

- Implement cross-system community training and clarify training requirements across agencies (R2, R11).
- Further explore Sex Offender Treatment Board (SOTB) requirements and assess alignment with CSB/PSB approaches (Discussion Idea – R20).
- Identify and begin piloting CSB/PSB clinical certification pathways (R11).
- Revitalize and strengthen regional CSB/PSB multidisciplinary teams (MDTs) (R1, R14).
- Expand service availability through workforce incentives and braided funding strategies (R10, R12, R16).
- Develop statewide guidance for agencies on roles, responsibilities, and trauma-informed standards (R3, R15).

Phase 3 (3–5 years):

- Implement the full statewide response pathway with clear intake, referral, and intervention protocols (R1, R3).
- Execute statewide certification pathways for CSB/PSB clinicians and MDTs (R11, R14).
- Scale funding strategies, including Medicaid alignment and braided models (R12).
- Embed accountability structures, including statewide data systems and annual reporting (R5, R17).
- Monitor outcomes and equity impacts, adjusting system design based on evaluation and lived experience feedback (R15, R18).

Recommendations contained in this report are advisory in nature. Implementation will require further analysis of statutory, budgetary, and administrative considerations by appropriate agencies and stakeholders.

Next Steps For Implementation

To move Oregon toward a coordinated, trauma-informed CSB/PSB response system, the committee highlights the following next steps:

- **Legislative Action:** Advocate for statutory and funding changes in 2026 and 2027 legislative sessions (R12, R17).
- **Governance:** Develop and resource a centralized Task Force to coordinate implementation (R5).
- **Training & Education:** Launch campaigns within 12 months, with dedicated funding and agency partnership (R7, R11).
- **Sustainable Funding:** Secure braided funding streams and enforce insurance compliance (R12, R13).
- **Accountability:** Maintain annual evaluations and partner reporting to track access, equity, and outcomes (R17, R18).
- **Legal Alignment:** Support the Jurisdiction Committee's recommendation to avoid "child abuser" labels for young children and ensure responses to sexual abuse cases with a child as the reported initiator align with HB 4086's trauma-informed framework (R4, R14).

Part II: Background Context

In response to the growing recognition of Problematic Sexual Behavior (PSB) in children and its direct links to childhood trauma, Oregon launched a comprehensive, trauma-informed initiative to evaluate and strengthen the state's response system. This effort is guided by the Oregon Health Authority's Trauma-Informed Approaches Policy, which emphasizes the need for services that are safe, trustworthy, collaborative, and culturally responsive.

Committee Scope and Focus

The HB 4086 CECSB Committee was convened to evaluate and improve Oregon's systems of care for children exhibiting sexual behavior challenges.

The primary legislative focus was identified to encompass two age groups: children ages 0–12 and youth ages 13-17.

The committee discussed these two age group classifications, but there was no consensus about whether the committee's recommendations should adhere to these age group classifications. What was discussed extensively was the need to focus more on the developmental needs of the child/youth rather than their chronological age.

Committee Scope:

Focus: Children ages 0–12
Discussion: 13–17 considered, but not consensus*
DOJ Position: Statewide system should cover all children

During committee deliberations, a DOJ representative noted that any statewide system ultimately should apply to all children, regardless of age, due to the overlapping service and legal pathways. This reflects the perspective of DOJ staff representatives in the workgroup, not a formal agency policy statement.

**Note on Consensus: Committee members did not reach full consensus on whether the work should formally include youth 13–17. Some felt the current focus should remain on 12 and under, highlighting that the Juvenile Justice system, including but not limited to the Oregon Youth Authority (which only accounts for 5% of juvenile offenders) and county Juvenile Justice Departments, oversees the pathway for youth ages 13-17. While others argued that policy and practice changes must address all minors for system alignment. For example, Child Welfare's scope is much broader, with a responsibility to ensure safety for children regardless of the initiating child's age or involvement with Juvenile Justice. This report reflects both perspectives and notes gaps affecting all age groups.*

ODHS Statutory Role

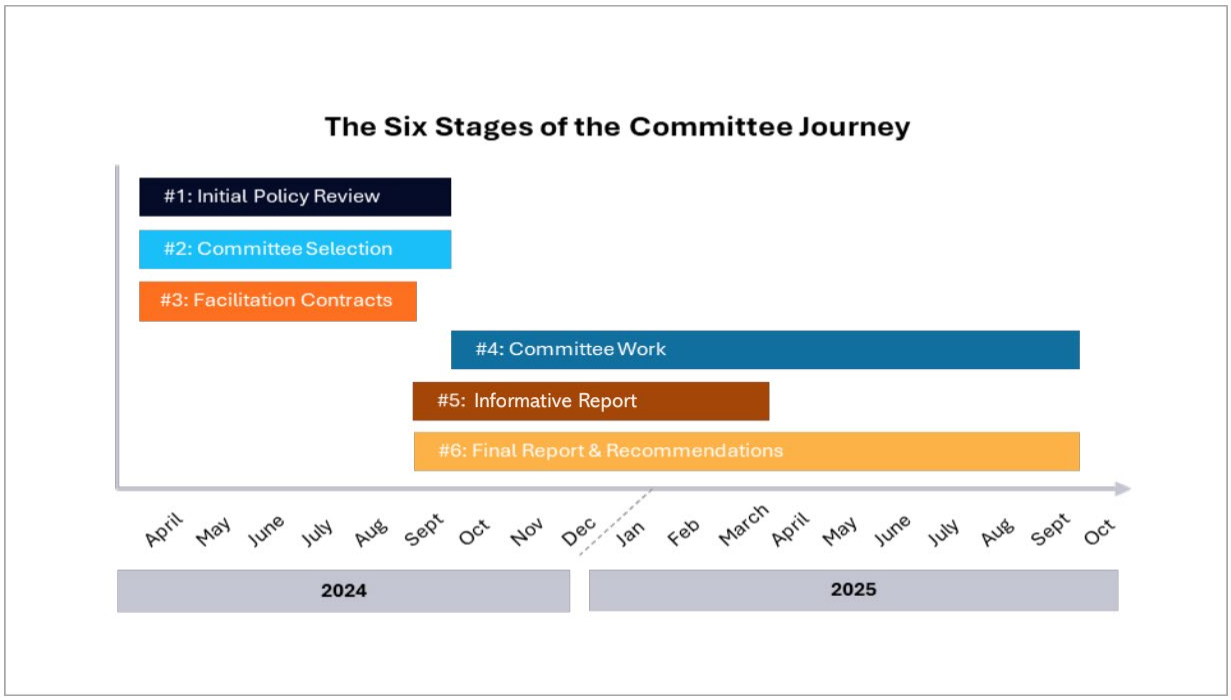
The Oregon Department of Human Services (ODHS) – Child Welfare (CW), plays a critical role in responding to children with CSB:

Statutory Basis: ODHS-CW is guided by ORS 419B.010 and 419B.015, which require mandatory reporting and response to suspected child abuse, including cases where children can be identified as alleged perpetrators. Because there is no statutory clarity on the scope of "alleged perpetrators of abuse," ODHS has historically been required to respond even in cases involving young children with CSB. This lack of clarity was a central issue taken up by the Jurisdiction Committee.

Example: In cases where a 9-year-old engages in sexual behavior with a sibling, ODHS-CW receives the report, initiates a child safety assessment, and coordinates with law enforcement and clinical providers to ensure both safety and therapeutic support.

ODHS-CW is not the only agency that responds to CSB/PSB. Law enforcement also responds to reports of PSB. In addition to their general mandatory reporting obligations under ORS 419B.010, law enforcement carries distinct legal mandates under the criminal code that guide investigation and enforcement actions in alignment with their mission of upholding public safety. Clinical providers and school systems are also common initial points of disclosure. Schools also hold legal obligations under Title IX when CSB/PSB occurs in the school context. Title IX requires schools to provide supports to impacted students and, in some cases, conduct formal investigations. However, while statutory mandates are consistent statewide, agency policies and procedures—especially within clinical and educational systems—can vary across regions. This variation affects not only responses, but also the early identification of concerning behaviors. To address these disparities, the CECSB Committee aims to inform all responding agencies and promote trauma-informed, standardized understanding and treatment across Oregon.

The Committee Journey



Stage 1: Initial Policy Review (Apr-Sept 2024)

Upon passage of the HB4086 bill, ODHS-CW sought in-kind support through an existing relationship with the Doris Duke Foundation to fund an initial policy review related to the tasks outlined in the bill specific to state statutes. The review was conducted by a reputable national organization – the Bi-Partisan Policy Center (BPC). This review was presented to the legislature in September of 2024 and shared with committee members of both HB4086 committees – Jurisdiction and CECSB. This review

was preliminary in nature and only included an analysis of public policy, leaving the practice analysis and final recommendations to the contracted facilitators of the two committees.

Stage 2: Inter-Agency Steering Committee and HB 4086 Study Committee Selection (Apr-Sept 2024)

While BPC worked on the policy analysis, ODHS-CW established an inter-agency steering committee, including individuals outside of the agency to define the committee selection process. This included partners from ODHS-Office of Training, Investigations, and Safety (OTIS), ODHS-Office of Developmental Disability Services (ODDS), Oregon Health Authority (OHA), System of Care Advisory Council (SOCAC), Oregon Youth Authority (OYA), and those with lived experience with the child welfare system. This committee developed the process for selection of committee members and selected members based on a variety of criteria, including but not limited to: primary/secondary role selected to represent on one or both committees (and total number of applicants for that role), answers to 4 narrative questions, geographic representation across the state, lived experience specific to child welfare, and other forms of representation to provide diverse perspectives (race, sexual orientation/gender identity, disability, etc.).

Stage 3: Facilitation Contracts (Apr-Aug 2024)

Without time for a full competitive procurement process, ODHS-CW sought approval for emergency procurement. During this time, ODHS-CW engaged in the process of securing approval, identifying potential facilitators with experience, and fully executing contracts by August 2024.

Stage 4: Committee Work (Sept 2024-Sept 2025)

Committee members began with an orientation by ODHS-CW in September 2024 and both the Jurisdiction and CECSB committees held “kick-off” events in October of 2024. Compliance with public meeting laws were met by posting agendas publicly on the ODHS-CW webpages, holding a location at a public office for anyone who wanted to observe meetings in real time, recording meetings, and posting videos and minutes online:

- Children Exhibiting Complex Sexual Behavior (CECSB): https://www.oregon.gov/odhs/agency/Pages/hb4086-cecsb.aspx
- Child Welfare Jurisdiction: https://www.oregon.gov/odhs/agency/Pages/hb4086-jc.aspx

Stage 5: Preliminary Supplemental “Informative Report” (Aug 2024 - Feb 2025)

This was a deliverable specific to the CECSB Committee Facilitators. Given the expertise of BPC being in national public policy analysis, and in consideration of the additional requirements outlined in HB4086 around clinical expertise, the CECSB Facilitators (Just Build Village Then, LLC members Dr. Denicia Carlay, Ranecia Cormier, & Shannon Scott) were asked within their contract to produce a “Supplemental Informative Report”. This review was intended to be prepared for the committee to provide information to support the group's recommendations and the final report. This informative report became the HB4086 - Children and Adolescents Exhibiting Complex Sexual Behavior: A review of services, interventions, and system responses, and focused on the following deliverables:

- Identification of evidence-based or promising programs or practices to address and support children/youth exhibiting CSB/PSB.
- Pathways to treatment – Expanding upon policy reviews.
- Identification of the current state of services and resources available in Oregon to children 12 years of age and under exhibiting CSB/PSB, their families and caregivers.
- Identification of the gaps in the services and resources available to families impacted by CSB/PSB.
- Identification of national best practices on trauma-informed multidisciplinary responses to children exhibiting CSB/PSB.
- Analysis of solutions to identify and provide support, treatment and resources for children exhibiting CSB/PSB, their families and caregivers.

Stage 6: Final Report and Recommendations (Sept 2024-Sept 2025)

The Just Build Village Then (JBVT) facilitators were responsible, as the contracted clinical experts, to complete a final study with recommendations to the legislature by September 15, 2025. While the facilitators carried the formal responsibility for transmitting recommendations, the process was intentionally co-designed: committee members' expertise, perspectives, and deliberations shaped and informed every stage. This approach reflects the belief that Oregon's committee members are experts in their own right, and that the final recommendations represent a shared product of both facilitation and committee collaboration.

The CECSB Committee Container

The committee met regularly from October 2024 through August 2025, contributed to an informative review of CSB/PSB services, interventions, and system responses, engaged in system mapping, and subject matter expert consultations to inform its recommendations.

- Workgroups focused on Community Education, Judicial Alignment, Behavioral Health & Treatment Models, Funding Streams, and System Coordination.
- Expert input was solicited from clinical providers, law enforcement, child welfare, statewide CSB/PSB representatives, and survivor advocates.
- Full workgroup narratives are included in the Appendices for reference.

Understanding Complex Sexual Behaviors in Children

Children's sexual development exists on a continuum that reflects their age, cognitive development, environment, and life experiences. While many behaviors are developmentally appropriate and reflective of curiosity, others may be considered "concerning" or "problematic" if they are intrusive, aggressive, or do not respond to adult intervention. The HB4086 informative report emphasized that behaviors labeled as "complex" or "symptomatic" are often learned or conditioned responses to environmental stressors such as trauma, neglect, or exposure to sexual content, rather than evidence of intent or malice. Assessment of such behaviors must be contextual and developmentally informed.

In determining whether the sexual behavior is unhealthy with young children (ages 12 and under), ATSA directs us to evaluate the following[15]:

- Whether the behavior is common or rare for the child's developmental stage and culture.
- Understanding if the behavior violates shared cultural norms/expectations.
- The frequency of the behavior.
- The extent to which sex and sexual behavior has become a preoccupation for the child.
- Whether the child responds to guidance and correction from adults or continues unabated after healthy corrective efforts.

The distinction between normative, concerning, and problematic sexual behaviors (PSBs) is critical. Concerning behaviors might be unusual but are typically correctable with guidance. In contrast, PSBs are characterized by persistence, coercion, harm, or developmental inappropriateness and require therapeutic intervention. Children may exhibit these behaviors for various reasons, with the highest correlation being to adverse childhood experiences (ACEs).[16] Although much of the research on PSB focuses on individual trauma or exposure, there is a growing recognition of intersecting risk factors, including exposure to domestic violence, trafficking, online pornography, and sexual exploitation. These overlapping harms increase risk for dysregulated behaviors and require trauma-informed, cross-sector screening. This context of risk factors that contribute to PSB highlights that effective, trauma-informed responses to child maltreatment and ACES are critical aspects of the prevention of PSB. Oregon should commission additional research to understand and address these intersections in system response.

What are Adverse Childhood Experiences (ACEs)?

Adverse Childhood Experiences (ACEs) are traumatic events in childhood, such as abuse, neglect, or household dysfunction (e.g., exposure to domestic violence, parental substance use, or incarceration). The landmark CDC-Kaiser Permanente ACEs Study (1997) found a strong, graded relationship between the number of ACEs and negative health and behavioral outcomes across the lifespan. High ACE scores are linked to increased risk of mental illness, substance use, chronic disease, and behavioral challenges—including problematic sexual behaviors in children.

Importantly, language matters—labeling a child a "perpetrator" can cause lasting harm; instead, using trauma-informed terms and intentional language that externalizes the behavior from the individual is essential. Terms such as "initiating child" and "impacted child" are recommended.

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[15] Association for the Treatment and Prevention of Sexual Abusers (ATSA) Task Force on Children with Sexual Behavior Problems. (2023). Children With Sexual Behavior Problems (2nd Edition). ATSA.

[16] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Initiating Child	Impacted Child
The child who exhibits the sexual behavior. This term avoids labeling the child as a perpetrator, recognizing that such behaviors may stem from various factors, including developmental issues or exposure to inappropriate content.[17]	The child who is affected by another child's sexual behavior. This term acknowledges the experience of the child without assigning victimhood, which can carry implications for their self-perception and development.[18]

Some children/youth initiating PSB cause harm, and when they do, those impacted may identify or be identified by the system as a victim/survivor. It is important to honor their experiences and needs, and work towards accountability. This proposed language is intended to promote effective solutions to that harm.

Addressing PSBs requires a whole-child, ecological approach that includes both individualized assessment and support for the family and community context. The report discourages punitive frameworks traditionally used for adults, noting that most children do not continue these behaviors into adolescence or adulthood if they receive early, educational, and appropriate support. Interventions should be trauma-informed, strengths-based, and focused on fostering safe, healthy relationships.

For more information, review the full informative report included in the appendix: HB4086 - Children and Adolescents Exhibiting Complex Sexual Behavior: A review of services, interventions, and system responses.

[17] PowerPoint Decision Guide for Multidisciplinary Teams Addressing Problematic Sexual Behaviors (from the National Children's Alliance Problematic Sexual Behavior Workgroup in 2022) / ncalliance_6afddca83b060d5d1795c8f0c8b787df.pptx.

[18] PowerPoint Decision Guide for Multidisciplinary Teams Addressing Problematic Sexual Behaviors (from the National Children's Alliance Problematic Sexual Behavior Workgroup in 2022) / ncalliance_6afddca83b060d5d1795c8f0c8b787df.pptx.

Part III: System Analysis (Current State + Gaps)

National and State Landscape

Nationally, the prevalence of PSBs is difficult to quantify due to inconsistent definitions and varied reporting systems. Approximately one-third to one-half of all child sexual abuse cases are committed by other youth,[19] with a little under 30 percent of these cases committed by children who are twelve years old or under.[20] Children's Advocacy Centers (CACs) and Multidisciplinary Teams (MDTs) have increasingly played a role in identifying CSB/PSBs, though approaches differ significantly by community and supporting impacted children is the primary focus of CACs. Many jurisdictions lack formal protocols, contributing to fragmented and inequitable responses. It is vital to acknowledge that CACs and MDTs are required to do certain work pertaining to the impacted child. Taking on new efforts to expand support to initiating children without supporting funding is unrealistic given these requirements.

In Oregon, multiple agencies play roles in identifying and addressing cases of CSB and PSB, including ODHS-CW (Oregon Department of Human Services - Child Welfare), Oregon Health Authority (OHA), Oregon Youth Authority (OYA), CACs, Law Enforcement Agencies, county juvenile departments (who handle the majority of cases that are charged), Oregon Department of Education (ODE), and local MDTs. However, there are significant gaps in data collection and service coordination. For example, ODHS-CW data between 2018–2023 shows that there were 2,013 screened in reports for sexual abuse cases with a child as the reported initiator and547 were substantiated, meaning that child sexual abuse was found to have occurred. A dispositional finding of substantiation of a CPS assessment is not always correlated with Child Welfare intervention or opening a case. Opening a case is based on a safety threat and safety decision. Within these substantiated child welfare reports, youth initiating PSB were overwhelmingly male and white, though data collection practices likely obscure the full picture, particularly for younger children and girls.

Innovative county-level models in Oregon, inclusive of Marion, Washington, Yamhill and Clackamas Counties' HUBB/HBB teams, illustrate how localized, community-led responses can better meet the needs of children with PSBs. These teams offer non-punitive, supportive interventions that involve caregivers and professionals across systems. However, only a handful of Oregon's counties have such dedicated teams, and many regions—especially rural ones—lack infrastructure or funding to implement similar models. This underscores the need for statewide coordination, investment in community-based solutions, and standardization of definitions and protocols.

The following section ("Current Oregon Response") provides a detailed look at how Oregon's agencies and communities currently respond to CSB/PSB, including processes for reporting, assessment, treatment, and judicial involvement.

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[19] Wamser-Nanney, R., & Campbell, C. L. (2020). Childhood sexual abuse characteristics, abuse stress, and PTSS: Ties to sexual behavior problems. Child Abuse & Neglect, 105, 104290.
Gray, A., Pithers, W. D., Busconi, A., & Houchens, P. (1999). Developmental and etiological characteristics of children with sexual behavior problems: Treatment implications. Child Abuse & Neglect, 23(6), 601-621.
Finkelhor, D. (2009). The prevention of childhood sexual abuse. The future of children, 169-194.

[20] DeLago, C., Schroeder, C. M., Cooper, B., Deblinger, E., Dudek, E., Yu, R., & Finkel, M. A. (2020). Children who engaged in interpersonal problematic sexual behaviors. Child abuse & neglect, 105, 104260.
Puzzanchera, Charles, Hockenberry, Sarah, and Sickmund, Melissa. 2022. Youth and the Juvenile Justice System: 2022 National Report. Pittsburgh, PA: National Center for Juvenile Justice.

Current Oregon Response

Oregon's current response to children exhibiting Complex Sexual Behavior (CSB) involves multiple agencies and service systems, but it is fragmented, inconsistent, and often difficult for families to navigate. This section summarizes the current system, highlights its gaps, and introduces promising practices from other states.

Currently, children with CSB/PSB may encounter one or more of the following system components:

- Mandatory Reporting and Investigation: Reports are required under ORS 419B.010 when there is reasonable cause to believe a child has been abused. Children can be identified as alleged perpetrators, and reports often trigger both Child Protective Services (CPS) and law enforcement responses. According to Oregon Child Welfare, schools (along with law enforcement) contributed to about 41.5% of screening reports in FFY 2023[21]. As a result, children with CSB/PSB may also become involved in school-based disciplinary processes, special education evaluations, or student support services, depending on how the behaviors are understood and addressed within the educational system.
- Assessment and Screening: Some counties have access to specialized screening and assessment tools, but usage varies widely, and there is no statewide standardized process. Responses can include SIRC assessments (School Safety and Prevention System, Sexual Incident Response Committees) and/or Title IX sexual harassment investigations when conduct occurs within school programs. These processes may occur alongside and in coordination with ODHS-CW, law enforcement, or other responses.
- Clinical Intervention: Access to evidence-based treatments such as PSB-CBT, TF-CBT, MST-PSB, and PBT depends on local availability. Many regions lack trained providers, creating delays in intervention.
- Judicial and Legal Interface: Children may be referred to juvenile court if their behavior is categorized as delinquency, although practices differ across counties. Judges often receive inconsistent recommendations due to gaps in cross-system coordination.

Within Oregon, there is also precedence of key legislation passed to create institutional policies and practices that focus on effective prevention, assessment, and early intervention methods for CSB and PSB for children attending public schools. The except below is taken from the HB4086 Informative Report:

- In 2020, Senate Bill 52, also known as Adi's Act, was passed, mandating schools to develop comprehensive plans for student suicide prevention, intervention, and aftercare. This bill led to the creation of a School Safety and Prevention System ("System") to support the health and well-being of Oregon students and school communities.[22] The System is designed to provide school districts with a multi-tiered system of supports ranging from curriculum-based universal prevention programs, to safety-based crisis interventions. The "System" provides for School Safety and

[21] Oregon Department of Human Services. (2024). *Child Welfare Data Book 2023.* Salem, OR: ODHS Child Welfare Division. Retrieved from https://www.oregon.gov/odhs/data/cwdata/cw-data-book-2023.pdf

[22] Retrieved from https://www.oregon.gov/ode/students-and-family/equity/ssp/pages/default.aspx in May 2025.

Prevention Specialist (SSPS) located around the state to receive training, consultation, and case management for schools, educators, and community partners in the areas of children sexual violence, SIRC, sex trafficking, and the sexual exploitation of children. SIRC is a school-based process that includes assessing, intervening and the coordination of services for students across the state. While it does not provide treatment, it does provide a bridge and level of support for recognizing the signs of PSBs early on and intervening through a coordinated effort with community partners.

- Every region across the state is supported by a SSPS, allowing community partners, such as professionals in the mental health, juvenile justice, and social work fields a more direct connection with schools and districts when it comes to treatment options for children Education Service Districts (ESDs) often collect data and support schools with processes and protocols.
- While Oregon is actively seeking to enhance their pathways for children exhibiting CSB and PSB, there is already statewide use of a national best practice: the Sexual Incident Response Committees (SIRC). SIRCs are a formal school-based process that offers a comprehensive, multi-disciplinary, and multi-stage system for assessing, intervening, and identifying incidents of problematic sexual behavior in school aged children.[23] These committees ensure that cases are handled with equity, sensitivity, and in alignment with state laws and district policies. Through both Level 1 and Level 2 assessments, the SIRC model builds upon the Behavior Safety (Threat) Assessment, incorporating the Salem-Keizer Cascade Model[24] as a framework, to address concerns efficiently and effectively.
    - **Tier/Level 1:** The SIRC model uses a Level 1 protocol to address most cases of problematic sexual behavior at the school level. The purpose of the Level 1 meeting is to determine if the presenting sexual behavior is concerning or problematic, and if so, what the best method should be outlined to address it. This initial assessment is carried out by a school-based team, which typically includes an Administrator, a School Counselor, a Psychologist, or Social Worker, and a School Resource Officer or law enforcement representative. If the situation requires additional expertise, the team can escalate the case to a Level 2 assessment, ensuring more specialized intervention while optimizing the use of district resources. In Oregon, most Level 1 cases are seen at the elementary level (approximately 55%), and are able to be addressed at this stage. There are considerably more Level 2 cases evaluated at the high school level (approximately 64%), and roughly 60% of cases identified through SIRC are special education students.[19]

    - **Tier/Level 2:** If a high risk is identified, which occurs for roughly half of Level 1 identified students, the Level 2 protocol is activated. At Level 2, a collaborative, multidisciplinary team that includes representatives from schools, public mental health, law enforcement, juvenile justice, child welfare, and other community-based services convenes to outline a clear plan for supervision and intervention to ensure the safety of the child initiating PSB and the general public. Schools can request assistance with Level 2 assessments at the district or county level or by partnering with their School Safety and Prevention Specialist.[25]

[23] Kenney, J. Wilson. Problematic Sexual Behavior in Schools: How to Spot It and What to Do About It. Rowman & Littlefield, 2020.

[24] Public Consulting Group. 2023. Behavioral Threat Assessment (BTA) Solution Salem-Keizer Cascade Model, retrived from: https://behavioralthreatassessments.com/wp-content/uploads/2023/11/behavioral-threat-assessment_salem-keizer-model-reference-sheet.pdf

[25] Kenney, J. Wilson. Problematic Sexual Behavior in Schools: How to Spot It and What to Do About It. Rowman & Littlefield, 2020.

Gaps in Response and Services Available to Children & Families

Significant gaps exist in how systems identify, assess, intervene, and support children exhibiting CSB or PSB. These gaps include inconsistent definitions, lack of formal protocols across jurisdictions, limited access to trained mental health professionals, and insufficient coordination among systems like child welfare, education, and juvenile justice. Most responses are reactive—initiated only after harm has occurred—rather than preventive, and focus on criminalizing the child as a problem rather than addressing their behaviors as a symptom. Many children fall through the cracks, particularly if their behaviors don't meet the threshold for legal substantiation.

The lack of early, preventive interventions for children exhibiting concerning sexual behaviors results in a cascade of negative outcomes across systems. Children 12 and under often face risk of family separation, placement disruptions when in foster care, and exclusion from programs due to younger age. Youth over 12 with PSB face non-placement, temporary lodging, and increased legal risk. Families struggle to manage sibling safety and trauma recovery without adequate support. Schools, hospitals, and community partners report insufficient training, staff capacity, and resources to respond appropriately, leading to inconsistent and sometimes harmful responses.

Families often encounter stigma, confusion, and limited guidance when navigating services for a child with PSB. Many fear legal repercussions or public labeling and are hesitant to seek help. In Oregon, access to services is often dependent on involvement with ODHS-CW, county juvenile departments, or OYA - meaning children who don't reach these systems may not receive needed interventions. Even once involved within these systems, Oregon children are still not getting access to needed treatment and placement due to scarcity of resources. Placement types include foster/resource homes, therapeutic foster care programs, Qualified Residential Treatment Programs (QRTPs), or other non-QRTP settings like Behavioral Rehabilitative Services (BRS) programs. Many youth wouldn't need access to residential programs if they receive appropriate access to lower levels of care. Schools are also a critical point of concern and support. Districts and Education Service Districts (ESDs) provide important behavioral health and special education services, and many are the first to notice early warning signs. However, procedures for consistently assessing or responding to CSB/PSB vary due to limited funding and staffing. While training is available, it is often not accessible or sustained, and partnerships with community providers remain inconsistent.

Caregiver Voices

"Our Juvenile Department worker used graphic terms and aggressive language with my son. It was retraumatizing and reversed progress we had made."

"We felt gaslit by DHS. They didn't seem to know what they were doing, and they didn't have resources for us."

* Note: This is a small sample of a handful of caregivers that spoke to the Committee about their concerns and recommendations for change. While this does not reflect all caregivers of CSB/PSB youth nor the actions of every child welfare and juvenile justice employee, it does speak to themes within the system and community to be addressed through iterations of the HB4086 work

In addition, some children exhibiting CSB/PSB may also be students with disabilities covered under the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act. In these cases, schools are legally required to develop effective support plans, which may intersect with therapeutic and intervention needs. Better alignment between school-based supports (IEPs and 504

plans) and community or clinical interventions presents an important opportunity to strengthen Oregon's response.

At the same time, Oregon lacks a clear, consistent pathway for educating youth with complex sexual behavior concerns who cannot attend school in person due to safety or probation restrictions and who are also restricted from online access. Current practices vary widely, leaving gaps in both academic continuity and equitable treatment. Establishing a mandated process through ODE to ensure access to appropriate instructional alternatives—whether paper-based curricula, caretaker-supported kits, or other models—would close a significant system gap.

Children exhibiting early warning signs of CSB/PSB are often not assessed until behaviors escalate significantly, frequently due to limited professional capacity. While structured procedures were put in place in 2020 to support youth impacted by sexual violence, more resources and ongoing funding are needed to sustain these supports and expand early intervention.[26]. Delays in assessment are frequently due to limited professional training, lack of clarity on normative vs. concerning behaviors, and inconsistent referral pathways. A statewide assessment protocol should be implemented to ensure timely identification, reduce harm, and shift from reactive to proactive system response. In the education context, Oregon has already identified the SIRC (School Safety and Prevention System, Sexual Incident Response Committees) process as the framework supported by ODE for schools. SIRC, supported through the School Safety and Prevention System (SSPS) and legislative mandates, provides training and protocols for school and district responses. Ongoing support and alignment across education, child welfare, and clinical systems are needed to ensure that SIRC and other assessment processes work together as part of a coordinated statewide approach.

Note: Each gap is paired with a recommended action. For detailed recommendations, see Part IV: Recommendations.

Rural and underserved areas face even greater barriers.	
Out of 36 Oregon counties, 4 currently have active PSB MDTs. Most counties have no formal PSB MDTs or access to trauma-informed behavioral health services. Even when services exist, funding and workforce shortages prevent broad access. The fragmented nature of Oregon's response systems limits the ability to collect accurate data, provide timely interventions, or ensure equitable support statewide.	**Recommended Action (see R15, Part IV):** Expand community-based, trauma-informed models and strengthen regional MDTs through a coordinated statewide framework led by state and county partners.

[26] In the 2019 Legislative Session, House Bill 2327 was passed creating the statewide School Safety and Prevention System ("System") to support the health and well-being of Oregon students and school communities. The System is designed to provide school districts with a multi-tiered system of supports ranging from curriculum-based universal prevention programs, to safety-based crisis interventions. The "System" provides for School Safety and Prevention Specialist (SSPS) located around the state to receive training, consultation, and case management for schools, educators, and community partners in the areas of youth sexual violence, SIRC, sex trafficking, and the sexual exploitation of youth. Senate Bill 52, also known as Adi's Act, was also passed, mandating schools to develop comprehensive plans for student suicide prevention, intervention, and postvention.

Accountability and Identification Gaps

With disparate responsibility across agencies, there is no shared framework for accountability, and no standardized process for identifying and responding to children and youth with PSB/CSB. This lack of coordination leads to inconsistent identification, referral, and follow-up, leaving gaps in care and uneven outcomes across the state.

Recommended Action (see R1, R5, Part IV): Develop a cross-agency accountability framework and statewide intake/response protocols to improve consistency while allowing for local flexibility.

Resource Gap

Oregon faces a critical shortage of mental and behavioral health practitioners, particularly those trained to understand and treat complex sexual behaviors in children and youth. This gap is especially pronounced in rural areas, where families often lack access to qualified providers.

While continuing education (CEUs) can help deepen expertise, the current Sex Offense Treatment Board (SOTB) and Certified Clinical Sexual Offense Therapist (CCSOT) licensure and certification requirements for working with this population are often experienced as overly burdensome. For many providers, especially early-career professionals, the path to full certification can feel like pursuing a second license—an intensive process that contributes to workforce attrition and deters new practitioners from entering the field. Administrative delays in processing certifications further exacerbate access issues, according to committee members familiar with the process.

Recommended Action (see R11, R16, Part IV): Reevaluate certification requirements and create accessible, tiered training pathways to expand the provider pipeline.

The Oregon Sex Offender Treatment Board (SOTB) was established under the administration of the Oregon Health Authority (OHA). The original intent of the Board was to regulate providers who provide treatment for sexual offenders (adults and juveniles) and to establish guidelines and protocols around best practice in the treatment of sexual offenders. The main goal is to provide consumer protection. It established a Title Act in 2018 under HB2633, meaning anyone in the state of Oregon who wishes to identify as a sex offender therapist must be certified through the SOTB.

Assessment Gap

Oregon lacks a centralized or consistently designated entity responsible for assessing complex or problematic sexual behaviors (CSB/PSB) in children and youth. This leads to inconsistent practices, delays in care, and assessments that may be inappropriate or misaligned with developmental and trauma-informed standards. When families seek advice about their child's behaviors, they often receive mixed messages by different professionals, which can contribute to distrust and disengagement with systems that may be able to help. In some areas, families are referred to providers without the necessary expertise, while in others, assessments are shaped by punitive systems rather than healing-centered care.

Recommended Action (see R1, R3, Part IV): Establish statewide trauma-informed assessment protocols and designate trained regional teams for timely evaluations and referrals.

Inconsistent Messaging

Without clear alignment, education and intervention efforts across systems can contradict each other and confuse communities. As Oregon works to raise awareness and improve responses to CSB/PSB, there is a risk of over-reacting or unintentionally pathologizing developmentally typical behavior—especially in younger children. Poorly framed messaging can contribute to stigma, fear, or the creation of a new category of "bad kids", which undermines healing and inclusion.

Recommended Action (see R7, R10, Part IV): Develop a statewide, trauma-informed communication strategy co-designed with families, providers, and communities.

Funding Fragility

Overreliance on grants, pilot projects, or short-term funding streams jeopardizes the long-term sustainability of effective CSB/PSB interventions. Programs launched with temporary funding often struggle to scale, retain staff, or embed within community infrastructure once initial funding ends. This creates a cycle of starting and stopping services, which undermines trust and continuity for families.

Recommended Action (see R12, R13, Part IV): Secure dedicated state funding and Medicaid reimbursement to stabilize and sustain prevention, treatment, and coordination efforts.

Cultural Pushback

In some communities, particularly those with more punitive views of child/youth behavior, efforts to address CSB/PSB through trauma-informed, non-criminalizing approaches may face resistance. Misunderstandings about intent, fear of normalization, or deeply held cultural beliefs can limit community uptake and erode support for critical services.

Recommended Action (see R7, R19, Part IV): Tailor engagement strategies to local contexts, using trusted messengers (faith leaders, educators, parent advocates) to build support.

Policies Affect Access

Current policies—across education, healthcare, and behavioral health—can create unintended barriers to timely and appropriate services for children/youth with CSB/PSB. These may include restrictive eligibility requirements, narrow definitions of service need, or lack of cross-agency flexibility to fund holistic interventions. Some of these barriers stem from state-level policies and administrative rules, while others are tied to federal programs such as Medicaid, where definitions and funding streams may constrain service delivery.

Recommended Action (see R3, R12, Part IV): Review and amend state policies to support early intervention, culturally responsive care, and flexible service pathways.

Workforce Burnout

Providers working with CSB/PSB populations face emotionally demanding situations, secondary trauma, and often operate without adequate supervision, compensation, or community support. These conditions contribute to burnout and high turnover, putting long-term service capacity at risk.

Recommended Action (see R9, R16, Part IV): Embed provider wellbeing supports (reflective supervision, peer learning networks) into all service models.

Inaction Due to Complexity

One of the greatest risks is failing to act because the issue of CSB/PSB is complex, uncomfortable, or lacks a clear lead agency. When systems delay or avoid intervention, children and youth with unmet needs may not receive appropriate support, increasing the risk that concerning behaviors continue into adulthood. Research has shown that up to half of adults who engage in sexual offending behaviors acknowledged a childhood or adolescent onset for these abusive behaviors. At the same time, evidence also demonstrates that when children receive high-quality, evidence-based, trauma-informed interventions, recidivism rates are extremely low—around 2%.[27]

Recommended Action (see R1, R5, Part iV): Treat CSB/PSB work as prevention, invest in coordinated systems, and assign responsibility to a cross-agency Task Force.

Lacking a System-Coordinated, Preventive Infrastructure

Oregon is actively seeking to enhance its pathways for children exhibiting CSB and PSB, as there is already statewide use of a national best practice: the Sexual Incident Response Committees (SIRC). SIRCs are a formal school-based process that offers a comprehensive, multi-disciplinary, and multi-stage system for assessing, intervening, and identifying incidents of problematic sexual behavior in school-aged children. While the utilization of SIRC within school systems shows promising efforts within Oregon, there is currently no coordinated prevention strategy across child-serving systems. Schools, ODHS-CW, childcare, IDD, STRF, and treatment systems have no shared protocols, screening tools, or educational models for early identification of CSB/PSB. This leads to missed opportunities for early support, forcing families and systems to respond reactively after behaviors escalate.

Recommended Action (see R6, R8, Part IV): Develop a prevention framework including SIRC expansion, consistent K–12 sexuality education, and outreach to parents/childcare providers.

For more information, review the HB4086 CECSB informative report in the appendix.

[27] National Center on the Sexual Behavior of Youth. (n.d.). Children with problematic sexual behavior. U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. https://www.ncsby.org

Judicial Alignment

Legal and judicial systems play a pivotal role in how Oregon responds to children exhibiting complex or problematic sexual behaviors. Yet, as the committee's work revealed, these systems often operate with fragmented standards, unclear statutory guidance, and inconsistent use of trauma-informed practices. The following sections highlight opportunities for greater judicial alignment (see R14), clarify challenges within Oregon's current mandatory reporting laws (see R4, R6), and draw from promising practices in other states. Together, these analyses point toward the need for coordinated pathways that reduce unnecessary legal involvement while ensuring safety, accountability, and access to appropriate supports.

As part of its work, the CECSB committee reviewed how cases involving CSB/PSB currently move through Oregon's judicial and child welfare systems. The table below summarizes the current state, the challenges identified by the committee, and potential solutions suggested for consideration.

Current Pathway	Observed Challenges	Potential Solutions (for consideration, see Recommendations R4, R6, R14)
Child abuse reports involving CSB/PSB routed to ODHS-CW/LEA	Uneven county responses and lack of standardized clinical assessment of PSB (beyond CPS safety/risk assessment)	Develop statewide intake and response protocols
Juvenile court referrals for CSB/PSB cases	Courts receive inconsistent info on risk and treatment	Create regional CSB/PSB MDT-supported judicial guidance and training
Coordination across agencies	Confusion about roles and data sharing (As noted by DOJ representatives in committee discussions; not a formal agency policy statement)	Establish centralized oversight and reporting

The following table describes the intended future state of how a coordinated CSB/PSB pathway could support Oregon's courts. It does not reflect the current system, but rather highlights opportunities for alignment between multidisciplinary teams (MDTs) and judicial processes. It is exploratory and ties into formal recommendations in section IV.

Judicial Involvement May Be Appropriate When	What Judges Can Expect	How the Pathway Supports the Court System
A child's behavior meets the threshold for legal adjudication.	Reports from multidisciplinary teams (MDTs) including behavioral health, education, and child welfare.	Reduces unnecessary formal petitions for young children.
There is a sibling sexual abuse case involving custody, visitation, or safety planning.	Trauma-informed safety plans co-designed with families.	Offers clear, evidence-based alternatives to detention or prosecution.

The child is already court-involved for another matter.	Behavior assessments that differentiate between normative, concerning, and problematic behavior.	Supports equitable, developmentally informed judicial decision-making.
A diversion or probation agreement includes CSB/PSB-related treatment or supervision.	Use of non-criminalizing terms: initiating child, impacted child.	Strengthens MDT and judicial coordination using statewide tools and shared language.

These findings were based on research, case studies, and input from the Community Education subcommittee's expertise on judicial alignment. Findings reflect review of current statutory requirements and observed practices in multiple counties

Mandatory Reporting Clarification

Current ORS requirements:

- ORS 419B.010 – Mandated reporters must report when they have reasonable cause to believe a child has been abused.
- ORS 419B.015 – Reports must be made to ODHS or law enforcement and both entities are required to cross-report all allegations to the other.

Key Clarification:

- Under ORS 419B.005, children can be considered perpetrators of abuse — a statutory interpretation that often surprises professionals. While enhanced mandated reporter training and clear guidance could help reduce unnecessary criminalization, training alone cannot resolve this issue. If the intent is to exempt children from being classified as perpetrators, statutory clarification or amendment would be required. These observations were provided by DOJ staff during committee deliberations and do not represent a formal DOJ agency recommendation.

Taken together, the challenges outlined in judicial processes and mandatory reporting laws underscore the need for a coordinated, developmentally appropriate system. Oregon's current statutory framework sometimes drives children into the legal system in ways that may not enhance safety or healing. To address these gaps, the committee's recommendations (R4, R6, R14) call for statutory clarification, judicial training, and non-criminalizing referral pathways. The committee also examined models from other states that have successfully reduced unnecessary court involvement while strengthening family-centered and trauma-informed responses.

Best Practices and Evidence Informed Approaches

The committee's recommendations are informed not only by Oregon's current gaps, but also by a growing body of national and international research on what works. Before turning to the design of Oregon's proposed pathway, it is important to highlight the best practices and evidence-informed approaches that guided the committee's work. These models demonstrate how coordinated, trauma-informed, and non-criminalizing responses can improve outcomes for children and families, while reducing unnecessary system involvement.

The HB4086 CECSB Informative Report highlights several evidence-based and evidence-informed clinical models that are effective in addressing Problematic Sexual Behavior (PSB) in children and adolescents. These include trauma-informed interventions such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), which addresses the underlying trauma that often contributes to inappropriate behaviors, and Problematic Sexual Behavior-Cognitive Behavioral Therapy (PSB-CBT), which is specifically designed to treat children with PSB. Family-based models like Multisystemic Therapy for PSB (MST-PSB) show promising results by involving caregivers directly in the treatment process.

Community-oriented and healing-centered approaches are also emphasized, particularly models that focus on safety planning, psychoeducation, and non-stigmatizing support. Multi-Disciplinary Teams (MDT) like Oregon's HUBB and HBB teams incorporate these strategies by coordinating care across systems while supporting families with information and referrals—often before behavior escalates. These models prioritize reducing adjudication and instead intervene early to redirect development through supportive, culturally sensitive, and developmentally appropriate care.

Best practice system responses include comprehensive, multidisciplinary coordination through MDTs, ensuring that mental health, law enforcement, child welfare, and education systems work collaboratively. National models in states like Minnesota, Texas, and New Jersey—as well as internationally in Australia and New Zealand—demonstrate how statewide, trauma-informed, non-criminalizing responses can successfully reduce recidivism and promote healing. Importantly, best practices reject interventions that lack scientific validity or can retraumatize children and youth. For example, the use of polygraphs in treatment is not recommended and should be discontinued, particularly for children and adolescents, as it is not evidence-based and may cause harm.

Proven Impact: Coordinated, Evidence-Based Responses Work

Counties using Minnesota's statewide MDT model reported a 30% decrease in repeat PSB incidents among participating youth, along with faster access to evidence-based treatment (average wait time cut from 12 weeks to 4 weeks).[3]

Pilot regions in Texas that adopted MST-PSB and coordinated intake saw recidivism rates drop by half and avoided more than $1 million annually in projected juvenile justice costs.[4]

After implementing its centralized MDT review and clinical-first pathway, New Jersey reduced juvenile court referrals for PSB cases by over 40% within three years while maintaining high family satisfaction scores[5]

[28] New Jersey Department of Children and Family Services. DCF Releases Framework for Support and Healing in Problematic Sexual Behavior Cases. 2023, https://www.nj.gov/dcf/news/press/2023/approved/230523_psb_framework.html.

The HB4086 CECSB informative report recommends that Oregon develop its own standardized, evidence-informed response system that incorporates these best practices and expands access statewide.

In addition to the committee's formal recommendations, the Behavioral Health Workgroup identified several areas for further exploration. These were discussed as potential strategies to strengthen Oregon's system over time but were not advanced as formal recommendations of the full committee.

- Diversification of therapeutic modalities, to ensure children and families have access to multiple evidence-informed approaches.
- Greater clarity in service pathways for children with intellectual or developmental disabilities (I/DD), to ensure assessments and interventions are developmentally appropriate.
- Expansion of clinician specialization, to build expertise in CSB/PSB across Oregon's behavioral health workforce.

These ideas reinforce the intent of existing recommendations—particularly R11 (expand evidence-based models), R15 (ensure access in rural/underserved areas), and R16 (workforce pipeline and specialization)—and may serve as useful discussion points during future implementation planning.

For more information, review the full HB4086 CECSB informative report in the appendix.

Promising Practices: The New Jersey Model

New Jersey has implemented a coordinated, trauma-informed response that Oregon can adapt:

1. Centralized Intake & MDT Coordination – All reports involving CSB are routed through a multidisciplinary team for review.
2. Evidence-Based Treatment First – Families are offered PSB-CBT or MST-PSB as primary intervention, avoiding default court referrals.
3. Judicial Alignment and Education – Judges receive clear guidelines and data-driven recommendations from MDTs.

14 Southern Regional Children's Advocacy Center. Multidisciplinary Team Enhancement Initiative Readiness Guide for State Chapters. Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, 2021, https://drive.google.com/file/d/1ai--o7IeHutMwelwvyS3IwARUh71V_4-/view.
15 New Jersey Department of Children and Family Services. DCF Releases Framework for Support and Healing in Problematic Sexual Behavior Cases. 2023, https://www.nj.gov/dcf/news/press/2023/approved/230523_psb_framework.html.

New Jersey's experience demonstrates that a coordinated, clinical-first pathway can reduce unnecessary court involvement, strengthen judicial consistency, and improve outcomes for children and families. For Oregon, this model offers a clear roadmap: invest in multidisciplinary teams (R1, R14), expand access to evidence-based treatment (R11), and create referral and reporting pathways that avoid labeling children as perpetrators (R4, R6). By adapting these proven strategies within Oregon's statutory and cultural context, the state can build a trauma-informed system that prioritizes healing and safety while reducing reliance on punitive responses.

Why Oregon Needs a New Pathway

The analysis above makes clear that Oregon's current response to children exhibiting complex or problematic sexual behaviors is fragmented, inconsistent, and often harmful. Families encounter confusing pathways, courts lack clear guidance, and children too often face criminalizing responses instead of healing supports. While promising practices exist in a handful of counties and in other states, they remain isolated rather than systemic. To close these gaps, Oregon must adopt a coordinated, statewide pathway—one that is trauma-informed, developmentally appropriate, and family-centered. The following recommendations outline the essential components of this new pathway.

Part IV: Recommendations (The New Pathway)

The committee's work made clear that Oregon's current responses to children with complex or problematic sexual behaviors are fragmented, inconsistent, and often harmful. Families face confusing and uneven pathways, providers struggle without adequate training or resources, and courts are left with limited tools to guide developmentally appropriate decisions. At the same time, national and international models demonstrate that trauma-informed, evidence-based, and family-centered approaches can successfully reduce recidivism, improve outcomes, and minimize unnecessary court involvement.

To address these gaps, the committee recommends a statewide CSB/PSB response pathway that is clear, equitable, and sustainable. The following recommendations, organized into five categories—System-Level, Legal & Judicial, Clinical & Service, Family & Community, and Funding & Sustainability—reflect both the challenges identified in Oregon's current system and the best practices observed nationally. Together, they form the foundation for a coordinated pathway that is "good enough for now and safe enough to try," while also establishing a roadmap for continued refinement and improvement over time.

System-Level Recommendations

R1: Establish a statewide response pathway with clear protocols

Oregon's current responses to children with complex or problematic sexual behaviors (CSB/PSB) are fragmented and inconsistent. Reports may be routed to child welfare, law enforcement, or juvenile court, but there is no standardized clinical assessment beyond the CPS safety/risk framework, and no coordinated pathway to ensure equitable access to treatment. This unevenness results in families receiving mixed messages and experiencing delays or gaps in services, while courts and agencies often make decisions based on incomplete information. In some counties, children are unnecessarily drawn into formal petitions; in others, families lack access to any specialized support.

The committee recommends establishing a statewide CSB/PSB response pathway that creates consistency across all counties while allowing for local flexibility in implementation. This pathway should include standardized intake and response protocols, integration of multidisciplinary team (MDT) reviews, and access to developmentally appropriate assessments and trauma-informed interventions. Building on existing MDT and SIRC structures, the pathway should reduce unnecessary court involvement and ensure that families can access support earlier and more equitably. National models, such as New Jersey's coordinated clinical-first pathway, demonstrate how statewide alignment can reduce recidivism and strengthen family outcomes by prioritizing non-criminalizing, evidence-informed care. Oregon's pathway should follow this example, offering families clarity and coordination across child welfare, behavioral health, education, and judicial systems.

R5: Create an Implementation Task Force and a phased roadmap with clear accountability

The committee recognized that building Oregon's statewide CSB/PSB pathway will require deliberate phasing, strong governance, and clear accountability. Current systems operate in silos, with inconsistent roles across agencies and limited mechanisms for oversight or coordination. Families, providers, and even agency staff often struggle to understand who is responsible for what, leading to delays, duplication, or missed opportunities to intervene early. Without a central structure, Oregon risks uneven implementation and a lack of shared accountability across regions.

The committee recommends establishing a cross-agency Implementation Task Force to guide the development and rollout of the statewide pathway. This task force should include representatives from OHA, ODHS, OYA, DOJ, courts, education, community providers, and family/youth voices. Its charge would be to oversee the creation of phased implementation milestones, provide technical assistance to counties, and ensure fidelity to trauma-informed, non-criminalizing principles.

Drawing from system change best practices, the task force should adopt a roadmap approach:

- **Phase 1** (0–12 months) focuses on statutory clarifications, training pilots, and initial governance
- **Phase 2** (1–2 years) expands judicial training, MDT coverage, and workforce development
- **Phase 3** (3–5 years) establishes full statewide access, standardized protocols, and sustainable funding. By creating this dedicated task force, Oregon can avoid piecemeal reform and instead ensure consistent, accountable implementation of the new pathway.

R17: Determine Oversight Structure for Statewide Accountability

A recurring theme in the committee's analysis was the lack of a centralized oversight body for CSB/PSB cases. Currently, responsibility is spread across ODHS Child Welfare, OHA behavioral health, OYA, local courts, and education systems. This fragmentation has led to confusion about roles, inconsistent reporting and data sharing, and uneven accountability. Even within the committee's own discussions, agency representatives noted that it was unclear which system "owns" oversight for children with problematic sexual behaviors. Without a clear authority, Oregon cannot ensure equity, standardization, or fidelity in its response.

The committee recommends that Oregon policymakers designate a statewide oversight structure to steward the CSB/PSB pathway. Two options were identified:

1. placing oversight with OHA, given its Medicaid authority and role in behavioral health system transformation; or
2. housing oversight within the existing System of Care (SOC) Advisory Council, leveraging its cross-agency governance role.

The legislature and agencies must make this determination to avoid duplication and ensure accountability. Regardless of placement, the oversight body should be charged with monitoring fidelity, reporting on statewide implementation, and ensuring continuous improvement. Establishing this structure will provide the necessary backbone for a coordinated, evidence-informed pathway that operates consistently across Oregon's counties.

Legal & Judicial Recommendations

R4: Clarify mandated reporting expectations through statutory amendments and training.

The committee identified significant confusion and unintended consequences in Oregon's mandated reporting laws as they apply to children with problematic sexual behaviors. Under ORS 419B.005, children can be considered "perpetrators" of abuse, a statutory interpretation that surprises many professionals and can drive unnecessary criminalization. While training can help clarify obligations, it cannot resolve the fundamental statutory issue. The current framework contributes to inconsistent practices across counties and sometimes leads to punitive responses rather than supportive interventions.

The committee recommends that Oregon clarify mandated reporting requirements through statutory amendment and guidance. Specifically, lawmakers should consider revising ORS 419B to prevent young children from being classified as "perpetrators" while ensuring that all children involved receive safety planning and appropriate services. In addition, statewide training and guidance should be provided to mandated reporters to reduce confusion and support consistent, trauma-informed responses. This recommendation aligns with Department of Justice staff observations during committee deliberations and reflects the committee's consensus that Oregon must reduce pathways that unnecessarily criminalize children.

R6: Support referral/treatment pathways that avoid "child abuser" labels for young children.

Labeling children as "child abusers" when they engage in concerning or problematic sexual behavior was identified as both harmful and developmentally inappropriate. Committee members emphasized that such labels rarely improve safety and can create long-term stigma that follows children across education, child welfare, and judicial systems. Instead, family-centered safety planning and developmentally tailored treatment are more effective at addressing the behaviors while supporting healing and accountability.

The committee recommends that Oregon develop referral and treatment pathways that avoid applying the "child abuser" label to young children. This includes creating consistent language across systems—such as "initiating child" and "impacted child"—and ensuring that reports lead to trauma-informed assessments and services rather than criminalizing responses. By shifting language and pathways, Oregon can reduce stigma, improve equity, and help families access support without fear of lasting negative consequences for their children.

R14: Develop MDT-supported judicial guidance and trauma-informed judicial training

Courts play a pivotal role in cases involving children with CSB/PSB, yet judges often receive inconsistent or incomplete information to guide their decisions. Current pathways sometimes result in unnecessary petitions, overreliance on detention, or inequitable outcomes across counties. Judges also face challenges in differentiating between normative, concerning, and problematic behaviors, which can lead to decisions that are not developmentally appropriate.

The committee recommends that Oregon develop MDT-supported judicial guidance and training to align court responses with trauma-informed, developmentally appropriate practices. Judicial training should include the use of non-criminalizing language, access to behavior assessments that clearly differentiate developmental patterns, and guidance on evidence-based alternatives to detention or prosecution. By equipping judges with better tools and aligning them with MDT processes, Oregon can strengthen judicial decision-making, reduce unnecessary petitions, and ensure equitable treatment for children and families across the state.

R19: Consider Statutory Exemption for Children from "Perpetrator" Classification

While training and pathway reform are essential, the committee recognized that Oregon's statutory framework itself remains a barrier to a truly non-criminalizing system. Under ORS 419B.005 (juvenile dependency code), children may be classified as "perpetrators" of child abuse. This framework was designed primarily for adults, and its application to children leads to founded abuse reports against minors. Although criminal charges are not determined by ORS 419B, the dependency system's "perpetrator" designation can still have long-term collateral consequences for children and families.

The committee recommends that lawmakers explore statutory exemption options to prevent children from being classified as perpetrators of child abuse within the dependency code. This would align Oregon with best practices nationally and internationally, where children are understood as requiring support and intervention rather than punitive labeling. While the precise statutory pathway requires further legal analysis, the committee affirms that exempting children from "perpetrator" status is necessary to reduce harm and create a system aligned with developmental science.

Clinical & Services Recommendations

R2: Invest in services and workforce (evidence-based treatment, training, supports)

The committee found that many families across Oregon cannot access timely, evidence-based treatment for children with CSB/PSB, particularly in rural and underserved regions. Providers report long waitlists, limited specialized training, and uneven distribution of expertise. Without investment, families either go without services or rely on interventions that are not evidence-informed and may cause harm.

The committee recommends that Oregon expand investment in services and workforce capacity to ensure that children and families statewide can access appropriate care. This includes funding specialized clinical positions, creating incentives for providers to train in CSB/PSB treatment, and integrating reflective supervision and peer support to reduce burnout. Investment should also prioritize equity, ensuring that rural, frontier, and culturally diverse communities have access to services tailored to their needs.

R8: Expand Sexual Incident Response Committees (SIRC) in schools/early learning

Some schools and early learning programs in Oregon have developed Sexual Incident Response Committees (SIRCs) to coordinate responses to sexual abuse incidences with a child as the reported initiator. Where implemented, these committees reduce overreactions, provide consistent safety

planning, and connect families to appropriate resources. However, access to SIRCs remains limited and inconsistent across the state.

The committee recommends expanding SIRC models statewide so that all schools and early learning providers have access to a clear, trauma-informed response framework. This expansion should include training, technical assistance, and alignment with MDTs to ensure coordination across systems. By institutionalizing SIRCs, Oregon can create safer, more supportive educational environments and reduce reliance on exclusionary discipline or law enforcement referrals.

R9: Strengthen provider supports (reflective supervision, peer networks).

Providers working with children with CSB/PSB report high levels of stress, isolation, and secondary trauma. Without adequate support, turnover increases and access to specialized services decreases. Current systems do not consistently offer reflective supervision, peer consultation, or other supports that help providers sustain their work.

The committee recommends strengthening provider supports by embedding reflective supervision, peer consultation networks, and ongoing training into Oregon's service delivery system. These supports will help retain skilled clinicians, improve service quality, and reduce burnout. Investing in provider well-being is a critical step toward ensuring sustainable statewide capacity to deliver evidence-based care.

R16: Build workforce pipeline through training, certification, and higher ed partnerships.

Oregon's behavioral health workforce lacks sufficient specialization in CSB/PSB treatment. Few clinicians receive formal training or supervision in evidence-based models, and higher education pathways do not consistently prepare graduates for this area of practice. Without intentional investment, Oregon will struggle to meet demand for specialized services.

The committee recommends building a workforce pipeline and specialization strategy to increase the number of clinicians trained and certified in CSB/PSB interventions. This includes integrating CSB/PSB training into higher education programs, developing certification pathways, and creating incentives for clinicians to specialize. Expanding workforce capacity will ensure that Oregon can implement the statewide pathway sustainably and provide consistent, high-quality care.

Family & Community Recommendations

R10: Expand use of family navigators to connect families with services.

Families often experience the system as confusing and overwhelming, especially when multiple agencies are involved. Caregivers expressed the need for trusted guides who can help them understand processes, access services, and advocate for their children. Some regions have piloted family navigator roles, but these supports are not widely available.

The committee recommends expanding family navigator programs to connect families with services, reduce stigma, and promote engagement in treatment. Navigators should be trained in trauma-informed practices, cultural responsiveness, and CSB/PSB-specific supports. By providing consistent guidance,

navigators can help families feel less isolated and more empowered, improving participation in treatment and outcomes for children.

R7: Launch education and training campaigns within 12 months

Caregivers, schools, and professionals often lack accurate information about CSB/PSB, leading to stigma, fear, and reliance on punitive responses. Families report feeling isolated and judged when seeking help, while mandated reporters and educators express uncertainty about how to respond appropriately.

The committee recommends launching a statewide education and training campaign within 12 months to raise awareness and build confidence in responding to CSB/PSB. Campaigns should provide accessible, culturally responsive resources for caregivers, schools, and professionals, reduce stigma, and normalize help-seeking. Training should include developmentally appropriate approaches, trauma-informed practices, and clear referral pathways so that children and families can be supported rather than criminalized.

R11: Expand statewide access to evidence-based treatment models (TF-CBT, MST-PSB, PSB-CBT, PBT)

Oregon lacks sufficient availability of evidence-based treatment models such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Problematic Sexual Behavior–Cognitive Behavioral Therapy (PSB-CBT), and Multisystemic Therapy for Problematic Sexual Behavior (MST-PSB). Families often wait months for care or must travel long distances to find trained providers. In some cases, children receive interventions that are not evidence-informed and may retraumatize them.

The committee recommends expanding statewide access to evidence-based treatment models, ensuring that every child and family in Oregon can receive timely, appropriate care. This includes supporting training for clinicians, developing certification pathways, and investing in service delivery infrastructure. Expanding access to these models will reduce recidivism, promote healing, and align Oregon with national best practices.

R15: Expand trauma-informed models in rural/underserved areas

Children and families from communities of color, LGBTQ+ youth, and those with disabilities experience disproportionate harm in the current CSB/PSB response system. These inequities are compounded in rural and underserved areas, where access to services is already limited. Without intentional focus on equity, Oregon risks reinforcing disparities as it builds a new pathway.

The committee recommends that Oregon embed equity and community engagement into every stage of implementation. This includes developing culturally responsive models of care, engaging community leaders in pathway design, and ensuring families have a voice in ongoing oversight. Oregon should also clarify age scope in statute (R18) to ensure consistency in how children and youth are treated, while maintaining developmentally appropriate responses. By centering equity, Oregon can ensure the statewide pathway is both effective and just.

Funding & Sustainability Recommendations

R3: Define and standardize CSB/PSB terminology in statute/policy

A lack of standardized terminology across agencies contributes to confusion, inconsistent reporting, and difficulties in funding alignment. Terms such as “child-on-child abuse,” “perpetrator,” and “offender” are applied inconsistently, often with stigmatizing consequences for children. Without clear statutory definitions, Oregon cannot create consistent protocols or funding mechanisms.

The committee recommends that Oregon define and standardize CSB/PSB terminology in statute and policy. This will reduce confusion, support cross-agency coordination, and create the foundation for sustainable funding and service delivery. Standardized language is also essential for training, data collection, and public communication.

R12: Legislative mandate for braided funding across systems

Currently, services for CSB/PSB are funded inconsistently through a patchwork of county, state, and federal dollars. This results in gaps, inequities, and challenges sustaining programs across regions. Families may lose access when funding streams shift, and agencies struggle to braid resources effectively without legislative direction.

The committee recommends that the legislature mandate braided funding across systems to sustain the statewide pathway. This should include clear requirements for collaboration across child welfare, behavioral health, education, and juvenile justice agencies, as well as mechanisms to ensure funding follows children and families rather than program silos.

R13: Secure Medicaid Reimbursement and Enforce Insurance Compliance

Many evidence-based treatments for CSB/PSB are not reliably covered by Medicaid or private insurance in Oregon, leaving families to pay out-of-pocket or go without care. This creates inequities in access and undermines the sustainability of specialized services. Providers also report difficulties billing for CSB/PSB treatment under existing codes, which limits their ability to expand services.

The committee recommends that Oregon align Medicaid and private insurance coverage to ensure consistent reimbursement for evidence-based CSB/PSB treatment. This includes enforcing parity laws, clarifying billing codes, and providing technical assistance to providers. Ensuring coverage is critical for sustaining a statewide treatment system and reducing financial barriers for families.

R18: Clarify Age Scope in Statute

Oregon statutes and policies are inconsistent in how they apply to children and youth with CSB/PSB. Some systems treat cases involving children 12 and under differently than those involving adolescents (13-17), while others apply the same statutory framework regardless of age. This inconsistency creates confusion and can lead to responses that are developmentally inappropriate.

The committee recommends that Oregon clarify the age scope in statute to ensure consistent, developmentally informed responses. Statutory language should recognize developmental differences while maintaining a continuum of trauma-informed services for both children and adolescents. This clarification will support equity, standardization, and fidelity in implementation.

R20: Explore Creative Funding Models

To sustain services long term, Oregon will need to look beyond traditional state funding streams. Federal Medicaid dollars, private insurance, and local investments can form the foundation, but innovative financing mechanisms are also necessary. Other states have piloted creative approaches such as Pay for Success, public-private partnerships, and insurance incentives to support prevention and early intervention.

The committee recommends that Oregon explore creative funding models to strengthen sustainability and expand reach. By diversifying funding sources, Oregon can ensure that the CSB/PSB pathway remains stable, equitable, and responsive to community needs over time.

Alignment with the Jurisdiction Committee

The HB 4086 Jurisdiction Committee examined Oregon's current approach to allegations of sexual abuse with a child as the reported initiator, with a focus on whether children should be labeled as "child abusers." The committee highlighted that labeling young children rarely improves safety and can have long-term negative impacts. Instead, they recommend prioritizing family-centered safety planning, developmentally appropriate interventions, and connecting children and families to support services.

The CECSB Committee's work directly supports these goals.

- R1 (Statewide Response Pathway) and R14 (Judicial Alignment) create consistent, trauma-informed alternatives to unnecessary petitions or adjudications.
- R6 (Avoid "Child Abuser" Labels) explicitly supports the Jurisdiction Committee's recommendation to use CSB-informed referral and treatment pathways instead of harmful labels.
- R11 (Evidence-Based Treatment Expansion) and R15 (Trauma-Informed Models in Rural/Underserved Areas) ensure that children and families across Oregon can access developmentally appropriate interventions.
- R5 (Implementation Task Force) provides the governance needed to integrate these approaches across systems.

Taken together, these recommendations outline a coordinated, trauma-informed, and developmentally appropriate pathway for Oregon. But recommendations alone will not change outcomes for children and families—implementation is key. The committee recognized that building this pathway requires deliberate phasing, strong governance, and sustainable funding. Some steps can begin immediately with existing resources, while others will require new legislation, investment, and ongoing oversight.

The following section, Part V: Implementation Roadmap, translates the recommendations into an action plan. It sets out core design principles, identifies short- and long-term priorities, and outlines a phased timeline for statewide rollout. By moving from vision to implementation, Oregon can ensure that these

recommendations do not remain aspirational, but instead become the foundation of a practical, sustainable pathway that improves outcomes for children, families, and communities across the state.

Disclaimer on Recommendations: The recommendations in this report reflect system-level strategies and are intended to guide future planning. In some cases, they identify OHA, ODHS, or other state agencies as potential leads; however, these agencies note that additional resources and capacity would be necessary to implement proposed system changes. Certain recommendations may also require statutory changes or further consultation with legal system stakeholders, including the Oregon District Attorneys Association, to ensure alignment and feasibility. Finally, many recommendations are intentionally broad and will require collaboration across multiple partners (e.g., Oregon Department of Education, Oregon Health Authority, Department of Human Services, local government, county systems, and community-based providers). Further scoping will be needed during implementation to assign specific responsibilities, determine resourcing, and phase activities.

Part V: Implementation Roadmap (How to Build the Pathway)

The recommendations outlined in Part IV describe the essential elements of Oregon's new CSB/PSB response pathway. Implementation is the process of translating those recommendations into practice: establishing governance, building capacity, securing sustainable funding, and ensuring accountability across systems. The committee emphasized that implementation must be phased, allowing Oregon to begin with immediate, low-cost actions while planning for long-term structural changes. This roadmap is designed to provide clear guidance on who should lead, what should happen first, and how progress will be measured, ensuring that Oregon's pathway is both achievable and sustainable.

Core Principles for Oregon's Pathway

The committee agreed that Oregon's new pathway must be grounded in a set of core principles to guide decision-making, implementation, and long-term sustainability. These principles provide a consistent framework across agencies and communities while leaving room for local adaptation.

Trauma-Informed: The pathway must recognize the impact of trauma and avoid retraumatization. Professionals need training, caregivers need support, and system design must prioritize safety, dignity, and healing.

Developmental: Responses must reflect developmental science, matching interventions to a child's age and stage. The goal is to guide healthy development with supportive interventions—not punishment.

Family-Centered: Families are essential partners in healing. They should have clear information, access to navigators and peer supports, and culturally responsive services that reduce isolation and strengthen protective factors.

Non-Criminalizing: Children should not be labeled or treated as offenders. The pathway avoids stigmatizing language and processes, offering community-based interventions and alternatives to petitions, while ensuring accountability and safety.

Together, these principles provide the foundation for Oregon's new pathway. They are not optional features, but essential commitments that must guide every phase of implementation—from immediate pilots to long-term system change. The following roadmap describes how Oregon can put these principles into practice through phased, accountable steps.

Core Elements for Oregon's Pathway

Taken together, the recommendations outlined above add up to a new, coordinated pathway for Oregon. To make the vision concrete, the following section summarizes the core elements of the proposed system—what it will look like once fully implemented. These elements illustrate how families,

providers, courts, and agencies will interact in a consistent, trauma-informed, and developmentally appropriate framework.

It is important to note that responsibility for safety depends on the pathway. In cases involving families, ODHS Child Welfare holds primary responsibility. In schools, districts are responsible under ODE's School Safety and Prevention framework. In community settings where no caregiving relationship exists, law enforcement has the lead role. While these systems often overlap, clarity about lead responsibility is essential to avoid duplication and to ensure safety responses are appropriate to the setting.

1. **Centralized Intake and Review:** All cases involving CSB/PSB will be routed through a centralized intake and review process coordinated by Multidisciplinary Teams (MDTs). MDTs will serve as the first point of coordinated decision-making, ensuring that each case is considered through a trauma-informed, developmentally appropriate lens. This process is not intended to delay urgent child safety actions required under ORS 419B. If ODHS-CW identifies an immediate safety threat to another child, protective custody or dependency petitions may proceed without awaiting MDT review. Similarly, urgent protective responses remain the responsibility of child welfare and law enforcement. Once immediate safety needs are addressed, MDTs will guide pathway decisions to ensure alignment across systems. Over time, and once statutory definitions and jurisdictional guidance are clarified, MDTs will help determine whether a clinical-first response is sufficient or whether judicial involvement—whether through the dependency court or, in some cases, delinquency court—is appropriate (e.g., in cases involving harm, coercion, child safety, or exploitation). The pathway will also include a visual system flowchart that maps the process from mandatory reporting (ORS 419B.010) into the intake review, with tailored tracks for home, school, and community settings.

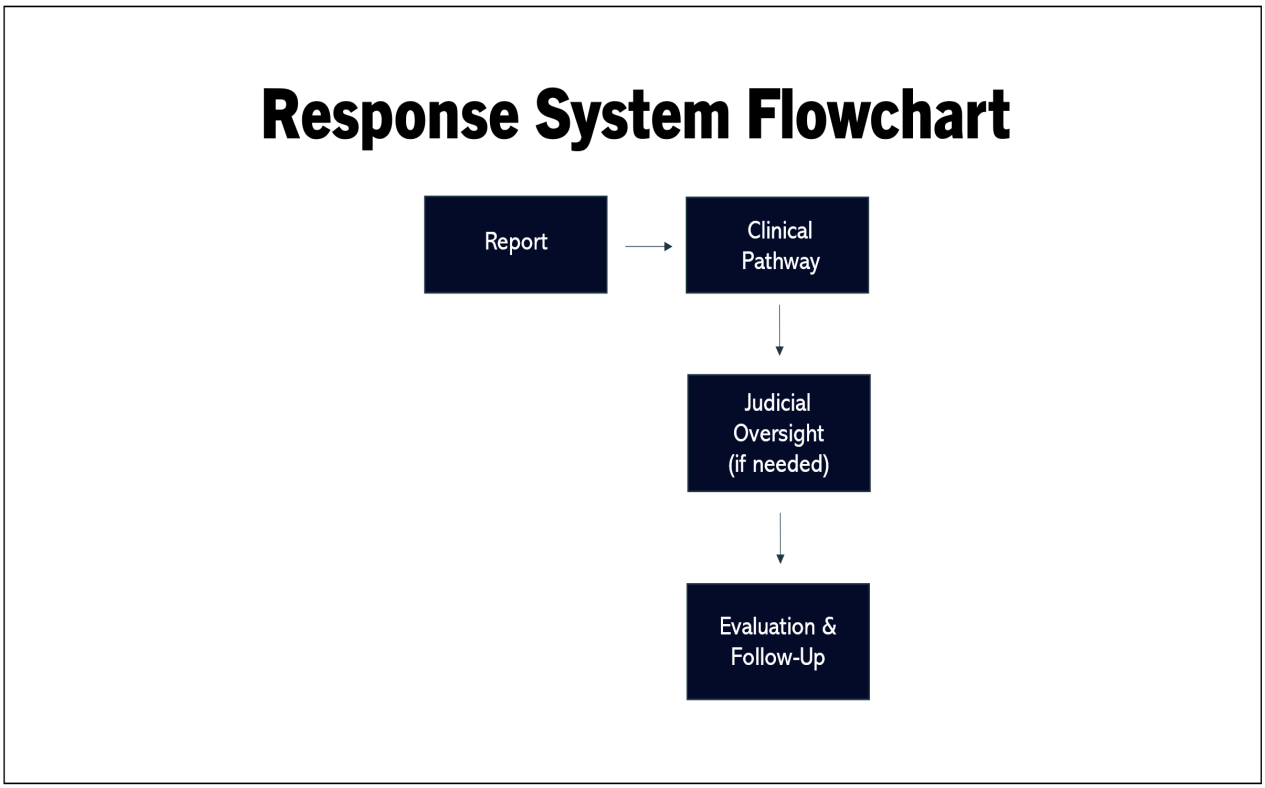
2. **Evidence-Based Clinical Pathway:** Whenever possible, children and families will be directed into a clinical-first pathway. Interventions such as PSB-CBT, TF-CBT, MST-PSB, and PBT will be prioritized based on the child's developmental stage, severity of behavior, and family context. Services will be family-centered and trauma-informed, focusing on healing, reducing stigma, and preventing escalation. Children will be assessed based on developmental stage rather than chronological age. While current practice often distinguishes between 0–12 and 13–17, Oregon will move toward developmentally informed clinical assessment and care across ages 0–25, reflecting adolescent brain science and the disproportionate impact of trauma and cognitive disabilities. This framing is intended for treatment and service design, not expansion of child welfare or juvenile justice jurisdiction.

3. **Immediate Response and Decision Points:** Clear guidance will outline the steps that follow a disclosure or suspicion of CSB/PSB, including:
    a. Whether the concern is reported to the child abuse hotline and/or law enforcement.
    b. Who is responsible for notifying caregivers of each involved child.
    c. Whether the behavior meets the threshold for a criminal investigation or CPS assessment.
    d. Whether the CAC conducts an assessment for the impacted child, and which trauma-informed entity assesses the initiating child.
    e. How the Oregon Child Abuse Hotline (ORCAH) documents and routes calls to clinical vs. legal pathways.

f. Whether families receive therapeutic referrals (not only investigative contact).

4. **Judicial Oversight (As Needed)**
    a. Court involvement will be reserved for cases requiring legal or safety intervention. When judicial engagement is necessary, judges will receive standardized assessments and MDT recommendations to inform decisions. System actors—including district attorneys and juvenile departments—will be encouraged to:
        i. Request MDT consultation early when the nature of the behavior is unclear.
        ii. Provide courts with full developmental context, including trauma history, clinical assessments, and capacity-to-consent considerations.
        iii. Default to therapeutic and family-centered responses in cases where evidence of harm, coercion, or exploitation is not present, while ensuring that safety concerns are fully assessed and addressed.

5. **Statewide Coordination and Data Sharing**
    a. ODHS and OHA will provide statewide oversight, policy alignment, and data reporting. Local MDTs will operate under uniform protocols to ensure consistent practices across counties. A coordinated data system — inclusive of ODHS, OHA, OYA, and other relevant partners — will support case tracking, identify gaps, and provide feedback for continuous improvement, while safeguarding family privacy.



System Partner	Key Responsibilities
MDT	Intake review, cross-agency coordination
Clinical Providers	Deliver evidence-based therapy (PSB-CBT, MST-PSB)
ODHS/OHA	Oversight, policy alignment, data reporting
OYA	Data sharing and coordination for youth under juvenile justice supervision
Judicial System & Law Enforcement	Respond to serious crimes and safety threats as required; follow standardized guidance to ensure alignment with therapeutic pathways when appropriate

Feasibility Table

While the committee elevated 20 recommendations for Oregon's new CSB/PSB pathway, not all can be implemented at the same pace. Some are possible to begin immediately with current resources, while others will require new legislative action, dedicated funding, or further deliberation. The table below summarizes each recommendation according to feasibility, organized into four categories: Committee Elevated Priorities, Early Wins, Strategic Investments for Scale, and Areas for Continued Deliberation.

These recommendations are intended to work in concert, ensuring that Oregon can build a coordinated, sustainable, and equitable approach to addressing CSB/PSB, while also improving access to timely, culturally responsive, and developmentally appropriate interventions. At the same time, the committee recognizes that agencies are not positioned to assume additional unfunded workloads. Implementation will require dedicated resources, and further discussion with SOCAC and other system partners will be essential to determine realistic capacity and next steps.

Committee Elevated Priorities

Recommendation	Feasibility with Current Resources
R1. Establish a statewide CSB/PSB response pathway with clear protocols.	Requires new funding/legislative action for statewide adoption. Possible to begin now with pilots that integrate MDTs and SIRCs, using existing county resources and OHA/OJD support.
R2. Invest in services and workforce (evidence-based treatment, training, supports).	Requires new funding for specialized clinician positions. Reflective supervision and peer networks could expand immediately through ODHS/OHA partnerships.

R3. Define and standardize CSB/PSB terminology in statute/policy.	Requires statutory change; could be introduced in 2026 legislative session.
R4. Clarify mandated reporting expectations through statutory amendments and training.	Requires statutory amendment. In the interim, statewide training and guidance could be implemented with current DOJ and OHA resources.
R5. Create an Implementation Task Force and phased roadmap with clear accountability.	Can be done immediately. One option is to create a subcommittee of the System of Care Advisory Council (SOCAC), which is already established under OHA. Responsibility for staffing should be clearly designated — either to OHA or ODHS as the lead agency — with dedicated resources to ensure meaningful participation from individuals with lived experience.

Early Wins

Recommendation	Feasibility with Current Resources
R6. Support referral/treatment pathways that avoid "child abuser" labels for young children.	In the short term, practice guidance, MDT protocols, and judicial standards can encourage the use of developmentally appropriate terminology and reduce reliance on stigmatizing labels in daily interactions and documentation. However, creating a true alternative pathway that eliminates "child abuser" designations for young children will require statutory changes.
R7. Launch education and training campaigns within 12 months.	Tiered approach is feasible but will require dedicated resources and workload alignment: • Tier 1 (families/community) via CBOs with ODHS/OHA support and funding; • Tier 2 (child-serving providers) via professional associations with agency staff time and support reprioritized to avoid unfunded burdens; • Tier 3 (specialized CSB/PSB providers) requires new funding and higher ed partnerships to expand expertise and workforce capacity.

R8. Expand Sexual Incident Response Committees (SIRC) in schools/early learning.	Schools and early learning programs already implementing SIRC or MDT-style models can strengthen and expand their use immediately through existing local resources and cross-agency collaboration. However, achieving consistent, statewide coverage — so that all schools and programs have access to a functioning SIRC process — will require new investment and state-level support.
R9. Strengthen provider supports (reflective supervision, peer networks).	Can be integrated now using current reflective supervision and training networks; scaling requires new funding.
R10. Expand use of family navigators to connect families with services.	Requires new funding; pilot expansion possible by contracting with CBOs and tribal partners.

Strategic Investments for Scale

Recommendation	Feasibility with Current Resources
R11. Expand statewide access to evidence-based treatment models (TF-CBT, MST-PSB, PSB-CBT, PBT).	Requires new funding. OHA could start with regional pilots and training initiatives coordinated with higher ed partners.
R12. Legislative mandate for braided funding across systems.	Requires new funding/legislative action; could be tied to ODHS, OHA, ODE, and OYA.
R13. Secure Medicaid reimbursement and enforce insurance compliance.	Requires administrative and legislative action; provider technical assistance could start now.
R14. Develop MDT-supported judicial guidance and trauma-informed judicial training.	Judicial training can begin now in partnership with OJD, DOJ, and MDTs. Statewide consistency would require new funding for judicial education.

R15. Expand trauma-informed models in rural/underserved areas.	Telehealth and regional hub models can be piloted now; long-term expansion requires provider incentives and new investment.
R16. Build workforce pipeline through training, certification, and higher ed partnerships.	Requires higher ed partnerships and new funding. CEU courses and early certification efforts could begin now using current OHA/professional association infrastructure.

Areas for Continued Deliberation

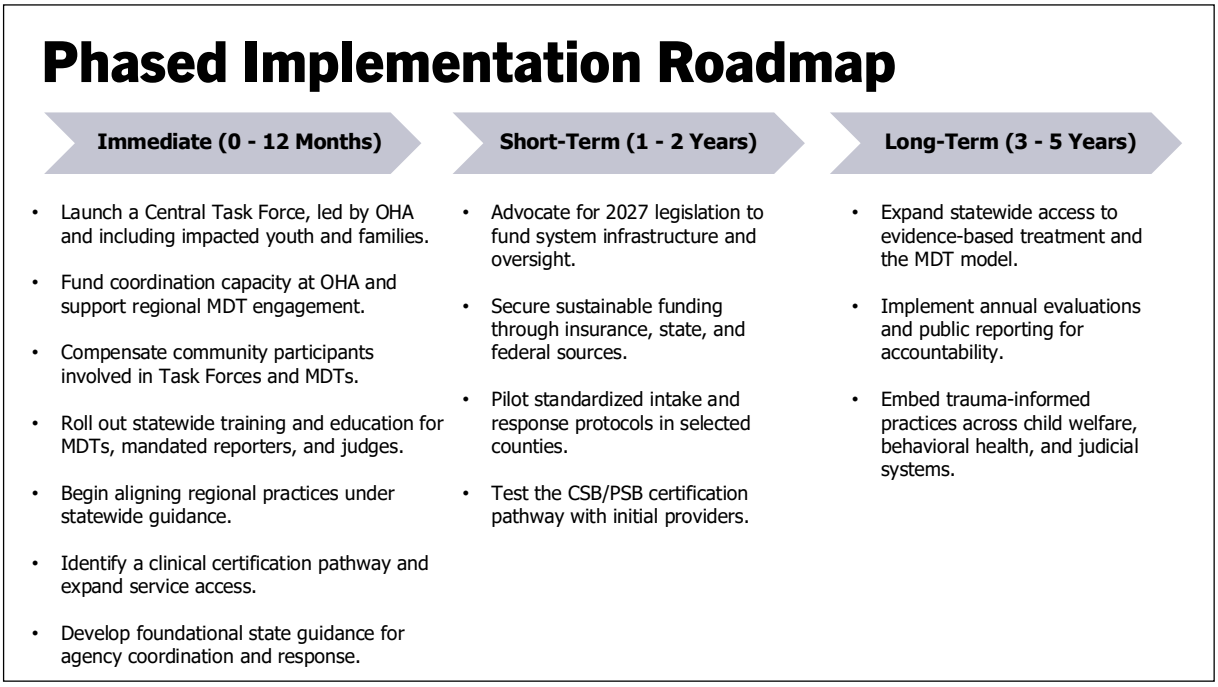
Recommendation	Feasibility with Current Resources
R17. Determine oversight structure (OHA vs. SOC Advisory Council).	Possible to designate now with executive/legislative action. Could be housed in SOC Advisory Council in the short term; a permanent OHA hub with dedicated staff would require new funding (~$200,000 for 1 FTE).
R18. Clarify age scope (12 and under vs. up to 18).	Requires legislative action; interim guidance could reduce inconsistency until statute is revised.
R19. Consider statutory exemption for children from "perpetrator" classification.	Requires statutory amendment; feasibility depends on legislative support.
R20. Explore creative funding models (e.g., Pay for Success, insurance incentives).	Possible to start now in the exploration/pilot phase with local CBOs and county governments. Large-scale rollout requires new funding streams.

The feasibility analysis highlights both the urgency and the complexity of building Oregon's new pathway. Some recommendations can be acted on immediately, while others require legislative change, new funding, or continued deliberation. To ensure progress without overextension, the committee proposes a phased implementation approach. The following roadmap lays out clear timelines and responsibilities for near-term action, medium-term investments, and long-term system change.

Phased Implementation Plan

- Phase 1 (0–12 months): Task Force, statutory clarifications, training pilots
- Phase 2 (1–2 years): Judicial training, MDT expansion, provider certification pilots
- Phase 3 (3–5 years): Full statewide response system, certification pathways, Medicaid alignment

To achieve a trauma-informed, coordinated, and effective response system, the committee recommends the following phased actions:



Immediate: Laying The Foundation (0–12 Months)

The first year of implementation should focus on building the infrastructure and shared understanding needed to launch Oregon's new CSB/PSB pathway. These steps are both achievable with existing resources and critical for demonstrating early progress while preparing for larger system change.

Establish Governance and Coordination

A central Implementation Task Force, led by OHA and inclusive of children, caregivers, and individuals with lived experience, should be convened to coordinate cross-sector implementation. To support this work, OHA should fund a dedicated FTE to manage the Task Force, coordinate with ODHS and OJD, and engage regional MDTs. Community members participating in Task Forces and MDTs should be compensated for their time and expertise, recognizing their essential role in shaping a responsive system.

Launch Training and Public Education
Education and training campaigns should be developed and launched for regional CSB/PSB MDTs, mandated reporters, and judges. These campaigns should emphasize trauma-informed, non-criminalizing approaches; use of developmentally appropriate language (such as "initiating child" and "impacted child"); and referral pathways that connect children and families to services rather than criminalizing them. Early campaigns should also provide clear, accessible guidance for caregivers and families.

Align MDTs and Expand Clinical Capacity
Existing MDTs should begin aligning their practices under statewide guidance to ensure consistency across counties. This includes strengthening coordination between MDTs and treatment providers and clarifying agency roles in referral and case review. At the same time, Oregon should identify a clinical certification pathway for CSB/PSB providers and take initial steps to expand availability of evidence-based treatment statewide.

Develop Interim Guidance
OHA and ODHS should issue statewide interim guidance for agencies to standardize language, reduce the use of harmful labels, and promote consistent practices while longer-term statutory changes are pursued.

Milestones by the end of Phase 1

- Implementation Task Force established, led by OHA with inclusive membership.
- OHA FTE funded and serving as coordinator for statewide and regional efforts.
- Community members engaged in governance and compensated for participation.
- Training campaigns launched for MDTs, mandated reporters, and judges.
- MDTs aligned under statewide guidance, with early coordination improvements.
- Interim statewide guidance issued to reduce harmful labels and promote consistency.

Phase 1 will create the infrastructure, relationships, and shared language needed to move into broader system expansion in Phase 2.

Short-Term: Scaling & Strengthening (1–2 Years)

With foundational structures in place, the next two years should focus on scaling Oregon's CSB/PSB pathway through targeted pilots, funding stabilization, and legislative action. Phase 2 builds on the infrastructure created in Phase 1 to expand consistency across counties, strengthen clinical capacity, and formalize statewide oversight.

Advance Legislative Action and Oversight
During the 2026 or 2027 legislative session, Oregon should pursue statutory changes to fund system-building, clarify mandated reporting laws, and formalize the statewide oversight structure (R3, R4, R17, R18). Advocacy during this period should be coordinated through the Implementation Task Force, with input from agencies, community members, and youth and family representatives. A clear governance home—whether OHA or the SOC Advisory Council—must be confirmed and resourced.

Secure Sustainable Funding
To stabilize the pathway, Oregon must secure sustainable funding streams. This includes ensuring reliable insurance and Medicaid reimbursement for evidence-based CSB/PSB treatment models (R13), while also pursuing braided state funding (R12) and federal grants. The Implementation Task Force should develop a financing plan that aligns resources across OHA, ODHS, ODE, and OYA ensuring that services can be scaled equitably statewide.

Pilot Standardized Pathways
Oregon should pilot standardized intake and response protocols in at least three counties, representing a mix of urban, rural, and frontier regions. These pilots should test MDT processes, referral pathways, and alignment between education, child welfare, behavioral health, and judicial systems. Evaluation of the pilots will generate lessons for statewide rollout in Phase 3.

Build Clinical Capacity
The CSB/PSB certification pathway identified in Phase 1 should be piloted during this stage, ensuring that clinicians are trained, supervised, and credentialed in evidence-based models. Training and certification should be coordinated with higher education partners and aligned with workforce pipeline strategies (R11, R15, R16). Expansion of evidence-based models such as TF-CBT, PSB-CBT, MST-PSB, and PBT should also begin, using pilots to test fidelity and outcomes.

Milestones by the end of Phase 2

- Legislative package prepared and advanced in the 2027 session.
- Oversight structure formalized with clear governance authority.
- Sustainable funding streams secured (insurance/Medicaid reimbursement and state/federal resources).
- Standardized intake and response protocols piloted in three counties.
- CSB/PSB clinical certification pathway piloted with higher ed and workforce partners.
- Clinical certification pathway identified; service expansion planning underway.
- Expansion of evidence-based treatment models underway in pilot regions.

Phase 2 will demonstrate Oregon's ability to move from planning to scaling, laying the groundwork for statewide adoption and sustainability in Phase 3.

Long-Term: Statewide Rollout & Sustainability (3-5 Years)

The final stage of implementation focuses on scaling the CSB/PSB pathway statewide and embedding it into Oregon's systems for long-term sustainability. By this stage, governance, funding, and pilots should be established, allowing Oregon to focus on universal access, accountability, and continuous improvement.

Expand Access to Evidence-Based Treatment and MDT Coverage
Evidence-based treatment models—including TF-CBT, PSB-CBT, MST-PSB, and PBT—should be available statewide, with clinicians trained, certified, and supported across all regions. Oregon should also expand multidisciplinary team (MDT) coverage so that every county has access to a coordinated,

trauma-informed response structure. This ensures that families receive consistent, high-quality interventions regardless of geography.

Institutionalize Trauma-Informed Practices
To sustain culture change, trauma-informed practices must be institutionalized across child welfare, behavioral health, education, and judicial systems. This includes embedding trauma-informed standards in agency policies, contracts, training requirements, and evaluation frameworks. Agencies should also align staffing and service delivery models to ensure that non-criminalizing, developmental, and family-centered approaches become standard practice.

Ensure Accountability Through Evaluation and Reporting
Oregon should conduct annual evaluations and public reporting on the pathway's implementation and outcomes. These evaluations should track access, equity, fidelity to evidence-based models, and impact on child and family outcomes. Transparent reporting will strengthen public trust, inform continuous improvement, and ensure accountability across systems.

Milestones by the end of Phase 3

- Evidence-based treatment models scaled statewide, with equitable access in rural and underserved regions.
- MDT coverage expanded to all counties, integrated with statewide protocols.
- Trauma-informed practices institutionalized across child welfare, behavioral health, education, and judicial systems.
- Annual evaluation and public reporting established as a permanent accountability mechanism.

Phase 3 will mark the transition from system change as a project to system change as standard practice—ensuring that Oregon's CSB/PSB pathway is sustained, equitable, and responsive for generations to come.

Governance & Oversight

Strong governance and accountability are essential for ensuring that Oregon's CSB/PSB pathway is implemented consistently, equitably, and sustainably. The committee emphasized that governance must combine clear leadership authority with cross-agency collaboration and community accountability.

Lead Agency and Administrative Home
The committee recommends that the Oregon Health Authority (OHA) serve as the lead agency for implementation, given its statutory role in behavioral health, Medicaid financing, and Systems of Care transformation. Within OHA, the Child & Family Behavioral Health Unit could serve as the administrative home for the statewide Plan of Operation (POP), leveraging its existing provider connections, licensing authority, and systems-transformation experience. While ODHS will remain a critical partner, partners noted concerns about housing the work within ODHS due to its historical association with punitive responses. Final legislative direction will determine whether OHA or ODHS holds oversight authority, but OHA is strongly positioned to lead.

Permanent Statewide Task Force

To coordinate implementation, Oregon should establish a legislatively mandated, permanent interagency Task Force. This Task Force would provide leadership on strategy alignment, data collection, implementation fidelity, and system accountability. Its charge should include monitoring fidelity to HB 4086, overseeing adoption of CSB-related recommendations, and ensuring equity in service delivery.

Membership should include:

- State agencies: OHA, ODHS, OYA, ODE, DELC, DOJ, and OJD.
- County-level partners: juvenile departments, CACs, and juvenile justice systems.
- Community-based organizations: culturally specific providers, survivor advocacy groups, and clinical CSB/PSB providers.
- Caregivers, youth, and individuals with lived experience.

This inclusive membership ensures that both professional systems and impacted families are represented in decision-making.

Parallel Strengthening of MDTs

In addition to the statewide Task Force, Oregon must strengthen local multidisciplinary teams (MDTs) as the backbone of case-level collaboration. MDTs should include law enforcement, educators, clinicians, child welfare, juvenile justice, CACs, district attorneys, and victim advocates. Roles and responsibilities should be clearly defined through memoranda of understanding (MOUs) that establish collaborative processes. MDTs must also receive training in trauma-informed, developmentally appropriate, and culturally responsive practices. Existing models such as HUBB/HBB teams should serve as foundational references for replication and scaling.

Short- and Long-Term Expectations

Governance must balance immediate collaboration with long-term accountability:

- **Short-term**: Child-serving agencies are responsible for engaging in Task Force activities, coordinating individual cases through MDTs, and participating in system-improvement efforts.
- **Long-term**: Agencies must build competence, agree on shared and differentiated responsibilities, and adopt formal accountability strategies that clarify who is responsible for what.

Accountability Mechanisms

To ensure transparency and fidelity, the governance structure should include multiple layers of accountability:

- **Annual Public Reporting**: The Task Force should publish an annual report tracking access, equity, outcomes, and fidelity to evidence-based models.
- **Independent Evaluation**: Universities or research institutes should conduct annual evaluations of implementation outcomes and cost-effectiveness.
- **Legislative Oversight**: OHA should report annually to the legislature on implementation progress, barriers, and resource needs.

- **Community Feedback**: Caregivers, youth, and culturally specific partners should have structured opportunities to shape implementation and flag inequities.

Funding & Sustainability

Failing to invest in a coordinated, trauma-informed CSB response carries significant human and financial costs. Without early, preventive intervention, children face higher risks of placement disruptions, prolonged foster care, and repeated system involvement—all of which drive up public spending. Nationally, the total cost of foster care placements (including supervision, services, and overhead) averages about $31,789 per child per year (Child Trends, 2021). In Oregon, base foster care maintenance payments alone are $11,500–$12,300 per year (ODHS, 2020–2022), and the true per-child cost is likely much higher once services and supports are included. For youth requiring residential treatment, annual costs typically range from $30,000 to $50,000+ per child. At the highest end of the spectrum, juvenile justice incarceration approaches $100,000 per youth per year, with poor long-term outcomes. In Oregon, the most intensive youth incarceration settings (close custody under Measure 11)[29] cost nearly $96,000 annually per youth. By contrast, evidence-based CSB/PSB treatments such as MST-PSB, TF-CBT, and PSB-CBT cost only $6,000–$10,000 per child per year, plus one-time start-up costs ($50,000–$150,000 per site). These models consistently demonstrate lower recidivism, improved family stability, and reduced system involvement. Investing in treatment-first pathways is therefore not only a fraction of the cost of foster care, residential placements, or incarceration, but also prevents lifelong harm to children, families, and communities.

Oregon's current funding landscape for services supporting children exhibiting CSB is fragmented and insufficient for long-term system success. While Oregon has made recent investments in behavioral health and crisis response — including the Behavioral Health Workforce Initiative, ARPA-funded programs, 988 crisis line implementation, and the Measure 110 Behavioral Health Resource Networks — these efforts are largely tied to temporary funding, competitive grants, or broader systems not tailored to children with CSB/PSB. As a result, CSB/PSB-specific efforts remain vulnerable to disruption, inconsistency, and geographic inequity.

To support the implementation of a statewide trauma-informed response system, Oregon must adopt a durable and diversified funding model—one that blends multiple sources while prioritizing public responsibility, access, and equity.

Current Funding Landscape

The following is not an exhaustive list of resources, but rather examples of some of the funding streams that support services for children and youth exhibiting CSB/PSB and system building efforts in Oregon. A full fiscal analysis would need to be conducted to truly understand the landscape of state, federal,

[29] Measure 11 is a mandatory minimum sentencing law approved by Oregon voters in 1994 (ORS 137.700). It establishes mandatory prison terms for certain serious violent and sex-related offenses and applies to youth ages 15 and older who are charged with those crimes. Youth convicted under Measure 11 are typically placed in Oregon Youth Authority (OYA) close-custody facilities, with annual costs approaching $96,000 per youth.

and other funding sources that could support this population and the recommendations outlined in this report, which was outside of the scope for this committee.

Funding Source	What It Covers
IV-B/PSSF, FFPSA, CAPTA, CJA, CBCAP, other grants	Title IV-B / PSSF: Flexible family support funds. Could help with family-based CSB/PSB interventions. FFPSA (IV-E Prevention): Can fund approved evidence-based programs (e.g., TF-CBT, MST) that address mental health, substance use, and in-home parent skill-building. While not listed as "PSB-specific" on the IV-E Clearinghouse, these models can also be applied in cases where children exhibit PSB."[30] CAPTA: Improves CPS systems and training. Could strengthen CSB/PSB reporting and intake, but not treatment. CJA: Improves how abuse cases are investigated/prosecuted. Relevant if CSB/PSB cases go through court. CBCAP: Supports prevention programs for families. Could fund community supports that reduce CSB/PSB risk. Other Federal Grants: Competitive funds that could pilot or expand CSB/PSB response models.
OHA Behavioral Health Investment	Residential treatment, housing, workforce, Certified Community Behavioral Health Clinics
Juvenile Justice / Oregon Youth Authority (OYA) Funding	Supports close-custody and community supervision for adjudicated youth, including youth with CSB/PSB. Funding is primarily tied to correctional settings and supervision rather than therapeutic interventions. Could be leveraged for treatment partnerships but is not designed as a prevention or family support stream.
Oregon Health Plan (Medicaid)	Medicaid reimbursement via CCOs for CSB-aligned services
988 & Crisis System Funds	Mobile crisis response, peer respite, crisis navigation
SAMHSA Grants & Block Grants	MH/SUD services, training, trauma-informed care
OHA/Philanthropic Planning Grants	Pilot initiatives, regional planning, infrastructure design

[30] U.S. Department of Health & Human Services, Administration for Children and Families. (2024). *Title IV-E Prevention Services Clearinghouse.* Washington, DC: U.S. HHS. Retrieved from https://preventionservices.acf.hhs.gov

Funding Priorities and Investment Areas

To move from planning to implementation, the following funding priorities are critical:

- State Budget Allocations to support infrastructure, training, coordination, and oversight.
- Medicaid & Insurance Reimbursement for trauma-informed care, care coordination, and family support (including expanded Z-code billing).
- Federal Grants (e.g., SAMHSA, DOJ, Title IV) to support MDTs, community education, and prevention.
- Workforce Development Supports including scholarships, stipends, and graduate-level incentives for rural and culturally responsive providers.
- Philanthropic Start-Up Support for pilot programs and CBO capacity-building.
- School-Based Prevention Funding to integrate early education and trauma-informed practices into school systems.

Priority Area	Investment Focus	Purpose
Infrastructure & Capacity	Fund statewide hub, hotline, regional liaisons, and data systems	Establish consistent infrastructure and fill regional gaps
Workforce Development	Tuition support, stipends, training pipeline for CSB/PSB specialization	Build and retain a specialized, diverse workforce
Rural Pilots	Support local MDTs, outreach teams, and service navigation in high-need areas	Adapt system for underserved and frontier counties
Sustainable Policy Design	Medicaid reimbursement roadmap, expanded billing codes, and legislative support	Secure long-term funding mechanisms for core services and coordination

Path to Sustainable Funding

To ensure long-term viability, Oregon should pursue a braided and value-based funding strategy, drawing from Medicaid, general funds, federal grants, and philanthropy. Medicaid waivers should be explored to allow reimbursement for developmentally appropriate, trauma-informed care—especially in the absence of formal diagnoses.

Key strategic steps include:

- Develop a Medicaid Reimbursement Roadmap for CSB/PSB services, applying premium rates based on provider specialization, risk, and regulatory burden (similar to Qualified Mental Health Professionals and Culturally Specific Services under Oregon's 1115 waiver).
- Align reimbursement policies with clinical and legal complexity, ensuring providers are compensated appropriately for high-liability or court-involved cases.

- Advocate for a CSB/PSB-specific state budget line item to stabilize service infrastructure and Task Force operations.
- Leverage philanthropy strategically, prioritizing early innovation and pilot site capacity—but not substituting for public investment.

This approach must be grounded in equity. Underserved and historically marginalized communities—including rural counties, tribal regions, and culturally specific organizations—must be prioritized in funding decisions and implementation plans.

JBVT Facilitator Conclusion

While sustainable funding, infrastructure, and statewide coordination are essential, the most urgent next step is to create space for communities, providers, and families to come together across counties, across agencies, and across lived experiences to talk honestly about the challenges and possibilities of responding to children with complex sexual behaviors. The best part is these conversations cost nothing, but they build everything needed for actionable and sustainable solutions. Building coalitions, reduction of stigma, and demonstration of visible progress to the families most affected is the goal. Community members need to see action, not only plans. We recommend that Oregon immediately convene locally led conversations facilitated in partnership with culturally specific providers, families, and survivor leaders to begin aligning responses and showing that the state is serious about this work. This dialogue is the foundation for any effective, equitable, and lasting system response.

Appendices

1. Full List of Resources

The following resources informed the education, training, and system development work across the working groups:

Community Education & Training Resources

- Association for the Treatment and Prevention of Sexual Abuse
- Safe Kids Thrive – Steps Toward Child Abuse Prevention Manual (MA)
- NJCAP Online Trainings
- National Children's Alliance PSB Modules
- US Army PSB-CY Training (5-Day)
- APSAC – PSB Resources
- NACBH Online Courses
- MASOC Webinar Series (Free)

Childhood Sexual Development & Parent Guidance

- Early Open Often – Development Chart
- Childhood Sexual Development PDF
- Raising Children Network – Sexual Behaviour (Ages 4–6)

2. Glossary of Key Terms

- **Adverse Childhood Experiences (ACEs):** Potentially traumatic events occurring in childhood (e.g., abuse, neglect, household dysfunction). Research consistently demonstrates a strong correlation between ACEs and a range of negative health and behavioral outcomes later in life, including a heightened risk for exhibiting problematic sexual behaviors.
- **Association for the Treatment and Prevention of Sexual Abuse:** A professional organization dedicated to promoting research, education, and effective clinical practices for the assessment, treatment, and management of individuals who have engaged in problematic sexual behaviors, particularly those involving sexual aggression.
- **Child Sexual Behavior Inventory (CSBI):** A clinical assessment tool or framework used to differentiate between normative child sexual development and concerning or problematic sexual behaviors, often employed in diagnostic and treatment planning processes.
- **Children's Advocacy Centers (CACs):** Community-based, child-focused facilities designed to provide a coordinated, multidisciplinary response to allegations of child abuse. They integrate law enforcement, child protective services, prosecution, medical, and mental health professionals to conduct forensic interviews, medical evaluations, and provide victim support and advocacy, increasingly expanding their scope to include children exhibiting PSB.
- **Coordinated Care Organization (CCO):** Oregon's model for delivering integrated physical, behavioral, and dental health services to Medicaid enrollees, focusing on improving health outcomes and managing costs through local community partnerships.
- **CECSB (Children Exhibiting Complex Sexual Behaviors)**: A term used to describe children who display developmentally inappropriate or harmful sexual behaviors that may pose risks to themselves or others. These behaviors require a coordinated, trauma-informed, and developmentally appropriate response that goes beyond traditional systems such as Juvenile Justice or Child Welfare. In Oregon, CECSB efforts focus on developing a comprehensive and sustainable statewide support system tailored to the specific needs of this population.
- **Complex Sexual Behavior (CSB):** Refers to the full continuum of developmentally inappropriate, concerning, or harmful sexual behaviors in children and youth. This term was used within this committee to capture a broader range of behaviors than "problematic sexual behavior" alone, spanning from behaviors that may be intrusive but responsive to structured interventions (i.e., "concerning behaviors"), to more serious behaviors that may involve coercion or aggression.
- **Diversion:** A structured process used by courts, law enforcement, or juvenile departments to redirect children away from formal adjudication and into community-based services or supports. In CSB/PSB cases, diversion may involve counseling, family therapy, or education rather than charges or court proceedings. Diversion aims to reduce system involvement while addressing root causes of the behavior in a trauma-informed and developmentally appropriate way.
- **Evidence-Based Practices (EBPs):** Clinical interventions, prevention strategies, or treatment models that have demonstrated efficacy through rigorous scientific research and systematic

evaluation. The HB 4086 report emphasizes the implementation of EBPs for addressing problematic sexual behaviors to ensure optimal outcomes.

- **Healing-Centered Engagement:** A strengths-based, community-driven approach that positions healing as a collective process within communities, focusing on promoting well-being, cultural identity, and systemic change rather than solely on individual pathology or deficit. It's often highlighted in discussions of trauma-informed care.
- **HB 4086:** An Oregon legislative bill (2024) that mandated the Oregon Department of Human Services (ODHS) to conduct a comprehensive review of child abuse investigations, identify systemic gaps, and determine best practices, specifically including a focus on responses to children exhibiting complex or problematic sexual behaviors.
- **HUBB Teams (Healthy Understanding of Behaviors and Boundaries):** Specialized Multidisciplinary Teams (MDTs) established in some Oregon counties (e.g., Yamhill, Clackamas) designed for early intervention with younger children exhibiting problematic sexual behaviors, aiming to provide coordinated support and reduce the likelihood of formal adjudication.
- **Impacted Child:** In the context of sexual abuse cases with a child as the reported initiator, this term refers to the child who experienced the concerning or harmful behavior. It is used to acknowledge their experience while avoiding potentially stigmatizing or legally definitive labels.
- **Informal Supervision:** A voluntary agreement between a child, their family, and the juvenile department in which the child receives support and services without being adjudicated or having a formal petition filed. For PSB-related cases, informal supervision may include behavioral health treatment, restorative practices, and family-based interventions monitored by a caseworker or probation officer. It provides accountability and support without long-term legal consequences.
- **Initiating Child:** In the context of sexual abuse cases with a child as the reported initiator, this term refers to the child who exhibits the concerning or problematic sexual behavior. This neutral terminology emphasizes the behavior itself and allows for a focus on understanding the underlying factors rather than immediately assigning culpability.
- **Intensive In-Home Behavioral Health Treatment (IIBHT):** A Medicaid-funded service delivery model in Oregon designed to provide comprehensive, individualized behavioral health interventions within the child's home and community environment, often used for children with complex needs to prevent out-of-home placement.
- **Multidisciplinary Team (MDT):** A collaborative group of professionals from various disciplines (e.g., mental health clinicians, law enforcement, child protective services, medical professionals, educators, social workers) who collectively assess, investigate, treat, and support children involved in complex cases, such as those exhibiting concerning or problematic sexual behaviors. MDTs ensure a comprehensive and coordinated response.
- **Multisystemic Therapy for Problem Sexual Behavior (MST-PSB):** A family-based, evidence-based clinical intervention model that addresses problematic sexual behaviors by targeting the complex interplay of individual, family, peer, and community factors influencing the children's behavior.

- **Normative Sexual Development:** Refers to the typical range of sexual curiosity, exploration, and behaviors observed in children and adolescents that align with their developmental stage, biological maturation, and broader cultural and societal expectations, without causing harm or distress.
- **OASOTN (Oregon Adolescent Sexual Offending Treatment Network):** The Oregon Adolescent Sexual Offending Treatment Network (OASOTN) is committed to the prevention of sexual abuse by providing professional training and support, technical assistance, and legislative action. OASOTN promotes opportunities for training and collaboration of professionals that work with youth who have sexually abused. Additionally, OASOTN advocates for the highest standards in practice with youth who have sexually abused to promote individual, family, and community safety.
- **Oregon Department of Education (ODE):** The state agency responsible for overseeing public education in Oregon. It sets educational standards, administers state and federal funding, supports school districts, and monitors student performance to ensure quality education for all K-12 students in the state. ODE also develops policies, provides resources for educators, and ensures compliance with state and federal laws.
- **Oregon Department of Human Services (ODHS):** A principal state agency in Oregon responsible for administering a wide range of social services, including child welfare, and tasked by HB 4086 with reviewing current practices and identifying best practices for addressing child sexual behaviors.
- **Oregon Health Authority (OHA):** Oregon's state agency responsible for health policy, health care programs (including Medicaid), and public health. Its Trauma-Informed Approaches policy is a foundational framework for the coordinated statewide response discussed in the report.
- **Oregon Revised Statutes (ORS):** The compilation of all general and permanent laws of the State of Oregon, which are continually updated and govern various aspects of state operations and individual conduct.
- **Oregon Youth Authority (OYA):** As part of Oregon's juvenile legal system, OYA holds youth accountable and provides them with opportunities for reformation, either in the community on parole or probation, or inside secure facilities. OYA is responsible for youth ages 12 to 24 who commit crimes before age 18. OYA serves youth who are unsuccessful at the county level, who need more services than the county can provide, or who commit very serious crimes.
- **Outcomes-Based Funding:** A funding model where payments to service providers are linked to the achievement of pre-defined, measurable outcomes or improvements in client well-being, rather than solely on the quantity of services delivered. This encourages effectiveness and accountability. (This approach is sometimes referred to as "Values-Based Payments," but "Outcomes-Based Funding" is a more common and precise term in this context.)
- **Phase-Based Treatment (PBT):** An evidence-based clinical model often used in the treatment of trauma and problematic sexual behaviors, where intervention progresses through distinct phases (e.g., safety and stabilization, trauma processing, integration and consolidation) tailored to the client's readiness and needs.

- **Problematic Sexual Behavior (PSB):** Sexual behaviors in children that are developmentally inappropriate or potentially harmful to themselves or others. These may include behaviors that are aggressive, coercive, harmful, or persistent despite guidance or intervention, and typically require specialized therapeutic and systemic responses. The Association for the Treatment and Prevention of Sexual Abuse (ATSA) defines PSB as "those aged 12 and younger who initiate sexualized behaviors that are developmentally inappropriate or potentially harmful to themselves or others."

- **Problematic Sexual Behavior – Cognitive-Behavioral Therapy (PSB-CBT):** An evidence-based therapeutic approach specifically adapted for addressing problematic sexual behaviors in children, focusing on identifying and modifying cognitive distortions, behavioral patterns, and emotional regulation deficits linked to the behaviors.

- **Psychoeducation:** The process of providing individuals and their families with comprehensive information about their condition, treatment options, coping strategies, and relevant support systems. In this context, it often pertains to understanding trauma, sexual development, and behavioral interventions.

- **Sexual Abuse:** Any non-consensual or exploitative sexual activity imposed on an individual. In Oregon, definitions vary across statutes: under ORS 419B.005 (dependency code), sexual abuse includes circumstances that trigger mandatory reporting; under the criminal code (ORS 163), sexual abuse is further defined through specific criminal offenses against persons. Both carry serious legal and social ramifications.

- **Sex Trafficking:** A severe form of exploitation involving compelling or coercing an individual, often a minor, into commercial sex acts through force, fraud, or coercion.

- **Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT):** A well-established, evidence-based psychotherapy model specifically designed to address the unique needs of children and adolescents (and their parents/caregivers) struggling with the emotional and behavioral consequences of single or multiple traumatic events.

- **Trauma-Informed:** An organizational or systemic approach that recognizes the pervasive impact of trauma, understands potential paths for recovery, and integrates this knowledge into all aspects of service delivery. It emphasizes psychological safety, trustworthiness, peer support, collaboration, empowerment, and cultural responsiveness, aiming to avoid re-traumatization.

- **Z Codes:** A category of diagnostic codes (ICD-10-CM) used in medical billing and health records to describe factors influencing health status and contact with health services, including psychosocial and environmental circumstances (e.g., exposure to trauma, family disruption) that are not diseases or injuries themselves but impact health outcomes.

3. HB 4086 CECSB Informative Report

HB4086 Report: Children and Adolescents Exhibiting Complex Sexual Behaviors: A Review of Services, Interventions, and System Responses

4. Committee Methodology & Values

This report synthesizes the findings and recommendations from four dedicated workgroups. Each workgroup engaged with surveys of the community and constituent providers of CSB/PSB, Oregon caregiver focus groups, and other state entities leading healing centered pathways for CSB/PSB.

Additionally, the development of these recommendations and the overall strategic framework were informed by the HB 4086 Report: Children and Adolescents Exhibiting Complex Sexual Behavior: A review of services, interventions, and system responses, commissioned as part of Oregon's legislative mandate._This comprehensive review provided critical insights into “normative” sexual development, identification of CSB/PSB, national best practices, Oregon's current service landscape (including ODHS, OYA, ODE, CACs, and Regional PSB MDTs), and specific evidence-based and emerging clinical models (e.g., TF-CBT, PBT, MST-PSB, PSB-CBT).

The workgroups' contributions were cross-referenced and refined against the evidence base provided by this review to ensure alignment with best practices and the legislative intent. Information was gathered through a series of workgroup meetings, internal documentation review, and expert consultations.

The synthesis involved identifying overarching themes, synergies, and gaps across workgroup proposals, and then grounding these findings in the established evidence from the HB 4086 Report to develop comprehensive statewide recommendations.

Guiding Principles and Values

Throughout the 10-month journey of the CSB Committee, members were introduced to a range of research-based and healing-centered models and frameworks designed to support systems transformation. One of the foundational frameworks was Healing Centered Engagement (HCE), which moves beyond trauma-informed care to focus on well-being, identity, agency, and community connection. The committee explored the four key pivots of HCE—shifting from lens to mirror, hustle to flow, transactional to transformational relationships, and problem-solving to possibility-creating. Additionally, members engaged with the CARMA principles (Culture, Agency, Relationships, Meaning, and Aspirations) to guide healing-centered design and policy development.

The committee also learned and applied the Relational Theory of Change, a process for identifying long-term outcomes and working backward to clarify the strategies, partnerships, and conditions required for meaningful change. Members built logic models grounded in this approach to inform the pathway for children experiencing complex sexual behavior. To support leadership in the face of uncertainty and deeply entrenched issues, the committee was introduced to Adaptive Leadership, which distinguishes between technical and adaptive challenges and equips leaders to manage discomfort, hold space for conflict, and guide collective learning.

To support equity and power analysis, the committee explored the Four I’s of Oppression—ideological, institutional, interpersonal, and internalized—providing a framework for understanding how harm is reproduced across systems and within individuals. Somatic practices were regularly incorporated to support self-awareness, regulation, and processing of emotionally charged content, including

breathwork, grounding, and other body-based tools. The committee also deepened its understanding of Trauma-Informed Care, with a focus on Adverse Childhood Experiences (ACEs), the behavioral impacts of trauma, and the principles of safety, trust, and empowerment.

These models were not taught in isolation, but woven throughout the committee's sessions, grounding practices, and work group activities. Each session was structured to integrate these frameworks into policy analysis, design of pilot interventions, and partner engagement strategies. Together, they created a shared foundation for the committee to move forward with clarity, compassion, and a commitment to healing-centered systems change.

The CSB Committee was founded on a deep commitment to healing, justice, and systems transformation for children exhibiting complex sexual behaviors and their families. The work was guided by a clear set of principles and values developed collaboratively by committee members, facilitators, and lived experts. These principles grounded our process, shaped our decisions, and supported the collective accountability required to drive meaningful reform.

Shared Values

- **Intentional Kindness and Honesty**
  Commit to fostering a space where difficult truths could be spoken with care. Honesty was welcomed—even when uncomfortable—because trust and transformation depend on transparency.
- **Courage and Growth Mindset**
  Encourage each other to step into discomfort, circle back when needed, and remain open to learning. Mistakes were embraced as opportunities for reflection and growth.
- **Inclusivity and Family Voice**
  The perspectives of families most affected by system responses to CSB were centered throughout the process. Acknowledge that solutions must be shaped with—not just for—the communities we aim to support.
- **Accountability and Integrity**
  Committee members committed to follow through on the process, showing up prepared, engaged, and willing to hold ourselves and systems accountable.
- **Hope and Realism**
  Balance urgency with patience, holding space for both the possibilities we envision and the constraints we navigate.
- **Respect for Diverse Roles and Ways of Being**
  Recognize that every participant—facilitator, caregiver, advocate, or policymaker—brought essential perspectives. Value different communication styles, modalities of learning, and approaches to leadership.

Committee Agreements

To guide the committee's time together, the committee co-created community agreements that included:

- Practicing clear communication and controlled ways of sharing information.
- Allowing time to prepare and holding space by "stepping up and stepping back."
- Embracing a collaborative, structured process for rupture and repair.
- Maintaining patience, flexibility, and engagement throughout our 10-month journey.

Scope of Work across Working Groups

The scope of work for this statewide initiative was distributed across four dedicated working groups, each focusing on a key pillar necessary to build a trauma-informed, coordinated response to complex sexual behavior (CSB) in children. Together, their collective efforts aim to promote child safety, reduce harm, and establish sustainable systems for prevention, intervention, and recovery.

Workgroup Design: The HB4086 Children Exhibiting Complex Sexual Behaviors (CECSB) Committee worked both as a comprehensive team as well as independent workgroups. The purpose of this design was to provide smaller group spaces with diverse expertise to focus on specific elements pertaining to the array of individual, community, and systemic needs to be addressed. Through surveys and group discussion, the committee was divided into four workgroups: Community Education, Designing the System Response, Expanding Therapeutic Services, and Identifying Funding Streams

Workgroup 1: Community Education

Focused on reducing stigma and raising awareness about CSB. This group aimed to identify how Oregon could expand education and awareness for CSBs among the public and service providers, defining the 'community' broadly to include schools, healthcare, community partners, child care, courts, agencies, advocates, and legislators. The group proposes culturally competent, accessible public education campaigns and provider training programs. They recommend developing evidence-based curricula, outreach strategies, and long-term education pathways that cover mental health options, rights, funding, family implementation, child development (establishing a baseline understanding), trauma-informed delivery/care, and policies/procedures for working with the population.

- Focused on public education and destigmatization.
- Mapped existing educational resources and gaps.
- Developed strategies for culturally competent, statewide training and outreach to families, providers, and communities.

Workgroup 2: Designing the Response System

Charged with creating coordinated, trauma-informed systems of care and response for children along two age group pathways: children in early and middle childhood (roughly birth–12, but defined by developmental milestones) and adolescents and transitional-age youth (roughly 13–17, with emphasis on cognitive, emotional, and social development). This workgroup aimed to identify multidisciplinary teams, clarify agency roles, especially that of ODHS, and establish age-appropriate referral and treatment pathways. Legislation and practice standards are central to their vision.

- Tasked with designing trauma-informed response protocols.
- Mapped referral pathways and created age-appropriate, multidisciplinary response models.
- Worked to clarify agency roles and coordination needs, especially among ODHS, law enforcement, and clinical providers.

Workgroup 3: Therapeutic Services

Tasked with improving access to mental health care for children with PSB. Their plan involves statewide PSB-specialized training, creation of a centralized service hub, curriculum alignment, and improved integration across schools, healthcare, and child welfare systems.

- Assessed availability and quality of therapeutic and mental health services.

- Developed recommendations for statewide integration of evidence-based treatment options.
- Focused on reducing rural disparities, waitlists, and training gaps in clinical workforce.

Workgroup 4: Funding Streams

Focused on identifying sustainable funding mechanisms. This includes pursuing legislative support, insurer compliance on reimbursement codes, and securing philanthropic and government resources. They emphasize the importance of long-term, values-based payment models.

- Identified current and potential funding streams (e.g., Medicaid, grants, philanthropic sources).
- Proposed policy changes for long-term reimbursement mechanisms (e.g. It is crucial to note that Z-codes, while relevant to identifying and tracking sex offense-specific treatment, are insufficient as a standalone funding solution for the comprehensive needs associated with complex sexual behavior (CSB) in children. The current reliance on Z-codes primarily addresses "sex offense specific treatment," which often falls short of covering the full spectrum of trauma-informed, developmentally appropriate, and multidisciplinary interventions required for children exhibiting CSB. This narrow focus can inadvertently limit access to necessary therapeutic services, as many interventions fall outside of this specific coding.
- Therefore, the recommendation for braided funding from key system investors—including state agencies, Medicaid, and philanthropic partners—is paramount. This approach would allow for a more robust and flexible funding mechanism that can support the multifaceted nature of CSB response, encompassing prevention, early intervention, comprehensive assessment, diverse therapeutic modalities, family support, and workforce development.
- Furthermore, the development of a comprehensive cost rate analysis is essential. Such an analysis would accurately reflect the true costs of providing high-quality CSB services, factoring in non-billable hours (e.g., care coordination, case consultation, family engagement), specialized training and licensure requirements for providers, increased liability, and the importance of fidelity-based implementation of evidence-based clinical models. By understanding and accounting for these true costs, Oregon can advocate for sustainable funding models that are not solely dependent on the limitations of existing codes like Z-codes, thereby fostering a broader and more effective system response for therapeutic services and overall child well-being.)
- Developed a plan to ensure sustainable financial support across all counties.

Together, these workgroups took a systems-level view of the issue, identifying dependencies, shared challenges, and collaborative solutions. Their work was aligned to inform the legislative studies authorized under HB 4086, and to lay the groundwork for long-term, statewide infrastructure that addresses CSB in children through a lens of equity, safety, and healing.

Each workgroup produced detailed notes and supporting materials. To keep this report concise, only summary findings are included here. Full workgroup notes and materials are available upon request from ODHS and will also be made accessible online alongside the Informative Review. They do not represent official recommendations or positions of the CSB Committee, but rather reflect the contributions and perspectives of the participants.

6. Proposed Response System Design

To ensure consistent, trauma-informed, and developmentally appropriate responses to CSB/PSB across Oregon, the state must design and implement a statewide response pathway. This pathway should

clarify roles, decision points, and timelines for every partner involved when problematic or harmful sexual behavior is suspected or disclosed.

A key feature of this pathway is a comprehensive system flowchart—tailored by setting (home, school, community) and developmental stage rather than strict chronological age. The model acknowledges the evolving nature of child and adolescent brain development and recognizes that trauma and cognitive disability can affect developmental presentation.

The table below illustrates a proposed end-to-end response pathway for cases involving CSB/PSB. It outlines the key steps, the actors responsible at each stage, and the intended actions to ensure a coordinated, trauma-informed system of care. This framework is meant to demonstrate how existing agencies and resources could interact under a more standardized model.

Step	Actors	Actions	Notes
1. Identification & Reporting	Parents, Schools, Providers, Community Members	Behavior identified and reported to ORCAH (hotline)	Initial triage by PSB-trained screeners
2. Hotline Screening	ORCAH, PSB-trained screeners	Determine jurisdiction, notify MDT/Committee, feedback to reporter	If screened out, notify MDT and refer to supports; if screened in, assign trained CPS worker
3. Law Enforcement Response	LEA, PSB-trained detectives	Respond to reports, refer to MDT	Parallel pathway if LEA receives report
4. Family Contact - Initiating Child	PSB Navigator, MDT	Provide support, education, referrals, safety planning	Re-assess if family refuses services
5. Family Contact - Impacted Child	CAC, Therapist, MDT	Offer therapy, CAC services, trauma education	Screen for trauma exposure
6. MDT Oversight	MDT/Committee	Track case progress, assign services, monitor until resolution	Keep case open until thresholds met
7. System Coordination	Schools, MDT, PSB Navigators	Implement SIRC, provide training, coordinate care	Create no wrong door approach
8. Service Access	State Agencies, Providers	Provide accessible, reimbursable, trauma-informed services	Use Medicaid, flexible funds, and grant sources
9. Oversight & Evaluation	State Oversight Body	Collect data, ensure equity, improve system	Include lived experience in governance

This visual guide provides a high-level overview of how a suspected or disclosed behavior might move through the system, ensuring that:

- Children are assessed developmentally, not just chronologically.
- Legal, clinical, and child welfare pathways are clearly differentiated.
- Agency responsibilities are clearly defined and sequenced to avoid duplication and minimize trauma.

Clear guidance must accompany the visual, including:

- Immediate steps following disclosure.
- Clarification on when to notify caregivers.
- Routing guidance for ORCAH and CACs.
- Identification of services that support safety, accountability, and healing without criminalizing children.

To reinforce consistency and judicial alignment:

- District attorneys or juvenile departments should request early MDT consultation before adjudication when there is ambiguity.
- Agencies should present courts with comprehensive, developmentally informed assessments.
- Judicial decisions should be supported with context-sensitive information from MDTs, CACs, and community partners.

7. Funding Calculations & Additional Funding Opportunities

Reimbursements

This section specifically addresses Medicaid reimbursement for specialized services. Oregon's Fee-For-Service (FFS) payment schedule already acknowledges and compensates for provider specialization. For example, both Qualified Mental Health Associates (QMHAs) and Qualified Mental Health Professionals (QMHPs) can perform many of the same tasks, but QMHPs are reimbursed at a higher rate due to their advanced education, clinical skill, and judgment. This tiered payment structure is intentional—specialization is recognized and valued with a premium rate.

Similarly, Culturally and Linguistically Specific Services (CLSS) providers are reimbursed at higher rates because they bring additional, in-demand expertise that helps Oregon achieve equitable access to care. This raises the question: do children with Inappropriate or Problematic Sexual Behaviors (ISB/PSB) have the same equitable access to care?

Sex Offense Treatment Board (SOTB) services should be treated in the same way. The SOTB framework was created in Oregon (not federally mandated) to address a high-risk, high-liability area of care. These regulations are a proactive attempt to reduce systemic risk for providers, payers, and the public. SOTB supervision, risk assessments, case planning, and treatment are not routine mental health services—they involve managing elevated clinical and legal complexities such as community safety planning, judicial reporting, and heightened ethical scrutiny. They also require additional qualifications and a highly specialized skill set to ensure ethical, evidence-based, and trauma-informed responses for children with PSB.

Importantly, the regulatory structure created in Oregon for SOTB services inherently conflicts with the methodology and reimbursement logic used in the federal Medicaid framework. This misalignment prevents the application of a premium under traditional Medicaid standards. If SOTB regulations were

developed and implemented at a federal level, the specialty would likely be formally acknowledged, and a premium rate would likely be applied, just as it is for other recognized specialty areas.

If Oregon is willing to pay a premium for CLSS providers via the 1115 waiver, because of scarcity, risk, and the added value of specialized knowledge to meet a state goal of equitable healthcare, then by the same logic, it should pay a premium for SOTB services. The rationale is arguably the same if not more complex. CLSS enhances equitable engagement for an extremely unfairly treated population in healthcare, while SOTB services address immediate public safety, complex clinical treatment, and legal accountability for a highly stigmatized population, often requiring four times the documentation and frequent court appearances. Additionally, certain liability insurance providers have adjusted their rates based on the elevated risk and liability associated with specific specialties, similar to how physicians are rated differently from licensed clinicians due to risk exposure. This principle should apply to SOTB services as well. When providers are held to a higher regulatory standard and risk by specialty by the state, they should be compensated accordingly.

Failing to pay a premium for SOTB services de-incentivizes participation and creates workforce shortages. This defeats the purpose of the SOTB framework, undermines Oregon's safety and compliance goals, and runs counter to Medicaid's own principles of recognizing and reimbursing for specialty, scarcity, and risk.

Potential Creative Funding Solutions

Pay for Success / Social Impact Bonds
A financing model where private investors provide upfront capital for programs with measurable outcomes, and repayment is made by government or philanthropic partners only if agreed-upon outcomes are achieved. This approach reduces public-sector risk and incentivizes effective early intervention programs.
Example: Massachusetts Juvenile Justice Pay for Success Initiative — reduced recidivism for justice-involved youth through intensive wraparound services.

Local/Regional Tax Levies
Voter-approved taxes, such as property or sales tax increases, earmarked for prevention, treatment, and community education related to CSB. Levies can provide stable, multi-year funding insulated from annual budget fluctuations.
Example: Best Starts for Kids Levy – King County, WA — funds prevention and early intervention services for children and youth, including mental health supports.

Partnerships with Community-Based Organizations (CBOs)
Leveraging existing community infrastructure to quickly pilot and scale interventions. CBOs often have established trust with target populations, cultural competency, and flexible staffing structures that allow for faster implementation than large agencies.
Example: Oregon Community Foundation — partners with local nonprofits to deliver targeted interventions in rural and underserved areas.

Blended Public-Private Funding Strategies
Combining multiple funding streams — state, federal, philanthropic, and corporate — to support specialized services over the long term. This approach diversifies revenue sources, reduces dependency

on a single funder, and increases sustainability.
Example: LA County Arts Ed Collective Public-Private Partnership — successfully leveraged county, school district, and philanthropic funds to sustain programming.

8. Committee Members, Workgroup Leads, & Voting

Workgroup Leads

Workgroup	Primary Contact(s)	Affiliation	Email
Community Education	Anneliese Sheahan	Oregon Child Care Providers Together	oregonccpt132@gmail.com
Response System Design	Justine Kovak	Children's Center	justinekovak@childrenscenter.cc
Community & Mental Health Resources	Genna Naquin	Higher Ground	genna@highergroundcounseling.com
Funding & Sustainability	Debbie Moussa	Higher Ground	debbie@highergroundcounseling.com

Committee Members

Committee Members	Representing Entity
Alayna Weimer	Person with lived experience
Amanda K Barnhart	Experience with the federal Indian Child Welfare Act and Oregon Indian tribes
Amelia Kercher	Children's Advocacy Centers
Anneliese Sheahan	Childcare provider & Person with lived experience
Ashley Cross	Person with lived experience
Buck Pearce	Oregon Association Chiefs of Police
Debbie Moussa	Advocates for Children
Deborah Martin/ John Thomas	Oregon Youth Authority (John replaced Deborah)
Diane Deleon	Person with lived experience
Ellyn Bell	Department of Human Services
Genevieve Naquin	Children's Behavioral Health

Jennifer Johnson	Department of Education
Jennifer McGowan	Attorney Representing Children
Jessie Eagan	Oregon Health Authority: Child and Family Behavioral Health
Jocelyn Andersen	Juvenile Justice Department
Justine Kovak	County Child Abuse Multi-disciplinary teams with existing PSB subcommittees
Karen Rush	Licensed and classified school employee
Kristin Ward	Department of Justice
Mandy Augsburger	Certified Resource Parent
Melanie Kelly	Professionals who are licensed, certified or endorsed to provide services to children
Robbie Johnson	County Juvenile Departments
Sarah M Stewart/ Darian DeMarce (alternate)	Person with lived experience & Advocates for children
Susan M. Svetkey	Judge (non-voting)
Timothy O'Donnell	Oregon District Attorneys Association
Timothy Tannenbaum	Oregon State Sheriffs' Association
ToiNae Gibson/ Chris Peck	Community Developmental Disabilities Program (Chris replaced ToiNae)

Voting Record

In order to determine the level of consensus amongst committee members, a survey was sent out asking all members to vote on their level of agreement with each of the recommendations. The options provided a range of responses including:

- I consent to move this recommendation forward (i.e., it's good enough for now and safe enough to try)
- I consent in part to this recommendation moving forward (i.e., it's a good start but more discussion or changes are needed before I can support it)
- I do not consent to move this recommendation forward (i.e., it's not a recommendation I can get behind even if the language was modified)

While not all members of the committee participated in the survey (including those non-voting members), the following table represents the collective responses from the 16 members who did respond.

Key Recommendations	Committee Vote
R1. Establish a statewide response pathway with clear protocols.	Consent: **13** Consent with edits: **2** Do not consent: **1**
R2. Invest in services and workforce (evidence-based treatment, training, supports).	Consent: **12** Consent with edits: **4** Do not consent: **0**
R3. Define and standardize CSB/PSB terminology in statute/policy.	Consent: **11** Consent with edits: **5** Do not consent: **0**
R4. Clarify mandated reporting expectations through statutory amendments and training.	Consent: **12** Consent with edits: **1** Do not consent: **3**
R5. Create an Implementation Task Force and phased roadmap with clear accountability.	Consent: **12** Consent with edits: **4** Do not consent: **0**
R6. Support referral/treatment pathways that avoid "child abuser" labels for young children.	Consent: **12** Consent with edits: **4** Do not consent: **0**
R7. Launch education and training campaigns within 12 months.	Consent: **13** Consent with edits: **3** Do not consent: **0**
R8. Expand Sexual Incident Response Committees (SIRC) in schools/early learning.	Consent: **15** Consent with edits: **1** Do not consent: **0**
R9. Strengthen provider supports (reflective supervision, peer networks).	Consent: **16** Consent with edits: **0** Do not consent: **0**
R10. Expand use of family navigators to connect families with services.	Consent: **12** Consent with edits: **3** Do not consent: **1**
R11. Expand statewide access to evidence-based treatment models (TF-CBT, MST-PSB, PSB-CBT, PBT).	Consent: **13** Consent with edits: **3** Do not consent: **0**
R12. Legislative mandate for braided funding across systems.	Consent: **11** Consent with edits: **2** Do not consent: **3**

R13. Secure Medicaid reimbursement and enforce insurance compliance.	Consent: **13** Consent with edits: **3** Do not consent: **0**
R14. Develop MDT-supported judicial guidance and trauma-informed judicial training.	Consent: **12** Consent with edits: **1** Do not consent: **3**
R15. Expand trauma-informed models in rural/underserved areas.	Consent: **13** Consent with edits: **3** Do not consent: **0**
R16. Build workforce pipeline through training, certification, and higher ed partnerships.	Consent: **13** Consent with edits: **3** Do not consent: **0**
R17. Determine oversight structure (OHA vs. SOC Advisory Council).	Consent: **12** Consent with edits: **1** Do not consent: **3**
R18. Clarify age scope (under 12 vs. up to 18).	Consent: **14** Consent with edits: **2** Do not consent: **0**
R19. Consider statutory exemption for children from "perpetrator" classification.	Consent: **10** Consent with edits: **2** Do not consent: **4**
R20. Explore creative funding models (e.g., Pay for Success, insurance incentives).	Consent: **12** Consent with edits: **4** Do not consent: **0**

9. Considerations for Recommendations

Gaps & Areas for Coordination

ODHS Role Evolving and Implementation Varies: ODHS is statutorily required under ORS 419B to respond to allegations of child abuse, including cases where harm is caused by another child. However, ODHS does not have a mandate to respond to all cases of youth exhibiting PSB/CSB—particularly when no caregiving or familial relationship is involved. This limited scope has created uncertainty about ODHS's role and variation in practice across the state.

Historically, inconsistent statutory interpretation and the lack of a centralized intake system may have contributed to uneven responses. For example, before the Oregon Child Abuse Hotline was established, some counties may have screened in reports involving PSB for full CPS response at a higher rate than others.

When cases are accepted, service referrals depend heavily on local availability. Because ODHS does not directly provide treatment, families are often referred to community providers—who may or may not have the necessary expertise. This is especially challenging in rural areas, where certification in CSB/PSB treatment is not required. These issues reflect broader system gaps, not solely ODHS responsibilities.

To bring greater clarity and coordination, Oregon needs a statewide strategic roadmap that defines ODHS's responsibilities in prevention, early intervention, case coordination, and oversight. Such a roadmap should position ODHS as a convening agency, aligning interagency roles, clarifying referral pathways, and ensuring equitable service access statewide. It should also adapt to jurisdictional recommendations currently under discussion, so that ODHS's role remains aligned regardless of statutory or structural changes.

Accountability and Identification Gaps: With disparate responsibility across agencies, there is no shared framework for accountability, and no standardized process for identifying and responding to children and youth with CSB/PSB. This lack of coordination leads to inconsistent identification, referral, and follow-up, leaving gaps in care and uneven outcomes across the state. A unified, cross-agency accountability structure—paired with standardized screening and referral protocols—is needed to ensure that no child or family falls through the cracks.

Resource Gap: Oregon faces a critical shortage of mental and behavioral health practitioners, particularly those trained to understand and treat complex sexual behaviors in children and youth. This gap is especially pronounced in rural areas, where families often lack access to qualified providers.

While continuing education (CEUs) can help deepen expertise, the current initial licensure and certification requirements for working with this population are often experienced as overly burdensome. For many providers, especially early-career professionals, the path to full certification can feel like pursuing a second license—an intensive process that contributes to workforce attrition and deters new practitioners from entering the field. Administrative delays in processing certifications further exacerbate access issues.

The report recommends that Oregon reevaluate the current board and certification requirements for providers serving children and youth with CSB/PSB—particularly for children 12 and younger. A tiered or alternative certification approach could allow for more accessible, developmentally appropriate training pathways while still ensuring quality and safety. Aligning initial licensure and training opportunities with real-world workforce capacity is essential to expanding the provider pipeline and meeting the needs of children and families statewide.

Assessment Gap: *Oregon lacks a centralized or consistently designated entity responsible for assessing complex or problematic sexual behaviors (CSB/PSB) across systems. This results in inconsistent practices, delays in care, and assessments that may be inappropriate or misaligned with developmental and trauma-informed standards. In some areas, families are referred to providers without the necessary expertise; in others, assessments are shaped by punitive responses rather than healing-centered care. While schools have made progress through ODE's standardized SIRC protocols, alignment across child welfare, behavioral health, and justice systems remains a critical gap*.

Systemic Risks & Community-Wide Mitigation

Inconsistent Messaging: Without clear alignment, education and intervention efforts across systems can contradict each other and confuse communities. As Oregon works to raise awareness and improve responses to CSB/PSB, there is a risk of over-reacting or unintentionally pathologizing developmentally typical behavior—especially in younger children. Poorly framed messaging can contribute to stigma, fear, or the creation of a new category of "bad kids", which undermines healing and inclusion.

The report recommends developing a trauma-informed, developmentally appropriate statewide communication strategy. Messaging should be carefully designed in partnership with families, providers, educators, and individuals with lived experience to ensure it promotes understanding, reduces stigma, and supports right-sized responses.

Funding Fragility: Overreliance on grants, pilot projects, or short-term funding streams jeopardizes the long-term sustainability of effective CSB/PSB interventions. Programs launched with temporary funding often struggle to scale, retain staff, or embed within community infrastructure once initial funding ends. This creates a cycle of starting and stopping services, which undermines trust and continuity for families.

The report recommends advocating for legislative mandates and dedicated state funding to stabilize and sustain prevention, assessment, treatment, and cross-system coordination. Embedding these services into ongoing agency budgets and Medicaid reimbursement pathways will help institutionalize the work.

Cultural Pushback: In some communities, particularly those with more conservative or punitive views of children behavior, efforts to address CSB/PSB through trauma-informed, non-criminalizing approaches may face resistance. Misunderstandings about intent, fear of normalization, or deeply held cultural beliefs can limit community uptake and erode support for critical services.

To mitigate this, engagement strategies should be tailored to local context, using trusted messengers—such as faith leaders, educators, or parent advocates—to foster understanding and reduce fear. Grounding communication in shared values like child safety, family strength, and community wellbeing can build bridges across ideological differences.

Policies Affect Access: Current policies—across education, healthcare, and behavioral health—can create unintended barriers to timely and appropriate services for children with CSB/PSB. These may include restrictive eligibility requirements, narrow definitions of service need, or lack of cross-agency flexibility to fund holistic interventions.

The report recommends reviewing and amending policies that limit access to care, particularly for marginalized communities, rural areas, and children with co-occurring needs. Policy alignment should focus on supporting early intervention, culturally responsive care, and flexible service pathways that meet children and families where they are.

Workforce Burnout: Providers working with CSB/PSB populations face emotionally demanding situations, secondary trauma, and often operate without adequate supervision, compensation, or

community support. These conditions contribute to burnout and high turnover, putting long-term service capacity at risk.

To support workforce sustainability, the report recommends embedding provider wellbeing supports—including reflective supervision, mental health resources, and flexible schedules—into all service models. Establishing a tiered training structure and peer learning network can create space for mentorship, ongoing skill-building, and shared problem-solving, helping practitioners feel less isolated and more equipped in their roles.

Inaction Due to Complexity: One of the greatest risks is failing to act because the issue of CSB/PSB is complex, uncomfortable, or lacks a clear lead agency. When systems delay or avoid intervention, children and youth with unmet needs may not receive appropriate support, increasing the risk that concerning behaviors continue into adulthood. Without coordinated, early, and developmentally appropriate responses, the window for meaningful prevention and healing can be missed.

The report emphasizes the need to treat CSB/PSB work as a prevention strategy—one that supports long-term wellbeing, reduces future harm, and disrupts potential cycles of trauma. Oregon must invest in building systems capable of engaging with this complexity rather than avoiding it, ensuring children and youth are seen, supported, and not left behind.

Juvenile Justice Perspective (County Juvenile Depts. and Oregon Youth Authority)

Juvenile justice representatives expressed concerns that portions of the report reflect assumptions not discussed in committee meetings, may create confusion regarding age scope (children 12 and under vs. youth up to 18), and underemphasize a victim-centered approach. They also noted challenges with recommending OHA oversight given current capacity, and highlighted the need for further engagement with the Oregon District Attorneys Association regarding statutory impacts. While these representatives do not support all conclusions or recommendations, they stand ready to work with partners to strengthen Oregon's response to children—particularly those 12 and under—who engage in problematic sexual behavior.