



Home Office

Care Services Improvement Partnership **CSIP**

National Institute for
Mental Health in England



The needs and effective treatment of young people who sexually abuse: current evidence

Victims of Violence and Abuse Prevention Programme

The joint Department of Health and National Institute for Mental Health in England Victims of Violence and Abuse Prevention Programme (VVAPP) is working in partnership with the Home Office to develop evidence-based interventions that address the health, mental health and other related needs of individuals affected by domestic violence, child sexual abuse, rape and sexual assault, and sexual exploitation in prostitution, pornography and trafficking. It covers victims, survivors and abusers, including children, adolescents and adults both male and female.

READER INFORMATION

Policy	Estates
HR/Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working
Document Purpose	Best Practice Guidance
ROCR Ref:	Gateway Ref: 6262
Title	The needs and effective treatment of young people who sexually abuse: current evidence
Author	Department of Health – Health Care Partnerships Directorate and Home Office – Youth Justice and Children Team
Publication Date	October 2006
Target Audience	PCT CEs. NHS Trust CEs. Medical Directors. Directors of PH. Directors of Nursing, NHS Trust Mental Health Leads, Regional Public Health Group Sexual Health Leads.
Circulation List	Voluntary Organisations/NDPBs
Description	This document is being published by the Department of Health and Home Office to draw upon various sources in order to provide a base line of evidence on the needs and effective treatment of young people who display sexually abusive behaviour. The aim is too provide an overview of the current literature and thinking around these behaviours and treatments for them. The research in this area is still very much in its early stages and therefore should be viewed as pointing the way for the future development of this work.
Cross Ref	N/A
Superseded Docs	N/A
Action Required	N/A
Timing	N/A
Contact Details	Professor Catherine Itzin/Bob McDonald Victims of Violence and Abuse Prevention Programme Wellington House 133-155 Waterloo Road London SE1 8UG Bob.McDonald@dh.gsi.gov.uk Catherine.Itzin@dh.gsi.gov.uk
For recipient use	

Ministerial Foreword

As a society, we are united in condemning any form of sexual abuse. The Government has a duty to protect the public from the perpetrators of these crimes. But we are also committed to addressing prevention; stopping individuals developing these behaviours, particularly when they are children or adolescents.

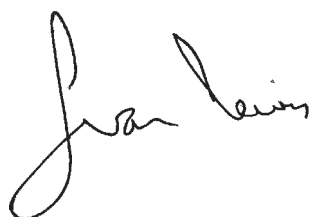
There is an increasing awareness within the Department of Health and the Home Office that a substantial minority of those who come into contact with the police in connection with sexual offences are adolescents. Health practitioners have been working for many years to develop interventions which are both therapeutic and preventative to ensure that the majority of these young people do not go on to become adult sexual offenders and those most at risk can be helped.

The Government has responded to these challenging issues and as part of our co-ordinated response, a joint Department of Health and Home Office conference was held in autumn 2003. This report stems directly from that conference and is an important publication because it provides the information we need to build our work in this area. It shows the real problem of under reporting sexually abusive behaviour among children and highlights the need for an effective and common assessment process which should lead to more effective treatment strategies.

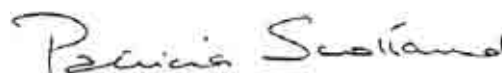
We intend to take these recommendations forward as part of the development of a National Strategy for Young People Who Sexually Abuse. This strategy will help to promote a more consistent and co-ordinated approach, in terms of screening, assessment and treatment, to those young people who display sexually inappropriate behaviour.

Significantly the Government has established a National Sexual Violence and Abuse Stakeholder Advisory Group with a focus on prevention and on increasing access to support and health services for victims of sexual violence and abuse. The Victims of Violence and Abuse Prevention Programme (VVAPP) is a joint Department of Health and Home Office initiative which includes work on adolescent and adult sexual abusers and offenders.

We remain committed to helping young people who engage in sexually abusive behaviour – for their own sake and the sake of those children at risk of being abused by them and we believe that this report will prove useful to current and future workers in this field.



Ivan Lewis
Department of Health



Baroness Scotland
Home Office

The needs and effective treatment of young people who sexually abuse: current evidence

Nathan Whittle, Susan Bailey and Zarrina Kurtz

**Joint Department of Health and National Institute for Mental Health in
England (NIMHE)**

Victims of Violence and Abuse Prevention Programme (VVAPP)

In Partnership with the Home Office

October 2006

Nathan Whittle	Research Assistant Adolescent Forensic Service, Bolton Salford & Trafford Mental Health NHS Trust
Susan Bailey	Foundation Professor of Child & Adolescent Forensic Mental Health. University of Central Lancashire Consultant Child & Adolescent Forensic Psychiatrist Adolescent Forensic Service, Bolton Salford & Trafford Mental Health NHS Trust
Zarrina Kurtz	Consultant in Public Health and Health Policy/Medical Adviser on Mental Health Commissioning to the National Specialist Commissioning Advisory Group of the Department of Health

Contents

1.	Executive Summary	3
1.1	Sources	3
1.2	Introduction	4
1.3	Associated problems in young sexual offenders	4
1.4	Risk Factors	5
1.5	Treatment approaches	5
1.6	Evidence for the effectiveness of service provision	6
1.7	Summary	6
1.8	Issues of concern and recommendations	7
2.	Introduction	9
2.2	Defining sexually abusive behaviour	9
2.3	Typology of young people who display sexually abusive behaviour	10
2.4	The prevalence of the problem	14
3.	Associated problems in young sex offenders	17
3.1	Learning disability	17
3.2	Mental health needs	18
3.3	Conduct Disorder	18
3.4	Post-traumatic stress disorder (PTSD)	20
3.5	Educational needs	21
4.	Risk factors	22
4.1	Previous abuse	22
4.2	Other risk factors	25
5.	Assessment	30
5.1	Identification/assessment	30
5.2	Risk Assessment	33
6.	Treatment approaches	37
6.1	Key principles	37
6.2	Prevention	38
6.3	Types of therapy	45
6.4	Placement	47
6.5	Post-discharge	49

6.6	Some good practice issues	50
6.7	Young people with learning disability	54
6.8	Young female sexual offenders	55
6.9	Young people from ethnic minorities	57
6.10	Drop-outs	57
7.	Evidence for the effectiveness of service provision	61
8.	Summary	65
9.	Issues of concern and recommendations	67
9.2	Strategy and commissioning	67
9.3	Identification and assessment	69
9.4	Service provision	69
9.5	Evaluation and research	71
	References	74
	Appendix 1	86
	Appendix 2: Service descriptions	87

1. Executive Summary

1.1 Sources

1.1.1 The paper draws upon:

- International research papers published in the area of young people who display sexually abusive behaviour and young people who have been sexually abused.
- A conference on 17th October 2003 hosted by the Department of Health and the Home Office. This brought together experts working within the field to discuss research, experiences and ways forward in addressing the needs and treating young people displaying sexually abusive behaviours.
- A background paper discussing the mental health needs of young people who display sexually abusive behaviour, produced for the above conference.
- Experts' comments on the draft paper.

The aim of this paper is to draw upon these sources in order to provide a base line of evidence on the needs and effective treatment of young people who display sexually abusive behaviour. It is not intended as a systematic review, but to provide an overview of the current literature and thinking around these behaviours and treatments for them. A MedLine and PsycInfo search was carried out for papers examining the needs of these young people and relevant treatment approaches. The findings reported from these papers were deemed by the authors to be the key findings or provide support for findings from other research. Training and assessment manuals provided by some delegates at the Department of Health/Home Office conference have been consulted and referred to along with the presentations and comments from those in attendance. The research in this area is still very much in its early stages and therefore should be viewed as pointing the way for the future development of this work. Some of the studies cited refer to young people under 24

and some under 18, however they all cover adolescence and provide valuable insight into the work being carried out.

1.2 Introduction

- 1.2.1 Due to the lack of knowledge regarding 'normal sexual development' and childhood sexuality it is difficult to define sexually harmful behaviours committed by young people. As research in this area has focused on young people who have committed serious sexual crimes there is little known about young people who display sexually problematic behaviours that have not reached the level where it would be regarded as criminal.
- 1.2.2 Young people who display sexually abusive behaviours are not a homogenous group both in terms of their offending patterns and their psychosocial needs.
- 1.2.3 Youth Justice Board figures state that sexual crimes account for 0.6% of young people that result in some sort of disposal (Youth Justice Board, 2005 – see *Appendix 1 for a breakdown by age, gender and ethnicity*), although most figures of the prevalence of sexually abusive behaviour will under-estimate the problem due to under-reporting of abusive behaviours and experiences.

1.3 Associated problems in young sexual offenders

- 1.3.1 Young people with learning disabilities are over-represented in figures for young people who display sexually abusive behaviours, although this may be due to the more repetitive nature of their offending behaviour, which results in them being more likely to be caught. Young people who display sexually abusive behaviours often have multiple concurrent psychosocial needs including conduct disorder, post-traumatic stress disorder and educational needs.

1.4 Risk Factors

- 1.4.1 Retrospective research has shown that the majority of young people who display sexually abusive behaviours have themselves been abused. However, while attention is often paid to the cycle of abuse, the majority of young people who have been abused do not go on to abuse.
- 1.4.2 Cluster analysis has revealed a number of static and dynamic risk factors, including high impulsivity and emotional loneliness and low self-esteem and assertiveness.

1.5 Treatment approaches

- 1.5.1 Primary, secondary and tertiary treatment approaches need to be considered in order to address the needs of young people who display sexually abusive behaviours. In reducing risk and building resilience, it is important to engage parents in prevention and it is imperative that young people are not labelled and stigmatised through engaging in therapeutic interventions.
- 1.5.2 It is important to gain as much knowledge regarding the needs of each young person through a comprehensive assessment process as, in order for intervention programmes to be effective, they should be tailored to meet the needs of the individual as opposed to a 'one size fits all' approach. Several tiers of intervention are needed, from those under parental supervision through to treatment services conducted within secure placements. Practitioners have expressed that treatment should be abuse-specific, holistic and multi-modal.
- 1.5.3 It is important to address issues within the community and provide follow-up services for those young people discharged from residential treatment services. This will require the co-ordination of service providers and constant communication between them. Resilience-based approaches to working with

young people displaying sexually abusive behaviours should aim to promote competence and healthy functioning, support positive developmental growth and enhance protective factors through holistic intervention.

- 1.5.4 The key to effective assessment and intervention is good communication between all agencies involved in the care and treatment of young people displaying sexually abusive behaviours.

1.6 Evidence for the effectiveness of service provision

- 1.6.1 The lack of randomised control trials and the ethical issues of withholding treatment from this group of young people mean that it is not possible to conduct prospective studies into the effectiveness of treatment, although it is possible to look at the effect retrospectively. Longitudinal studies are needed to measure the effectiveness of existing programmes, not only with regards to recidivism rates, but also in regard to how these programmes meet the psychosocial needs of these young people.
- 1.6.2 There is a serious issue of drop out rates from treatment programmes, which should be addressed by tailoring programmes to meet the individual needs of those young people who attend them. Young people cannot be blamed for dropping out of treatment programmes that do not address their needs.

1.7 Summary

- 1.7.1 Sexual abuse by young people is a serious issue, although the majority do not continue their sexual offending into adulthood. A great deal is known about the risk and protective factors for young people displaying sexually abusive behaviours, but the majority of this has come from young people within the Youth Justice System and therefore must be treated with caution as the

majority of offending does not come to the attention of the Criminal Justice System. It is imperative that behaviours are acknowledged, treated and researched prior to them being regarded as criminal (either through the seriousness of the behaviour or age of the young person).

- 1.7.2 There is a need for a robust assessment tool to assess the risk and protective factors for each individual that can then inform effective interventions. There are good indications of the requirement for holistic intensive and long-term interventions, tailored to the needs and circumstances of each individual child and family, based on detailed and holistic assessment.

1.8 Issues of concern and recommendations

- 1.8.1 There is a need to develop effective regional strategies for assessment and treatment and to support young people within their communities as far as is safely possible. Key issues are the diversity of interventions and the regional and national co-ordination of services. A secure database of services that can be accessed by professionals will aid this and increase the visibility of these services within professional networks.
- 1.8.2 It is important that multi-agency working takes place and a lead agency should be decided upon to co-ordinate the care and treatment of young people. Decisions made in this area should only be made after consultation with all the relevant agencies.
- 1.8.3 A common assessment tool should be developed based on advances in research, that draws upon information provided by the young person, their family and all the relevant social systems within the young person's life, including education services. There is a collective responsibility that these children are identified and appropriate service responses delivered, among universal health and education services and social services assessment of children in need.

1.8.4 There is a need to systematically evaluate research projects in order to identify good practice and build upon this in practice.

2. Introduction

2.1 This paper is a scoping review to produce a platform from which to develop an informed national framework of evidence based prevention, early identification, assessment and treatment for all children presenting with sexually abusive behaviours of varying nature and level of severity. The importance of co-ordinated policy, practice and research and development is explored with the recognition that important research projects are already underway, which will greatly inform the evidence-based treatment over the next 3–5 years. Not intended as a systematic review, this paper will provide a baseline of the current evidence surrounding the needs and effective treatment of young people who display sexually abusive behaviours. The age groups targeted in the research cited here has not been dwelt upon as some studies refer to young people under 24 and some under 18. However, they all cover adolescence and provide valuable insight into the work being carried out in this area.

2.2 Defining sexually abusive behaviour

2.2.1 There are currently difficulties in defining sexually harmful behaviours committed by young people due to the lack of literature on childhood sexuality and the lack of knowledge regarding 'normal sexual development' (Lovell, 2002). Definitions of abuse and offending do not translate into simple categories of behaviour as, while sexual abuse can be broadly defined as an imposition of power on a vulnerable individual, offending can be more specific and the differing perspective of professionals can hinder the consensual identification and recording of cases (Grimshaw & Salmon, 2000).

2.2.2 Ryan & Lane (1997) have offered an explanation of sexually abusive behaviour, defining it as:

...any sexual interaction with person(s) of any age that is perpetrated (1) against the victim's will, (2) without consent, or (3) in an aggressive, exploitative, manipulative or threatening manner.

2.2.3 With the focus of research within this area being on those young people who have committed serious sexual offences and the sexual behaviour of pre-adolescents, little information has been revealed about adolescents whose sexual behaviour problems has not reached the level where it would be considered as criminal offending (Letourneau, Schoenwald & Sheidow, 2004).

2.2.4 *Concepts, common measurements and definitions*

From a research, practice and policy perspective, in order to advance knowledge it is essential to understand the participants in any investigation and therefore to use concepts and measures that are widely used and validated. In the adult mental health research literature, even if we are unsure of the validity of, for example, certain DSM IV and ICD 10 diagnoses, the careful use of these criteria facilitates communication and understanding of the nature, assessment and treatment of, in this case, young sexual abusers. However, as Vizard (2002) has pointed out, there is as yet no diagnostic category for paedophilia for those under 16 years of age, either within DSM IV or ICD 10, suggesting the creation of a new DSM V and ICD 11 category of 'sexual behaviour disorder of childhood' with the appropriate operational criteria for the purpose of diagnosis, thus labelling the behaviour and not the child.

2.3 Typology of young people who display sexually abusive behaviours

2.3.1 The research literature on adolescent sexual offending and its relationship to juvenile delinquency strongly indicates that adolescent sex offenders are not a homogeneous group (Epps, 2003). In studying four matched groups of adolescent boys who had committed (i) sexual offences against children below the age of 10; (ii) sexual offences against female peers and women; (iii) non-sexual violent offences; and (iv) non-sexual and non-violent offences, three clusters of young offenders were identified, with sexually abusive young people represented to a greater or lesser

extent in each group. The three groups displayed the following characteristics:

- Developmentally impaired group – more of the child sex offenders, some sexual assaulters; higher levels of enuresis, encopresis, speech & language delay, learning difficulties; lower IQ, higher levels of victimisation through sexual abuse (intra- and extra-familial), emotional abuse and bullying; higher levels of sexually inappropriate behaviour at school and in the community; higher number of recorded sexual offences, especially in children's homes; higher levels of social isolation and withdrawn behaviour.
- Violent, physically abused group – there were no child molesters in this group; some of the young people had committed sexual offences against peers and women; there were higher levels of violent non-sexual offending; higher levels of childhood physical abuse; higher levels of violence at school, failure to attend and expulsion; no social isolation or withdrawn behaviour at school; more foster and residential placements; more placement moves; more offending and convictions of any type; no property-only offenders; more substance misuse; more likely to blame criminal behaviour on mental and emotional instability; more likely to have relationship problems with father or father figure; more evidence of hypermasculinity.
- Socialised delinquent group – most well adjusted; higher number of sexual assaults on female peers and women; some child sex offenders; fewer with a history of emotional and behavioural problems, neglect, sexual and physical abuse, special educational needs and peer relationship problems; lower number of foster and residential placements and fewer placement moves; higher full scale IQ and verbal IQ; higher reading age; higher age at first recorded offence; less delinquency; fewer family and educational problems; lower self-reported psychological problems.

- 2.3.2 Young people who commit sexual crimes against children show greater deficits in their psychosocial functioning than those who offend against pubescent females, as well as displaying less aggression in their offending and being more likely to be related to their victims (Hunter et al, 2003). Investigating 40 community projects and 3 Young Offender Institutions (YOIs), the Adolescent Sexual Abuser Project in Oxford identified 479 adolescent sex offenders, among whom 60% were identified as child molesters (60% of whom had abused a child outside of their own family), 4% were identified as exhibitionists, and 36% as peer aggressors/rapists (62% of whom were identified specifically as rapists) (Beckett, Gerhold & Brown, 2003).
- 2.3.3 Hendriks & Bijleveld (2004) contrasted adolescents who had abused children with those who had abused peers and found that levels of neuroticism and psychopathology were significantly higher in the child abusing group, who were also significantly more likely to have been bullied, have a lower self image and less contact with their peers. Significantly more adolescents in the child-abusing group had abused males and they were more likely to be related to their victims. Adolescents defined in this study as 'peer abusers' were actually more likely have to assaulted a stranger than a true peer. They used significantly more physical violence than the child-abusing group and this also tended to be present in their previous offending careers. However, while it is appealing due to the level of ease to categorise individuals displaying sexually abusive behaviours by the age of their victims, meaningful and reliable subgroups may have little to do with this (Worling, 2001).
- 2.3.4 Worling (2001) carried out a cluster analysis of personality variables on adolescent male sex offenders and found four distinct typologies. While there were significant differences between the groups, which provided external validation for the subtypes, there were no significant differences in terms of offender age, social economic status, history of child sexual

victimisation or age and gender of their victims. The four subtypes identified were as follows:

- Antisocial/Impulsive: Antisocial, impulsive, anxious and unhappy
- Unusual/Isolated: Unusual, undependable, isolated, controlled, trusting and spontaneous
- Overcontrolled/Reserved: Emotionally overcontrolled, responsible, reserved, reliable, suspicious of others and rigid
- Confident/Aggressive: Confident, self-centred, outgoing, aggressive, sociable, dependable, organised and optimistic

The Antisocial/Impulsive group represented over half of the young people who were most likely to have received criminal charges for their sexual offences and to have been victim of abusive, physical discipline from their parents.

2.3.5 Butler & Seto (2002) distinguish between two types of adolescent sexual abusers in terms of the persistency of their delinquent behaviours, proposing that life-course sexual offenders are antisocial and have a history of conduct problems that resemble other criminally versatile offenders. In comparison with sexual offenders whose antisocial behaviour does not persist beyond adolescence and non-offenders, those whose antisocial behaviour is more persistent show greater levels of anger, hostility and the endorsement of procriminal attitudes. The level of antisocial behaviour displayed by adolescent-only offenders is more similar to non-offenders than life-course persistent offenders.

- 2.3.6 In a regional adolescent service, sexually abusive young people were subtyped into two distinct categories: the sexual abuse reactive group (SARG), characterised by a history of childhood sexual abuse; and the emotional abuse reactive group (EARG), characterised by a history of childhood emotional abuse and inadequate maternal care. The SARG satisfied the criteria for paedophilia while the EARG targeted adolescent girls (Mutale, 2003).
- 2.3.7 In order to address the diverse population of these young people, further research and guidance is required, particularly in relation to those with a learning disability. The guidance provided by central government needs to be reviewed in order to ensure that there is clarity about the young people being referred to, i.e. all abuse by young people or solely sexual abuse (Hackett, Masson & Phillips, 2003).

2.4 The prevalence of the problem

- 2.4.1 Most figures of adolescent sexual offending will underestimate the extent of the problem, as the reporting rates for sexual offences to the police are still very low and this is probably exacerbated further when the offence is carried out by a young person (Langstrom, 2001). In outlining the development of treatments for adolescent sex offenders in Australia, Grant (2000) suggests that many offenders escape detection due to the reluctance of wider communities to accept or discuss issues of a sexual nature, regardless of whether or not they would be viewed as deviant.
- 2.4.2 Home Office statistics show that in 2003 approximately 25% of people convicted for sexual offences were aged between 10 and 24, although, due to the nature of these crimes, the prevalence rates are almost certainly an underestimate. According to the Youth Justice Board sexual offences account for 0.6% of crimes committed by young people aged 10 to 17 that result in disposal

of some sort (total number in 2002/03: 1,664), with a peak age in young people at 15 years and males accounting for 97% (Youth Justice Board, 2005). YJB figures cannot include acts carried out by children under ten years old and below the age of criminal responsibility. NSPCC projects are now reporting seeing a number of young people under the age of 10 (Lovell, 2002). Children under 10-years old make up 31% of young people seen by the NSPCC project in Coventry and 30% of those seen by NSPCC Lincolnshire between 1999 and 2002 were under 10-years old (*ibid*). The Young Abusers Project in London sees young people aged between 5 and 21 years who have displayed sexually abusive and other high-risk behaviours towards others (Vizard et al, 2003). While it is not possible to infer the scale of the problem in this age group from these individual areas, it is clear that these problematic behaviours can be identified and that services can be put in place to work with these young people before they reach the age of criminal responsibility.

- 2.4.3 In auditing the provision in Inner London for young people who have sexually abused, Grimshaw and Salmon (2000) found that the number of abusers identified by child protection services (24) and Youth Offending Teams (69) varied greatly. Less than half of the YOT cases were known to social services. This discrepancy was considered to contribute to obstacles in establishing the type and extent of need in this group. In the Prison Service Juvenile Estate (19 establishments: 14 for males and 5 for females), a total of 2,575 young men and 100 women are in placements commissioned and funded by the Youth Justice Board (YJB). In April 2003, 76 young men were categorised as having committed a sexual offence as their index offence. This does not include young people with sexual offences who are on remand, or where the index offence is more serious than a sexual offence (Thomson, 2003).

2.4.4 There are no studies upon which to base population estimates of the prevalence of sexually abusive behaviour, although estimates of officially known cases over a year suggest that about one in 1,000 12-17 year-olds is identified as displaying abusive behaviour. There is no accepted system of classification and diagnosis, and the literature indicates that abusive behaviour is under-reported (Grimshaw & Salmon, 2000).

3. Associated problems in young sex offenders

3.1 Learning disability

- 3.1.1 Young people with learning disabilities are over-represented within services for sexual offenders, although Thompson & Brown (1997) caution against concluding that young people with learning disabilities are more likely to sexually abuse than their peers. Young people with learning disabilities who sexually offend may be more repetitive and habitual in their choice of victims, and the location and frequency of behaviour (Hackett & Masson, 2003), as well as being more impulsive in their offending and more naive when challenged (Thompson & Brown, 1997). These factors may result in their over-representation in service statistics, although, probably, there is also under-reporting due to reluctance amongst parents, carers and professionals in accepting sexuality as part of the developmental process of young people with learning disabilities.
- 3.1.2 An outpatient service for individuals with learning difficulties found that 30% of those referred for offending behaviour were for sexual offences (Thomas & Singh, 1995). In their national survey of the prevalence of sexually abusive behaviours among adolescents using services across England and Wales, Hackett & Mason (2003) found that adolescents with a learning disability made up 25% of the workload for 53% of youth offending teams.
- 3.1.3 Amongst those in contact with G-MAP, the North West treatment service for young people who have sexually abused, young people with some form of learning disability constitute approximately half of referrals (O'Callaghan, 1998) while in another specialist service, Vizard et al (2003) report that 42% have mild learning disability and that 48% have statements of special educational needs.

3.2 Mental health needs

3.2.1 Clinical experience of working with young people who have sexually abused suggests that they have multiple psychosocial and behavioural problems, with their sexually abusive behaviour being just one of them (Vizard, 2004). An assessment service in the North West of England include the following indicators for concern (informed by research) when evaluating risks and needs in implementing treatment responses: high levels of trauma (e.g. own childhood victimisation or the witnessing of domestic violence), a formal diagnosis of conduct disorder, poor social and intimacy skills, and highly compulsive/ impulsive behaviours. Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), depression or other significant mental health problems are also considered a high concern (although not research informed) (AIM, 2001). Among young people referred to a national adolescent forensic child and adolescent mental health service, i.e. that have a mental health disorder, it is estimated that approximately 25% have abused children and women (Epps, 2004).

3.3 Conduct Disorder

3.3.1 While there is a higher prevalence of conduct disorder in young people who sexually offend compared to non-offending young people, it is not directly related to sexual recidivism. However, early onset conduct disorder is related to non-sexual recidivism – with offence-related factors such as the committing of an offence in a public area and involving a victim unknown to the young person more indicative of a risk for sexual recidivism (Langstrom, 2002). The study of adolescent sexual offenders has shown that those with a history of non-sexual offences have significantly more conduct problems in childhood than those with only a sexual offence history although when compared to non-sexual offenders, they are comparable in their childhood conduct problems (Butler & Seto, 2002). Dolan (2004) states that studies

of children with conduct disorder suggest that genetic or neurodevelopmental factors make more significant contributions to those who are notably callous than the parenting style used to socialise children.

3.3.2 Young people who sexually offend against children differ from those who offend against adolescent females display greater deficits in psychosocial functioning and an increased likelihood of being related to their victims (Hunter et al 2003). Research in Australia has found that sibling incest offenders are more likely to have other reported behavioural problems, including conduct disorder, than young people who have abused only outside of their family unit (Rayment-McHugh & Nisbet, 2003). However, in a study of adult sexual offenders who began offending before the age of 18, Knight & Prentky (1993) found that those who had been arrested during adolescence displayed more difficulties relating to attention, motor skills and speech and language than those who had committed sexual offences during adolescence and not been caught. They were also found to display more impulsive, aggressive and generally antisocial behaviour. The authors hold these characteristics as reasons for the increased prevalence of conduct disorder amongst young abusers, reasoning that it is their impulsivity and general criminal behaviour during adolescence that alerts them to the police rather than their sexual offending. This highlights the difficulties faced when attempting to determine the prevalence of sexual abuse carried out by young people and the mental health needs of this group (Langstrom, 2001). From these findings, Langstrom (2001) warns of overestimating precipitating characteristics, such as conduct disorder, as our knowledge concerning young people who sexually abuse comes primarily from those within the criminal justice system.

3.4 Post-traumatic stress disorder (PTSD)

- 3.4.1 PTSD in young people who have sexually abused may be caused by their own experiences of sexual abuse (if they have been abused), exacerbated further if they are not supported in their disclosure of this, and also by their own abusive behaviour. McMackin et al (2002) in studying 40 male sex offenders between the age of 12 and 17 identify that traumatic experiences and related emotions can act as triggers for young sexual abusers with 95% of their sample population having experienced a traumatic event that would be classified as a Criterion A traumatic event in PTSD, while 65% were judged to meet the criteria for PTSD by clinicians. In identifying offence triggers, intense fear was found in 37.5% of the sample, helplessness in 55% and horror in 20%. In 96% of these cases the offending behaviour was seen as relating directly to the individuals' trauma experiences. Of the sample in this study, 12.5% had been exposed to either physical or sexual abuse and 47.5% had been exposed to both, with a mean age of 4.6 years for onset of physical abuse and 7 years for sexual abuse.
- 3.4.2 Vizard (2004) cites a study by Hunter et al (1993), which reported upon the mental health problems displayed in a residential treatment programme for adolescents, finding that all of the female sexual offenders had been abused themselves and that nine out of ten of them were diagnosed with PTSD. The reluctance in accepting the abusive behaviour of these young people is heightened when the abuse is perpetrated by girls and they are regarded as being "abuse reactive", with focus placed upon their own abuse experiences, which results in many of them being omitted from official statistics (Vizard, 2004).
- 3.4.3 Through contrasting a group of sexually abused girls aged between 6 and 12 with control groups from a psychiatric outpatient department and from a general paediatric clinic, Cosentino et al (1995) found that the girls who had been sexually abused displayed more sexual behaviour problems

than the two control groups. Abuse perpetrated by fathers or stepfathers involving intercourse was associated with a marked increase in these behaviours, and a sub-group of girls among those who had histories of being sexually abused was found to have forced their sexual behaviours upon their siblings and peers. All of these girls had been subjected to prolonged sexual abuse that involved physical force, lasting more than 2 years, perpetrated by a parent.

3.5 Educational needs

3.5.1 In studying the characteristics of 227 young people who had been subjects of child protection strategy meetings due to allegations of sexually abusive behaviour over a six-year period, Taylor (2003) found that 70% had at least one reported school problem. The most prevalent problem was undisciplined behaviour (49%), followed by underachievement (48%), aggression/bullying (37%) and isolation (33%). Inappropriate sexual behaviour as a problem in school was reported in 28% of the sample and 13% had been bullied by other children. Of the 30% reported to have no school problems, some were reported by teachers to be “model pupils”.

4. Risk factors

4.1 Previous abuse

- 4.1.1 The data from most studies are obtained retrospectively; for example, Burton, Miller & Shill's (2002) study of 216 adolescent sexual offenders and 93 non-sexual offenders found that 79.4% of the sexual offenders reported having been sexually victimised compared to 46.7% of the non-sexual offenders. This study grouped the results by the gender of the perpetrator (male, female or both male and female), the method of abuse (e.g. physical force, threats, games, babysitting) and the worst victimisation reported (penetration, fondling or exhibitionism). Compared to the non-sexual offending group, significantly more of the sexual offending group reported having been abused by both males and females (43.9% compared to 9.6%, $p < .000$), were coerced by physical force (48.4% compared to 19.7%, $p < .000$) and experienced penetrative abuse (75% compared to 46.2%, $p < .000$). Bearing in mind the problem of under-reporting of sexual abuse when conducting research on adolescent sex offenders, the rate of sexual victimisation reported by this group is typically around 40% (Burton et al, 2002) although, while attention is often paid to the vicious circle of abuse, most of those who are victims of abuse in their own childhood do not go on to abuse others (Langstrom, 2001).
- 4.1.2 Based on a study of 227 children and young people in the West Midlands who had been accused of sexually abusing a child, Taylor (2003) found that males who chose male victims, including those who had chosen both male and female victims, had higher rates of previous abuse for both sexual and other kinds of abuse, than those who chose only female victims. While there were no significance levels calculated, the authors expressed that this finding is consistent with those of other studies (i.e. Becker & Stein, 1991); Benoit & Kennedy, 1992; Hanson & Slater, 1988; Worling, 1995). In younger abusers (pre-adolescence) the rates of previous abuse are higher, identified as ranging from 65% to 100% and it is more likely that the sexual

behaviours that they display are learnt and follow closely their own experiences (Hackett, 2003).

4.1.3 Systematic screening was carried out in a sample of 140 young people, aged 12-18 years, referred to a regional adolescent psychiatric service. This revealed that sexually abusive adolescents shared many characteristics with young people who presented with non-sexually abusive antisocial or offending behaviour. The development of sexually abusive behaviour among young people was significantly associated with male gender, poor maternal care, longer duration of childhood sexual abuse, and substance misuse. Sexually abusive behaviour was also significantly associated with ADHD symptoms, impulsive behaviour and suspiciousness, while school age prostitution was significantly associated with anxiety symptoms, sexual concerns, and self laceration (Mutale, 2003).

4.1.4 A prospective longitudinal study (7 – 19 years duration) of 224 male victims of sexual abuse found that 12% (n = 26) had subsequently become sexual abusers, all having committed their first offence before the age of 20 (Salter et al, 2003). Salter et al (2003) found that other risk factors increased the likelihood of a young victim becoming an abuser, particularly material neglect (odds ratio (OR) = 3.4), lack of supervision (OR = 3.0) witnessing serious intrafamilial violence (OR = 3.1) and having been abused by a female person (OR = 3.0). These findings support those of Skuse et al (1998), whose preliminary study found that the risk of adolescent boys, who are themselves victims of sexual abuse going on to abuse others is increased by life events that may not be related directly to their experience of abuse. In comparing 32 sexually abused boys who have subsequently abused others to 46 who had not, these authors identified a number of risk factors that preceded the sexually abusive behaviours in the sub-group of abusers (*found only in the cross-sectional, not the prospective, study):

- Lack of supervision

- Rejection by the family
- *Discontinuity of care
- Sexual abuse by a female
- Witnessing serious intrafamilial violence (physical and sexual violence directed against maternal figures)
- *Experience of physical abuse
- Cruelty to animals

4.1.5 In this sample, the severity of their own abuse was not found to be a risk factor. Boys who had not been abused who went on to abuse other children were also subject to families where there were high levels of physical violence directed against maternal figures.

4.1.6 Salter et al (2003) found that no single putative protective factor, nor a composite protective index, significantly reduced the risk of paedophilic behaviour. In their sample, it was found that at moderate levels of risk, a number of protective factors (good relationships with adults, siblings or peers, years spent in 'good' foster care, having non-abusive male or female carers) did lessen the likelihood of abusive behaviour being perpetrated by boys who had been sexually abused. However, protective factors have been found to be less effective in preventing abusive behaviour among boys with higher levels of risk (Bentovim, 2002).

4.1.7 Sexual offenders often report adverse childhood experiences (Beech & Mitchell, 2005) and the experience of an affectionless controlling style of parental bonding is highly prevalent amongst this group (Craissati, McClurg & Browne, 2002). Ward, Hudson & Marshall (1996) proposed how three insecure attachment styles are related to three different types of sexual offending:

- *Preoccupied attachment* will tend to lead to the individual seeking approval from others and will sexualise attachment relationships. This group are more likely to engage in sexual contact with children.
- *Dismissing attachment* increases the likelihood of the individual demonstrating hostility to others, which makes them more likely to offend against adult women.
- *Fearful/disorganised attachment* would lead the individual to seek intimacy via impersonal sexual encounters.

4.1.8 The result of an insecure attachment means that individuals may have difficulty interpreting social cues, thus affecting responses to others. Assertiveness can be regarded as hostility, friendliness as seductiveness, fear as surprise and anger as disgust (Burk & Burkhart, 2003).

4.2 Other risk factors

4.2.1 Based on the clinical records of 100 boys and girls aged between 3 and 7 who had been sexually abused, Hall et al (1998) outlined six significant predictors of later sexual behaviour problems in young people who have been sexually abused that related specifically to the abusive acts they had experienced. The young people in this study were assigned to three distinct groups based on the behaviours they presented with – developmentally “expected” child sexual behaviour; “sexualised” behaviour that is entirely self-focused; developmentally problematic interpersonal sexual behaviour). As this study was an exploratory pilot with a total of 237 variables, the authors decided that in order to reduce both Type I and Type II errors they would use the Bonferroni procedure to recalculate the significance levels (revised $p \leq .0002$). The six factors were:

- Sexual arousal of the young person during abuse ($p < .00001$)

- Sadism within abuse ($p < .0002$)
- Child blaming themselves for being abused ($p < .00001$)
- Young person groomed by perpetrator ($p < .00001$)
- Young person made to be “actively involved” in abuse ($p < .0002$)
- Young person made to watch perpetrator in sexual acts ($p < .0002$)

4.2.2 Grimshaw and Salmon (2000) summarise the evidence relating to offender profiles that seem to suggest that some offending is situational, in that the offender shows no particular preference for sexual offending. But ‘situation’ means more than ‘opportunity’; otherwise far more offending would be predicted than appears to be the case. Instead it appears that something in the situation offers an outlet for behaviour that might be directed elsewhere under other circumstances. It is therefore suggested that such offending fits into a wider delinquent pattern (Epps, 1999), with adolescent sexual offenders who also commit non-sexual offences displaying more behaviour and childhood conduct problems and fewer prosocial attitudes and beliefs than those who only commit sexual offences (Butler & Seto, 2002). Studying 114 adolescent male offenders, Butler & Seto (2002) found that in comparison to sex-only offenders, young people who committed both sexual and non-sexual offences scored higher on measurements of childhood conduct problems ($p < .001$), antisocial orientation ($p < .01$), substance abuse ($p < .01$), education/employment problems ($p < .001$), family problems ($p < .05$), peer relation problems ($p < .001$) and accommodation problems ($p < .05$).

4.2.3 The importance of the role of the young person’s family is clear as a protective factor, although, in research carried out by Great Ormond Street Hospital, 36% of maternal responses to disclosure of abuse were perceived as negative and only 44% wholly supported the young person (Hyde, Bentovim & Monck, 1995;

Monck et al, 1996). Subsequent mental health problems, measured as levels of anxiety, depression, PTSD and self esteem, while being partly influenced by the abuse itself, were significantly related to the support (or lack of it) that the young person received from their mother when disclosing their own abuse (Bentovim, 2002).

4.2.4 From studies of adults describing their own abuse, a minority of young people who sexually abuse continue this abusive behaviour into adulthood (Grubin, 1998). A study, in which data on risk were collected prospectively, before the victim of sexual abuse had committed his first offence, found that the witnessing of intrafamilial violence was significantly associated with re-enacting of sexual abuse after adjusting the odds ratio (OR = 39.7) (Skuse et al, 1998). Factors associated with this repetition are reflected in a high-risk sample, referred to a regional adolescent service, where 26.5% of 12 – 17 year-olds who had been abused went on to develop sexually abusive behaviour (Mutale, 2003).

4.2.5 By means of a cluster analysis of adolescent sexual offenders, Beckett, Gerhold & Brown (2003) identified three clusters with the third group sharing characteristics with recidivist adult child abusers from the STEP Programme. This group accounted for 22% of those in the cluster analysis although the re-offending rate in this group is not yet known. Adult recidivist child sexual abusers begin their sexual deviancy problems in adolescence and are characterised by a pattern of static and dynamic factors (*ibid*). (See Table 1).

Table 1: Comparison of recidivist adult child abusers and juvenile child abusers (Beckett, Gerhold & Brown, 2003)

	'High Deviancy' Recidivist Adult Child Abusers (STEP)	'Cluster 3' Juvenile Child Abusers
Personality		
Impulsivity	-	High
Self-esteem	Low	Low
Emotional Loneliness	High	High
Assertiveness	Low	Low
Locus of Control	External	External
Victims	Mostly male, mostly extrafamilial	Mixed, mostly extrafamilial
Developmental	90% abused	80% abused
Predicts treatment outcome	Yes	Awaiting results
Predict Recidivism	Yes	Awaiting results
Offence-specific		
Cognitive Distortions	High	High
Emotional Congruence	High	High
Justifications	High	High

4.2.6 Vizard et al (2003) outlined the influence of child psychopathy, highlighting the predictive validity of callous-unemotional traits (Frick & Ellis, 1999) along with impairments in moral reasoning and empathy, low distress with regard to the negative impact of behaviour and an aggressive response to fear or sadness (Gretton et al, 2001) being linked to violent recidivism in both adult and adolescent sexual offenders.

4.2.7 According to Worling & Langstrom (2003) the best-supported risk factors for estimating the risk of an adolescent committing a

sexual offence are the presence of deviant sexual interests, a history of committing previous sexual assaults, past sexual offences against two or more victims, committing offences against strangers, a lack of intimate peer relationships and a failure to complete offence-specific treatment programmes. Based upon an extensive review of the literature of factors associated with reoffending rates of young people who have sexually offended, the authors state that these factors have “the most defensible support and, therefore should be relied on most in the assessment of reoffending risk.”

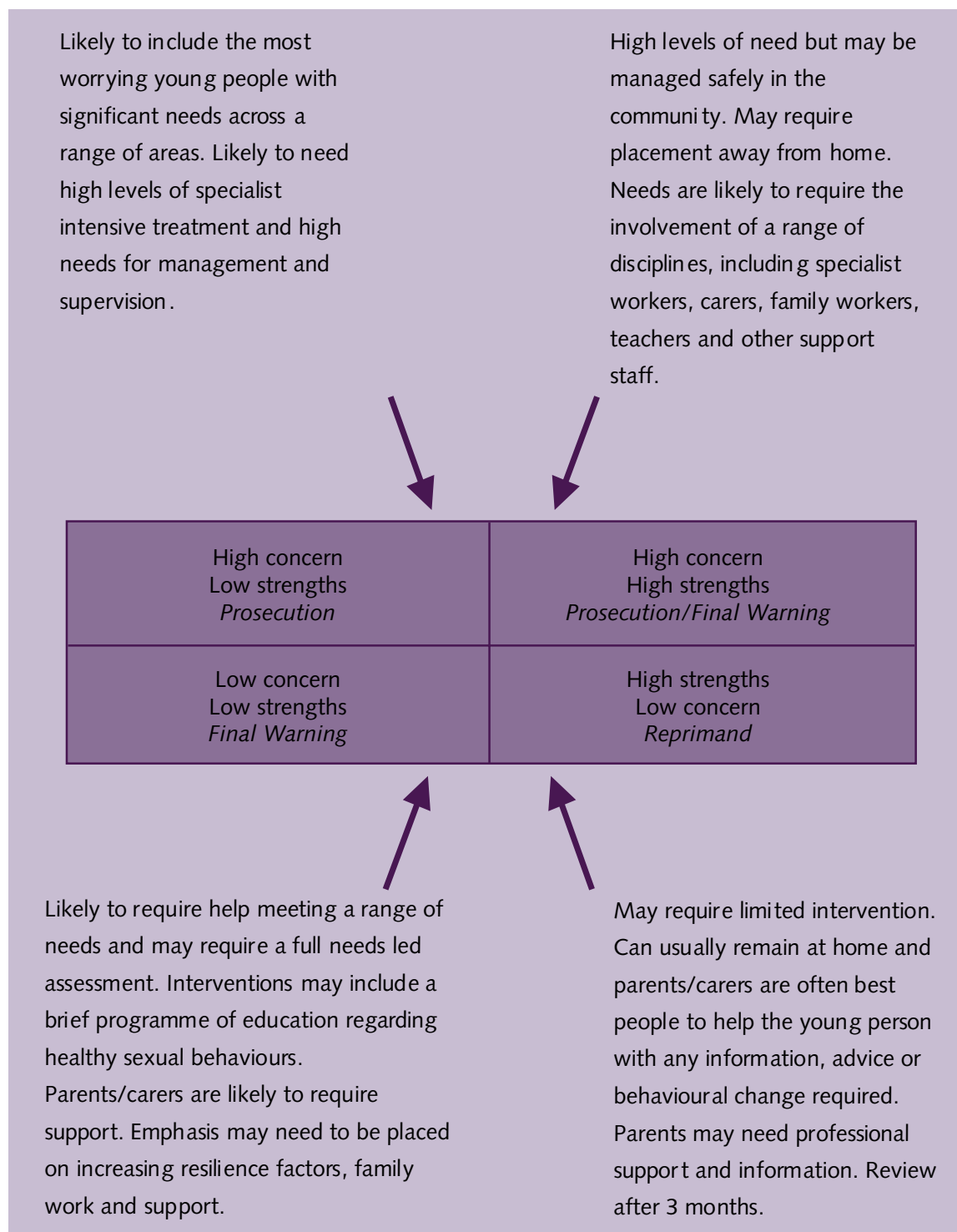
5. Assessment

5.1 Identification/assessment

- 5.1.1 Identification and assessment processes are the key to getting treatment right and currently more access is needed to assessment services. There is a need to identify and clarify different needs between sub-groups of young people displaying sexually harmful behaviours; for example, between those who have abused young children and those who have abused peers, and those displaying neuropsychiatric problems, learning disabilities, Asperger's syndrome and emotional instability (Misch, 2003). If there is a sub-group of young people displaying sexually harmful behaviours who have a higher recidivism risk, they need to be identified as early as possible, in order to effectively target interventions.
- 5.1.2 In order to gain as much knowledge about each individual young person during assessment, multi-service screening must take place to gather information from within the young person's many social systems, including their family, school, peer group and community. For example, young people arrested for, and admitting, their first sexual offences in Greater Manchester are bailed for 20 days to allow for an in-depth assessment to take place. The AIM Project assessment procedure involves the lead agency identifying the assessors, consultant and a date for the completion of the report, which should then assist in decisions regarding the identification of where to place services. This assessment procedure is designed to enable all professionals to then engage in dialogue with the assessors, the young person and their family in order to identify needs and motivate change. The process involves 4 domains of assessment (Offence specific, Developmental, Family/Carers and the Environment), which inform concern and strength continuums. These factors contribute to the outcome matrix (see *Figure 1*), a model which aims to support decisions made by the professionals by providing a framework within which to structure decision making (AIM, 2001).

- 5.1.3 The AIM Project also outlines assessment procedures for young people with learning disabilities and for children less than 10 years of age who display sexually problematic behaviours, as well as assessments for parents and carers.
- 5.1.4 Assessment models, while examining the possible risk of re-offending, should also focus on the young person's strengths, and interventions must demonstrate a balance between risk reduction and strength enhancement (O'Callaghan, 2003). When conducting an initial assessment with a young person arrested for and admitting their first sexual offence, AIM consider a continuum of indicators of strengths that focus upon the individual (e.g. the ability to reflect and understand consequences of offence behaviour, willingness to engage in treatment), familial factors (e.g. parents demonstrating good protective attitudes and behaviours, family having clear and positive boundaries) and other factors beyond this, such as the young person living in a supportive environment with an available network offering support and supervision. AIM also highlight in their strength continuum the importance of the young person having a good relationship with their school or employer. These indicators are considered to be high strengths (Print, Morrison & Henniker, 2001).

Figure 1: Outcome Matrix – from “Working with children and young people who sexually abuse: Procedures & Assessment” (Print, Morrison & Henniker, 2001)



5.1.5 Local co-ordinating bodies should ensure the availability of local assessment services that meet the needs of professionals working with these young people across both the child protection and the youth justice system (Hackett, Masson & Phillips, 2003). Guidance documents produced both locally and nationally currently offer very little information about interventions following initial assessment. The co-ordination of services at a local level should ensure that identifiable intervention provision is available to all professionals, specifically addressing referral routes and the funding issues within such services (*ibid*). In order to address this, guidance should be developed at a national level stating how effective working across child welfare and the youth justice system can be achieved, addressing issues both at a local and individual level (*ibid*).

5.2 Risk Assessment

5.2.1 In planning prevention programmes it is essential to have knowledge of risk factors for both disorders and triggered behaviours, that is both characteristics of the individual or environment that are present prior to the onset of the disorder and that increase the risk of the disorder developing in those exposed compared to those who are not (Harrington & Bailey, 2004). Professionals working with young people who display sexually abusive behaviours are often asked to carry out risk assessments that predict the likelihood of an individual committing further sexual or violent crimes. This is achieved either through the completion of an actuarial risk assessment, which provides no guidance on how research-identified risk factors can be reduced, or via clinical judgement, which until recently has been regarded as both idiosyncratic and not thoroughly grounded in research (Beech, Fisher & Thornton, 2003).

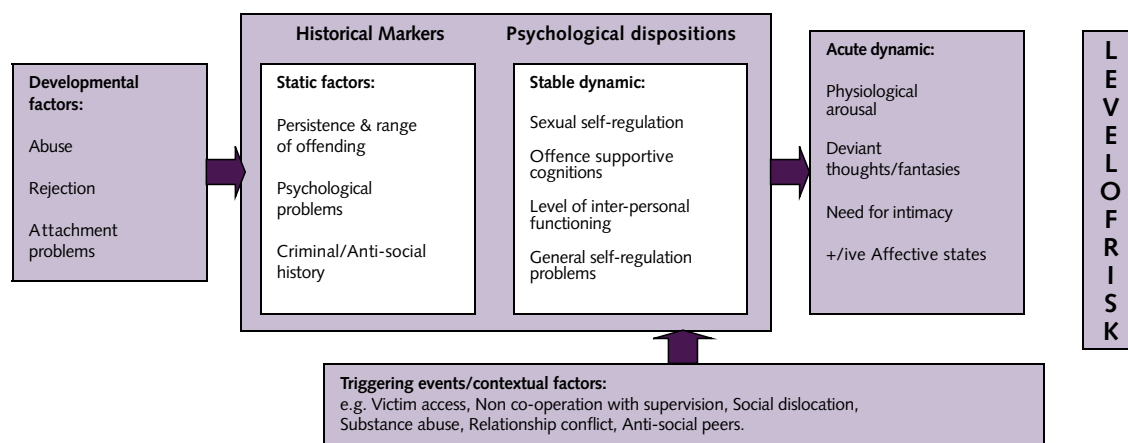
5.2.2 The two research-based risk assessment tools for use with adolescent sexual offenders – the Juvenile Sex Offender Assessment Protocol (J-SOAP) devised by Prentky et al (2000) and the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) developed by Worling and Curwen (2001) – are still in the early stages of development and aim to assess both the historical static factors related to previous sexual offences and dynamic factors, such as sexual interest, pro-offending attitudes, social factors and self-management (Beech Fisher & Thornton, 2003). Early research aimed to validate these tools have shown encouraging results although neither tool can yet provide definitive feedback regarding their predictive validity for future sexual offending – the critical question that they both aim to address (Worling, 2004; Righthand et al, 2005).

5.2.3 The employment of actuarial risk assessment instruments has a number of limitations as they are based upon static risk factors and regardless of how accurate this may be, they do not take into account changes in context (Beech & Ward, 2004). Ward & Beech (2004) outline an aetiological model for the prediction of risk in the light of four distinct psychological mechanisms that interact with one another. These mechanisms are:

- Intimacy and social skill deficits;
- Distorted sexual scripts;
- Emotional dysregulation; and
- Cognitive distortions

Their model (*Figure 2*) takes into account developmental factors, static factors, stable dynamic factors, acute dynamic factors and the triggering events that constitute contextual risk factors. In contributing to treatment programmes, the model acknowledges different contextual and triggering factors and that treatment needs vary according to the stable dynamic risk factors, which requires treatments to follow risk profiles on an individual basis.

Figure 2: An aetiological model of risk (Ward & Beech, 2004)



5.2.4 While the majority of research on antisocial behaviours has focused on risk factors, less attention has been paid to factors that improve outcomes – protective factors (Harrington & Bailey, 2004). It is not enough to state that the absence of a risk factor subsequently constitutes a protective factor, rather it must reduce the risk of a disorder or behaviour while still in the presence of a risk factor (Garmezy & Masten, 1994). The inclusion of the promotion of protective factors in prevention programmes may be more acceptable to those participating and could therefore have an important advantage over those programmes that focus solely on risk factors (Harrington & Bailey, 2003).

5.2.5 Recent years have seen the development of tools such as the Structured Assessment of Violence Risk in Youth – SAVRY (Borum, Bartel & Forth, 2003), which is based on structured empirically guided clinical judgement and is notable for the fact that it includes dynamic risk factors and protective factors that are rarely assessed by such instruments (Witt, 2003). The protective factors considered in the SAVRY are prosocial involvement, strong social support, strong attachment and bonds, a positive attitude towards intervention and authority, a strong commitment to school and the presence of resilient personality traits. While the presence of risk factors has a stronger relation to the development of antisocial behaviours

than the absence of protective factors, the diminishment of problem behaviours is more strongly related to the presence of protective factors (Jessor et al, 1995). This tool has since been expanded with the development of the SEX SAVRY for use with young people at risk of displaying sexually violent behaviour. In the Netherlands, the development of the BARO (Doreleijers & Spaander, 2002), originally focusing on the detection of psychopathology in young people, has spawned the SEXBARO for use with young sex offenders (Doreleijers, 2004). This tool aims to help advise judicial authorities with greater objectivity and quality, optimise the relationship between diagnostic quality and investment of time taking into account the diversity in the young people assessed and the offences they have committed (Doreleijers & Spaander, 2002).

6. Treatment approaches

6.1 Key principles

6.1.1 A number of key principles on the handling of juvenile sexual abuse cases by child protection and youth justice agencies were recommended by inter-departmental groups on sex offending and on child abuse in June 1994. The principles cited below were seen as priority issues at the time and still remain relevant today:

- a) the potential for conflict between the welfare of the juvenile abuser and the welfare of the victim must be recognised. In such cases the victim's welfare should be paramount over that of the offender.
- b) many juvenile abusers are themselves in need of care and protection and services must be provided for them. All juvenile abusers must, nevertheless, be held accountable for their abusive behaviour and made to recognise that it is unacceptable.
- c) child protection procedures should be followed in respect of both the child victim and the young abuser.
- d) an inter-agency and multi-disciplinary approach is essential in the management of the juvenile abuser.
- e) the management of the juvenile abuser should include comprehensive assessment and the option of treatment. Where, following assessment, treatment is to be provided, this should take place as soon as possible as this increases the likelihood of positive change in behaviour.
- f) consideration should be given to all the factors relating to the child victim and the juvenile abuser before a decision to prosecute is taken. This requires liaison and exchange of information between the process of work with the child victim and the abuser.

- g) sentencers should have access to information on the juvenile abuser's background of behaviour, and assessment of suitability for whatever type of treatment is available. It is recommended that all sentencers dealing with such cases should receive appropriate training on sexual offending.
- h) where possible the family of the juvenile abuser should be involved in the management of the case. This is particularly important where treatment is proposed, since involvement and commitment by parents is helpful if treatment is to be sustained.

6.1.2 Primary, secondary and tertiary approaches should be considered, covering prevention, treatment and longer-term support.

6.2 Prevention

6.2.1 Definitions of prevention within the public health sphere outline three kinds of preventative activity (Caplan, 1964; National Academy of Sciences, 1994). These are outlined in *Table 2* (Harrington & Bailey, 2004).

Table 2: A practical framework for interventions in adolescence (Harrington & Bailey, 2004)

Prevention (Primary Prevention: activities that reduce the incidence of a disorder in those who do not already have it)	Universal (aimed at the whole population)
	Selective (aimed at groups at high risk because of risk factors)
	Indicated (aimed at groups who have minimal but detectable signs of a disorder)
Treatment (Secondary Prevention: includes case identification and standard treatment for an established disorder)	Case identification
	Standard treatment for disorders known to increase the risk of a disorder developing
Maintenance (Tertiary Prevention: aim to reduce the recurrence of a disorder/behaviour and reduce any complications arising from it)	Compliance with long-term interventions.
	Aftercare and reduction of complications

6.2.2 Primary prevention addresses the need to build resilience and minimise risks, and includes family support, the Sure Start programme, and work in schools such as safe dating programmes. Relevant issues that can be addressed through the National Curriculum include consent, coercion, and the use and abuse of alcohol. However, effective prevention programmes require a clear definition of the problem that is being prevented (Harrington & Bailey, 2004), which is difficult in the context of sexually abusive behaviour displayed by children and adolescents due to the lack of a concrete behavioural definition.

6.2.3 Secondary intervention, importantly, will aim to break the cycle of abuse, where the abused child subsequently becomes an abuser. Here, while some research supports the social learning hypothesis (e.g. Burton, Miller & Shill, 2002), it is essential to take other factors into account. Intervention may be aimed at young people known to be at risk: identified sexually and physically abused children, those in contact with the youth justice system for non-sexual crimes; children on the 'at risk' register,

and children looked after by the local authority. It is evident that the roots of the abusive behaviours displayed by the young person, and therefore targets of effective interventions, do not lie solely with the young person (Bentovim, 2002).

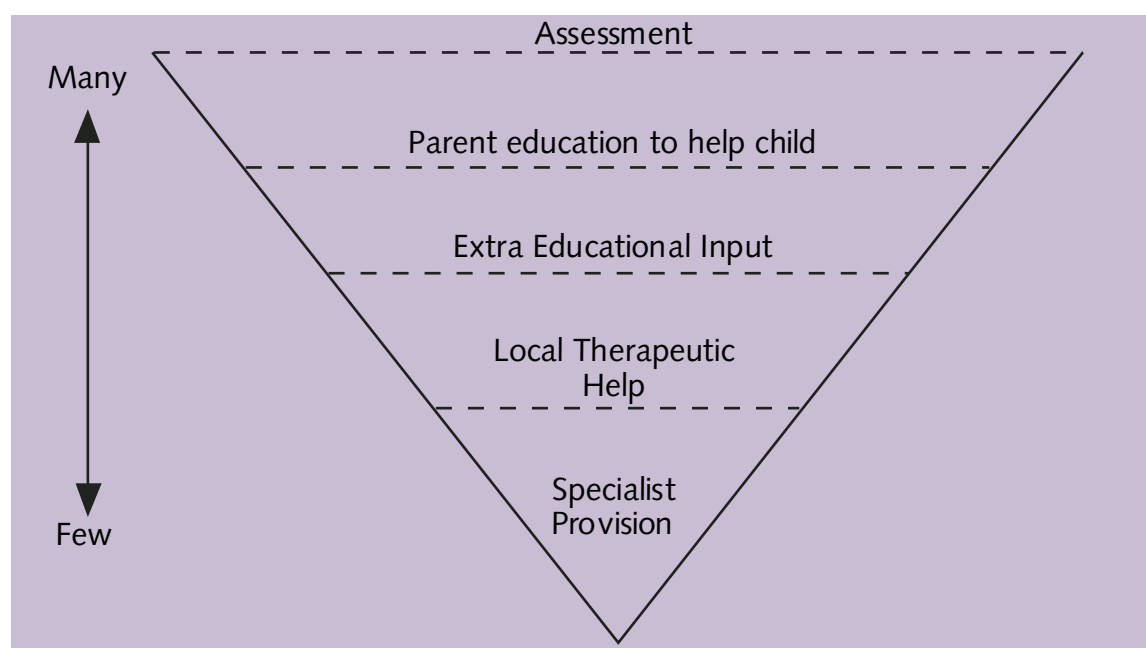
6.2.4 The third tier focuses upon those young people who are already displaying sexually harmful behaviours (Beckett, Gerhold & Brown, 2003). A continuum of service intensity should follow an in-depth assessment, which, as AIM point out, would ensure that young people enter into the right part of the system, preventing unnecessary use of specialist, intensive resources with lower risk cases. This would also support earlier interventions, with families offered appropriate levels of service. AIM outline the consequences of an inadequate initial response, including:

- Under and over-estimation of risk;
- Failure to provide the appropriate services;
- Low concern cases referred for intensive and lengthy intervention programmes;
- High concern cases not receiving sufficient level of intervention;
- Neglect of wider family and social factors influencing offending behaviour;
- Failure to engage parents; and
- Inter-disciplinary conflicts and miscommunication (AIM, 2001).

6.2.5 This involves several levels of treatment and service intensity, moving from a parental level, through general education, local therapy and finally to specialist therapy (Ryan, 1999) aiming to address various levels of need and concern (see *Figure 3*). In surveying practitioners working with young people displaying sexually harmful behaviour, Hackett, Phillips and Masson (2003) reported that 84% strongly agree that there is a need to develop

a tiered approach as some young people referred to treatment services will continue to pose a significant risk, requiring significant input whereas this will not be the case with the majority of young people.

Figure 3: Continuum of service intensity – Morrison (2001), adapted from Ryan (1999)



6.2.6 It is important to engage parents as they play a vital role in the reduction of risk and building resilience. In order to make a hopeful prognosis for treatment and the prevention of a victim of sexual abuse becoming a perpetrator, parents must be able to accept their roles and responsibilities, believing what the young person discloses and not blaming them for any pressures they may face from abusive partners. As previously stated (4.2.3), the level of mental health problems is significantly related to the maternal support that a young person receives when disclosing their own abuse (Bentovim, 2002). Parenting work should be developed to enable parents and carers to have a language with which to talk to their children about sexually harmful behaviour.

- 6.2.7 Many types of preventive interventions are being carried out within YOTs and social services, often jointly with the voluntary sector, such as NCH, NSPCC and Barnardo's. Family group conferencing and restorative justice are promising approaches (Barry, 2003). The Lucy Faithfull Foundation provides a wide range of programmes, focusing upon training for both staff and parents, providing assessment and treatment for children of all ages displaying sexually harmful behaviour, as well as working with child and adult victims of abuse (Brotherston, 2004).
- 6.2.8 The Sheffield-based "Junction" project offers parents training in protective behaviours, and includes teacher training and learning mentors to assist in identifying resilient behaviours (Misch, 2003). As well as providing services to young people who display less worrying behaviour and their families, these kinds of services play an important role in identifying those at higher risk, who may require more intensive interventions. There is a growing concern that adolescents who display sexually problematic behaviours, although not criminal, may be at risk of subsequent engagement in sexual crimes and it appears that these young people have more in common with younger children who display sexual behaviour problems than those of adolescent sexual offenders (Letourneau et al, 2004). The criminalising of such sexualised behaviours may be harsh as these young people may respond well to home-based treatment (*ibid*).
- 6.2.9 It is imperative that early victims of sexual abuse are not stigmatised and regarded as inevitable abusers. As the majority of young people who display sexually abusive behaviours do not continue these behaviours into adulthood, there is an issue to be raised regarding them being placed on the Sex Offender Register as this is a legacy that will then be with them throughout their lives and may lead to an increase in self-harming in this group (Thomas, 2003).

- 6.2.10 The prevention of sexually problematic and abusive behaviours could be divided into four tiers with education regarding 'normal' sexual behaviour forming the first tier. Informing parents, health visitors, nurseries and schools of basic information, ensuring that young people who display behaviours that cause concern are referred to the next tier. This second tier could advise parents and schools without criminalising the behaviour. A third tier of community-specialised projects could offer assistance if the behaviour persists. The final tier would be for those young people who are assessed as being too high risk for a community service or whose sexual behaviour indicates a need to protect the public (Haarbosch, 2003).
- 6.2.11 Specialist programmes need to consider the whole spectrum of offenders and potential offenders. Beckett, Gerhold & Brown (2003) outlined interventions for those young people classified as low need and low risk adolescents (e.g. programmes around victim empathy, relapse prevention, general/violent offending and primary health interventions), and for young people who are believed to have high needs and pose a high risk (e.g. mandated comprehensive cognitive/behavioural treatment, offence specific/social adequacy, emotional regulation/impulse control).
- 6.2.12 Training is needed to develop practitioner skills at all of these levels. Organisations such as Barnardo's and G-MAP currently provide training in some areas to teachers, teaching assistants, mentors and parents, but there is a need for protocols to be put in place to work with the police and Area Child Protection Committees (ACPCs) (Barnardos, 2003). The importance of training designated teachers has also been highlighted, as schools are often keen to be involved, supporting the young person and keeping them in education (Henniker, 2003). This training has been provided by the Manchester based project, G-MAP.

- 6.2.13 Within treatment services it is important that there is a framework in place for the provision of supervision for therapists due to the sexualised nature of the therapeutic relationship, which may pose a danger if overlooked. Such a framework would help reduce the risk of further abuse of vulnerable young people, reduce the danger of false allegations of sexual abuse by the therapist and is an essential part of reliable individual therapy (Hawkes, 2002).
- 6.2.14 Whilst it is important to address the needs of young people displaying sexually abusive behaviours, the family as a whole must not be neglected in the process. The development of more specific services supporting parents and carers affected by their children's sexually abusive behaviours should be developed, including opportunities for parents to meet others whose families have been affected by sexual aggression (Hackett, Masson & Phillips, 2003).
- 6.2.15 Money spent on interventions for antisocial young people in services is influenced by many other factors, including the attitudes of politicians and the general public towards behaviours considered to be deviant, as well as the portrayal of individuals and behaviours in the media (Harrington & Bailey, 2004). The location of existing services, government policies and the organisation and attitudes of those agencies that fund services greatly influence service development (*ibid*).

6.3 Types of therapy

6.3.1 There are high levels of consensus about the orientation of treatment work, including its aims, goals and components, among the services and practitioners surveyed by Hackett & Masson (2003); that these should be:

- Abuse-specific – the aim is to help young people understand and accept responsibility for their behaviour and develop strategies and coping skills to avoid abusing or offending again;
- Holistic – the goal is to promote the physical, sexual, social and emotional well-being of children and young people who have sexually harmed/abused; and
- Multi-modal – the goal is for carers to acknowledge what their child has done, believe in and support change, and take on responsibility for changing the context of the family.

6.3.2 The following theoretical approaches to intervention were endorsed as a core approach by those providing treatment among the wide range of services surveyed by Hackett, Phillips & Masson (2003):

- cognitive behavioural, by 56%
- relapse prevention, by 36%
- family systems theory, by 28%
- psycho-educative, by 26%
- ecological, by 15%
- psychodynamic, by 13%

- 6.3.3 Drawing upon validated treatment strategies, including strategic and structural family therapy, behavioural parent training and cognitive-behavioural therapy, multi-systemic therapy addresses factors within the individual and the family as well as extrafamilial factors that are related to serious antisocial behaviour in young people, including sexual offending. Correlations with nonsexual offending suggests that sexual offending is multidetermined and treatment approaches must therefore be flexible in order to address the multiple determinants of offending behaviour within the young person's naturally occurring social systems (Borduin & Schaeffer, 2002). Building on Bronfenbrenner's (1979) social-ecological perspective on behaviour – viewing the youth and their family, school, work, peers and community as interconnected systems – multi-systemic interventions target problems both within and between these systems, preferable within a natural environment with an individualised and flexible intervention so as to increase the ecological validity.
- 6.3.4 There is currently too much emphasis on small group work in treatment at the expense of skill development and contextual factors, e.g. family and peer problems (Epps, 2003), which will be factors that are pertinent to the young person's life upon discharge, and issues have been raised as to what happens to young people once they are discharged from treatment services (*see section on post-discharge at 6.5*).
- 6.3.5 Hawkes (2002) outlines the basic requirements for any therapist offering an individual treatment service to young people who have sexually abused. These are:
- clear child protection strategies in place with a policy of open-confidentiality requiring information regarding undisclosed child sexual abuse to be shared with the police, social services, and other relevant bodies;
 - experience of specialist training;

- a reliable research or theoretical base for the therapy;
- identifiable aims of treatment, both in general and specific to each patient;
- access to other disciplines;
- a physical safe setting for the therapist and young person with agreed guidelines for maintaining this;
- supervision from a skilled source;
- evaluation of the outcome.

6.4 Placement

- 6.4.1 Decisions as to whether a young person is prosecuted for a sexual offence should be made after a comprehensive assessment has taken place. The need to balance concerns regarding the young person should be considered, along with their strengths, and comprehensive models of assessment can support informed decision-making.
- 6.4.2 According to the assessment model developed by AIM and G-MAP, young people considered to be of high concern (e.g. having previous convictions for sexual offences, a formal diagnosis of conduct disorder, self-reported sexual interest in children, evidence of detailed planning) and possessing low strengths (e.g. appearing not to care what happens, having no social support) would be likely to require high levels of specialist intervention, management and supervision. The assessment model also supports that prosecution would be the best course of legal action for young people in this group. However, once this decision has been made there is still a need to consider where and how these services will be implemented. However, the strong support for tiered interventions that do not label young people displaying low-level problematic sexual behaviours means that it is possible to support them within their communities and possibly within their families (AIM, 2001).

6.4.3 In studying young people within foster care placements who have been sexually abused or who have abused, a particularly under-researched area, Farmer & Pollock (2003) draw out four areas for the effective management of abusive behaviour highlighting the need for supervision, effective sex education, the modification of behaviours and attention to the needs of the young person that may be underlying their behaviours. The placement of young people in Multidimensional Treatment Foster Care has shown some good early outcomes, specifically targeting the following areas:

- Reinforcement of normative and prosocial behaviours;
- Providing the young person with close supervision;
- Closely monitoring peer associations;
- Clear and consistent limits with non-violent consequences for rule violations;
- Encouragement of the young person to develop positive work habits and academic skills;
- Supporting a family member thereby increasing the effectiveness of parenting skills;
- Reduction of family conflict;
- Teaching the young person new skills for forming relationships with a positive peer group and bonding with adult mentors and role models

(Fisher, 2000).

6.4.4 Intensive support of young people with even seriously problematic sexual behaviour problems should be possible within the community, with therapeutic interventions offered by Child and Adolescent Mental Health Services likely to be as effective as those from a specialist service, although a lack of placements can confound this (Hackett & Mason, 2004 – Personal Communication). Through interviewing boys who had

attended outpatient treatment after sexually abusing other children, Lawson (2003) found that they recognised the damage caused to their relationship with their community and regarded their treatment as a step forward in repairing this relationship.

- 6.4.5 An audit of placements and provisions across the UK should be carried out and maintained in order to ensure an adequate supply of good quality care and accommodation for any young person unable to reside at home and specialist foster schemes should be encouraged to accommodate these young people (Hackett, Masson & Phillips, 2003).

6.5 Post-discharge

- 6.5.1 There is a need for follow-on treatment facilities in the community when young people are discharged from residential placements, as they will need to adjust to life back in the community and will require ongoing supervision and support. An illustration of supported re-integration back into society is the post-discharge service in Liverpool in which the young person is supported and trust is built up with supervision and support between themselves and a designated worker. This support is then gradually phased out depending upon their needs, i.e. 24-hour supervision at discharge, reduced to 16-hours, 8-hours and 4-hours per day to a point where daily supervision is no longer required (Mutale, 2003).
- 6.5.2 Support will be needed from the Prison Service when post-discharge services are being planned in order for them to be successful, as they play a major role in implementing treatment programmes for young people within the secure estate, preparing them for release. Successful post-discharge facilities will require the co-ordination of services, working together to support young people in all aspects of their re-integration into the community, as these young people should still be regarded as children in need. This issue supports the need for local

services that, in small teams, can have a substantial impact on young people.

- 6.5.3 When young people are discharged from treatment services there is a need to provide ongoing support for their parents (Hackett, 2003). Working closely with parents can give clues as to the developmental challenges that the young people face and bring a variety of benefits that can contribute to the change process (Hackett, 2001). Contributing to the process allows parents to demonstrate their commitment to the young person and increase parental self-esteem, as well as encouraging the young person to remain in the intervention and thus reduce the likelihood of re-offending (*ibid*).

6.6 Some good practice issues

- 6.6.1 Epps (1999) has stressed that adolescent sex offenders are not a homogeneous group, and that some, especially the sexual assaulters, are virtually indistinguishable from non-sexual offenders (Weinrott, 1996). He adds that current psychological thinking about criminal behaviour suggests that it has multiple determinants, and that offences that appear similar in nature may nevertheless be associated with different causal factors. Accordingly, using offence-related labels such as 'adolescent sex offender' to prescribe treatment seems to lack psychological sophistication and does little to guarantee that serious offenders are matched to the most appropriate types of intervention.
- 6.6.2 It is important to look at both the short term (i.e. current abuse) and long term issues (i.e. young people who currently display abusive behaviours, which may continue leading to them becoming adult paedophile offenders). Attention should also be paid to young people who abuse peers or older victims, as the current focus of work in this area tends to be on young people who abuse younger children. If initial assessments gather information from as many social systems in the young person's

life, the number of areas for possible intervention will be increased. A resilience-based approach to working with young people displaying sexually abusive behaviours should aim to promote competence and healthy functioning, support positive developmental growth and enhance protective factors through holistic intervention. O'Callaghan (2003) advocates adopting a resilience based approach to work with young people who sexually harm (see *Table 3*).

Table 3: A resilience-based approach to work with young people who sexually harm

Objectives:

- Promote competence/healthy functioning
- Support positive developmental growth
- Enhance protective factors

Strategies:

- Ecological/holistic assessment and intervention
- Evaluation based on risk and asset formulation
- Target risks
- Assist skill development and adaptive change

(adapted by O'Callaghan (2003) from Masten and Powell 2003).

6.6.3 These approaches should target risks, and assist skill development and adaptive change, and should be evaluated on a basis of risk and asset formulation (Masten & Powell, 2003). O'Callaghan (2003) cites specific targets for change as part of a resilience based approach (see *Table 4*). The inclusion of as many services in the young person's life in both the assessment

of their behaviour and in the treatment process will increase the ecological validity of such interventions as a more global picture of the young person's life will be available.

Table 4: Specific targets for change (O'Callaghan, 2003)

Specific targets for change:

- Sexual arousal [Risk]
- Social functioning [Asset]
- Emotional self-regulation [Risk]
- Coping skills [Asset]
- Thinking patterns [Risk]
- Positive life goals [Asset]
- Family support system [Risk/Asset]
- Social support system [Risk/Asset]

6.6.4 Of utmost priority in the assessment and treatment of young people who have displayed sexually harmful behaviours is the co-operation between practitioners involved in the young person's life in order to aid joined up working. Each young person will require different types of support at different times and communication between all services is required if the young person is to benefit fully from all of the interventions offered. In studying the foster care placements for young people with a history of being sexually abused or of displaying sexually abusive behaviours, Farmer & Pollock (2003) found that in 53% of the cases where a young person had abused others, this information was not shared with the caregivers.

6.6.5 In discussing the possible role of education services at the Department of Health/Home Office conference (October, 2003)

some practitioners expressed that education services could play a vital role in assessment and treatment programmes. They should be able to identify sexually problematic behaviours during early education and provide information on peer relations throughout childhood and adolescence. Early education services are not currently well linked into Mental Health Services and there is a need for more joined up working in this area with the involvement of BEST Teams, Pupil Referral Units and SEN Teams in the assessment and treatment process.

- 6.6.6 The Responsivity Principle of treatment states that service provision should be modelled individually to the learning styles and abilities of the offender with assessments used to find the best strategies for addressing their needs and therefore maximising the benefits of treatment (National Institute of Corrections, 2000). Interventions should be planned and delivered flexibly to take account of the individual situation of each young person. It is not appropriate simply to roll out a generic treatment approach for use with young people of all ages and intellectual ability. In providing effective services, the views of service users should be sought and recognised along with perspectives from families (Hackett, 2003). Coupled with this is the need for a higher profile for the needs and rights of these young people. Children who display sexually harmful behaviours are, first and foremost, children and should not be regarded as mini-adult sexual offenders.
- 6.6.7 Every effort should be made to promote the likelihood that young people remain in the treatment programme for the optimum period (*see section 7 on Service Effectiveness*). When developing services, there is a need to evaluate the young person's general propensity for offending, as well as their sexual interests and behaviours. In young people who also commit non-sexual offences, interventions should address the wider behaviours aimed to violate the rights of others, as this group of young people are more likely to reoffend than those who only commit sexual offences (Butler & Seto, 2002).

6.7 Young people with learning disability

- 6.7.1 There is overrepresentation of young people with learning disabilities in treatment services and while their offending behaviour is not regarded as being specifically linked to medical/mental illness, treatment services need to be adapted to meet the specific needs that they present. French (2003) stated that there is currently a lack of specialist services for young people with learning disabilities and for those who are diagnosed with conduct disorder. Also highlighted is the lack of services for violent sexual offenders and for boys who sexually assault non-child victims (Epps, 2003). The North West treatment service, G-MAP, operates on the principle that young people with learning disabilities/difficulties have “the same rights as other young people to develop and express their sexuality, but share the same responsibilities as others in the community to do so in a way that does not abuse or intimidate others.” (G-MAP, 2003).
- 6.7.2 There has been little empirical research conducted in this area, and that which has been carried out suggests that young abusers with learning difficulties may be more repetitive and habitual in their choices of victims, location and frequency of their behaviour as well as possibly justifying these behaviours through a perception of them as normal male behaviours (Hackett, Phillips and Masson, 2003). The habitual and repetitive nature of offending could be the reason for the overrepresentation of young people with learning disabilities in services and these issues should be kept in mind when planning treatments. Consideration of these young people’s social and cognitive functioning should also be considered. Interventions should bear in mind the implications of shorter attention spans and learning based more upon experience, thus requiring a more cautious use of language along with the repetition of messages (*ibid*).

6.8 Young female sexual offenders

- 6.8.1 The majority of research in the area of young people who display sexually harmful behaviours has focused on males and the issue of females sexual abuse has not been addressed to the same extent in either policy or research (Bunting 2005). Denov (2003) hypothesises that the reason for this lack of attention may be the tendency to view females as sexually passive and innocent, which influences broader views within society and subsequently affects legal practices, reporting practices and the responses from professionals. This denial of the potential for females to display sexually aggressive behaviours thus contributes to the lack of recognition of this issue. Matthews, Hunter & Vuz (1997) in examining 67 females and 70 males with a history of sexual offending found that PTSD, depression and anxiety was reported in over half of the female sample and there was a higher frequency of dysfunctional family history in the female sample (77.6% for females compared to 44.3% for males). This study also found that a higher proportion of the female sample had been victims of sexual abuse at a younger age with 64% abused before the age of 5 compared to 25.8% of males. From this work the researchers developed three typologies of young female sex offenders (outlined below).

Table 5: Typologies of young female sexual offenders (Matthews, Hunter & Vuz, 1997)

Type 1 Low offending frequency	Baby-sitting setting Lower history of abuse and family dysfunction Motivated by sexual experimentation
Type 2 Moderate offending frequency	Higher levels of psychopathology Higher levels of family dysfunction Apprehensive about their sexuality Offending mirrors own abuse experiences to differing degrees
Type 3 High offending frequency	Highest level of family dysfunction and psychopathology Younger at time of their own victimisation Over-sexualised behaviours Deviant arousal patterns

- 6.8.2 Research from the United States based on sex offender registration details, which compared 61 juvenile female offenders to 122 juvenile males found that females were younger when first arrested (Vandiver & Teske, 2006; Vandiver & Walker, 2002) and that their victim typology was split more equally between males and females (59% female, 41% male) whereas male offenders had more female victims (69%) (Vandiver & Teske, 2006).
- 6.8.3 The NSPCC surveyed Area Child Protection Committees and found that few of them had local policies and procedures in place that addressed the needs of females who had offended sexually and that the lack of awareness or acceptance of young females displaying abusive behaviours acts as a barrier to effective identification and response to this issue (Bunting, 2005). The recommendations from this report state that both national and local child protection policies should explicitly recognise that females do commit sexual offences and that in providing therapeutic services, professionals should routinely ask about sexual abuse perpetrated by females as a means of increasing the acceptance and understanding of this behaviour (*ibid*).

6.9 Young people from ethnic minorities

- 6.9.1 There is a need to ensure that diversity amongst services is geared towards working with young people and families from ethnic minorities. The NSPCC reports that: *“Appropriate and quality training in the area of sexually abusive behaviour and ethnically sensitive practice are key to providing effective treatment programmes to minority groups.”* Mir & Okotie (2002) state that training in anti-oppressive practice and working with clients and families from ethnic minority backgrounds should be a continuous process of professional development for all practitioners, not a one-off exercise. This study canvassed the views of a small sample of young people from ethnic minority backgrounds, half of whom expressed that they felt they would have benefited from having workers from the same ethnic background as themselves. In discussions with those young people who felt they would have benefited from this, issues surrounding the understanding of language and having a common understanding of religious practices appeared to be significant. The authors do not suggest that young people from ethnic minority backgrounds should always have a worker of the same ethnicity, as some young people may prefer to have a worker who is not of the same ethnicity.

6.10 Drop-outs

- 6.10.1 The effectiveness of treatment can be seriously compromised if a young person does not complete the treatment programme. Adult treatment drop-outs were found to have a recidivism rate for sexual offences five times that of those who completed treatment (Marques et al, 1994). Incomplete sexual offence-specific treatment is associated with an increased risk of non-sexual reconviction in adolescents (Rasmussen, 1999 – quoted in Edwards, 2003). Treatment drop-outs also affects the morale of the staff, and has financial implications. A report from Minnesota Residential Programs for Juvenile Offenders found completion rates of 30-50% (quoted by Edwards, 2003 – see *Table 6*).

Table 6: Treatment completer/drop-out comparison (from Edwards (2003))

	GROUP	
	Treatment completers N=24	Treatment drop-outs N=25
Average time since termination of treatment (range)	38.54 months (6 – 93 months)	45.52 months (6 – 107 months)
OFFENCE CATEGORY		
Sexual	0% (0)	16% (4)
Violent (non sexual)	8.3% (2)	32% (8)
Sexual and/or violent	8.3% (2)	44% (11)
Non violent general	25% (6)	68% (17)

6.10.2 SWAAY's completion rate for the period 1990-1999 was 49%. In studying the differences between young people who completed the SWAAY treatment programme and those who dropped out, Edwards (2003) reported that those young people who completed the treatment were less likely to be subsequently re-arrested for all offence types. However, it is recognised that re-offending rates are only one aspect of outcome measurement and that it can be argued that effective treatment can contribute to an improved life satisfaction, future positive relationships and employment.

6.10.3 Through studying the differences between young people who completed the treatment programme and those who dropped out, the authors have outlined variables that were significantly associated with treatment drop-out:

- Unemployed father;
- School refusal/ truancy;
- Expelled/ excluded from school;

- Fire setting;
- Bullying/fighting/aggression;
- Frequent absconding;
- Prosecution/ conviction/caution for a non-sexual offence;
- Conduct Disorder;
- Emotional Disorder;
- Less than 10 years of age when initial contact abuse was perpetrated;
- Victim 17 years+;
- Male victims;
- Extrafamilial victims;
- Child victim who is known, but not a relative;
- Anal penetration;
- Attitude supportive of sexual offending;
- Unwillingness to alter deviant sexual interests/attitudes;
- Selfish, callous, remorseless use of others;
- Poor regulation of affect and behaviour (impulsivity);
- Completely denies or significantly minimises sexual offences

6.10.4 The pre-treatment variable most significantly related to risk of drop-out was the young person having a previous conviction/caution for a non-sexual offence.

6.10.5 Reducing the number of young people who drop-out of treatment programmes will reduce staff burn out and thus the vital skills they possess will be kept within such services (Edwards, 2003). Cooper (1997) found that the length of staff experience was directly linked to the length of stay of

adolescents in treatment programmes. There is a need for specialist secure facilities in order to contain young people who drop-out of specialist residential placements and remain a high risk as well as the gradual reintegration of others back into community facilities. However, as many young people are not convicted, programmes whose aim is to address the needs of young people within the community should also be developed further.

- 6.10.6 Edwards (2003) suggests a possible strategy of controlled admission of those young people who are likely to drop-out of the treatment programmes, as group dynamics should not be ignored as a contributing factor to treatment drop-out. By only accepting one or two higher risk adolescents at any one time the formation of delinquent peer groups may be prevented.
- 6.10.7 It is important that treatment programmes are catered to meet the needs of the individual young person rather than aiming for a “one size fits all” programme, as young people cannot be blamed for being excluded or dropping out of programmes that do not meet their needs. It is also imperative to recognise that the factors that cause treatment drop-out are the same as factors that increase the likelihood of re-offending and so tailoring programmes to meet the needs of these young people is central to reducing their recidivism rates. Whether their needs can be met is a subject for future research, as it is essential to know what treatment programmes work for as many different sub-groups as possible. (Epps, 2004 – Personal Communication).

7. Evidence for the effectiveness of service provision

- 7.1 A follow up study of 49 young men who had attended a residential treatment programme at SWAAY (Social Work with Abused and Abusing Youth) between 1990 and 1999 (Edwards 2003; 2005), was carried out in order to assess whether there had been evidence of further sexual offending. As a group they were similar in characteristics to a group of young people referred to a community project at Great Ormond Street, over the same period (Skuse et al, 1998). Compared with the Great Ormond street group, the SWAAY group was more emotionally rejected, more likely to be living in the care system, and have a history of prolific and more indiscriminate sexually abusive behaviour, i.e. offences against peers and adults as well as children. Provided the SWAAY group completed the programme there was no evidence of further sexual offending (measured through PNC data, the Offender Index and the last known professional contact with the young person). Now even, as stated earlier, the under-reporting of such offences means that it is not possible to regard such results as absolute. The average follow-up period for this group was 38.54 months (range = 6 – 93 months) (see *Table 7* for breakdown of reoffending rates). Other research on the reconviction rates for sexual offenders has noted that they are at risk of reoffending for many years. Studying the reoffending rates of 419 adult offenders released from prison in England and Wales with a 21-year follow-up, Cann et al (2004) found that 24.6% sexually reoffended. If the SWAAY group continues to follow-up their group, more data on the effectiveness of their treatment will become available.

Table 7: Number (and percentage) of offenders in treatment drop-out and treatment completer groups, with subsequent criminal charges (Edwards, 2003; 2005)

	GROUP	
	Treatment completers N=24	Treatment drop-outs N=25
Average time since treatment ended	38.54 months	45.52 months
Range	6 – 93 months	6 – 107 months
Offence category		
Sexual	0% (0)	16% (4)
Violent (non sexual)	8.3% (2)	32% (8)
Sexual and/or violent	8.3% (2)	44% (11)
Non-violent general	25% (6)	68% (17)

- 7.2 A further study of outcome at SWAAY (Beckett & Gerhold & Brown, 2003) noted that the approach had a significant impact on the dynamic factors that are felt to be amenable to treatment. These factors included social desirability, sexual desirability; self esteem; a measure of emotional loneliness; locus of control in terms of feeling in control of one's life or not; a capacity for empathy with victims; the degree of cognitive distortions; emotional congruence with an inappropriately aged sexual partner; degree of young person's immaturity; the level of sexual knowledge, belief, and justification for behaviour. A relationship between emotional functioning and treatment outcome was found in a study using a classification system that separated the more from the less emotionally troubled delinquents (Atwood, Gold & Taylor, 1989).
- 7.3 Borduin et al (1990) and Borduin & Schaeffer (2002) compared a small group of adolescents assigned to multi-systemic therapy (MST) with those assigned to routine individual therapy in the community. They found that MST had positive results in spheres

such as family and peer relations, school performance and had a long-term reduction in criminal activity. The authors attribute this effect to the focus of the intervention on identified causes and correlates of sexual and other serious offending in adolescence and the flexible nature of the intervention. Using well-validated strategies in the young person's natural environment means that it addresses multiple determinants as opposed to only a small number and therefore provides an intervention that will impact upon the environmental causes of the young person's behaviour, the environment to which the young person will return (*ibid*). Though, by the authors admission, their original study was modest in size and scope (only 16 young people displaying sexually abusive behaviours were recruited) it was the first randomised trial with young sexual offenders to be published and showed promising results. Significantly fewer young people assigned to the MST group were, during the 3-year follow-up, arrested for sexual crimes (12.5% vs. 75.0%, $p < 0.40$), and the mean frequency of arrests for both sexual and non-sexual crimes was also considerably lower (0.12 vs. 1.62 and 0.62 vs. 2.25 respectively).

- 7.4 The placement of young people displaying sexually abusive behaviours into Multidisciplinary Treatment Foster Care (MTFC) has shown positive results in reducing their sexually inappropriate behaviours, although there is doubt as to whether the treatment principles are internalised as the young people still exhibit the propensity to re-offend, as assessed by their carers (Ownbey et al, 2001). Ownbey et al (2001) studied six young people aged between 8 and 12 displaying a range of sexually problematic behaviours (ranging from staring at another person's genitals to anal intercourse) who were placed on an intensive MTFC programme. The core elements of the programme included the placement of the young people in intermediate-term foster care, professional family support, vigorous safety planning, bi-monthly support meetings and educational meetings for parents and training for the placement

families and the children placed with them. After 24 months in the programme, the offence frequency for all six young people was reduced to an average none per week from, in 3 cases, a basepoint average of more than 18 (19.63, 18.56, 18.04). However, on a measure of the young people's propensity to re-offend (10-point scale – 1.00 = extremely unlikely to re-offend; 10.00 = extremely likely to re-offend) 4 of the 6 young people scored 5.00 or above. MTFC has shown promising early results in lowering the general re-offending rates of adolescents who complete 6-months of the treatment, although additional studies are needed to compare the long-term treatment possibilities (Smith, 2004), as well as more research into its use with adolescents displaying sexually abusive behaviours.

8. Summary

- 8.1 Sexual abuse by children and young people is a problem among young offenders and this paper aims to provide a baseline of the evidence of the needs and effective treatments for these young people. There is an accumulating set of research findings, which now indicate that a climate of violence within the family, its origin in the abusive experiences of the parents, does have a profound effect on children and young people's development. Living in a climate of violence appears as a potent factor for boys who have been sexually abused to go on behaving abusively. Young sexual abusers tend to have considerable other social, mental health, learning disability and educational needs. A proportion of children who sexually abuse continue to do so in adult life and a greater number continue to commit non-sexual offences. In studying the financial costs to adult services of young people diagnosed with conduct disorder, Scott et al (2001) found that by age 28, the costs for service provision for those previously diagnosed was 10 times that of those with no diagnosis. They state that antisocial behaviour in childhood is a major predictor of how much an individual will cost society and while the large cost falls on many agencies, few agencies contribute to the preventative measure that would be more cost effective.
- 8.2 The knowledge base surrounding the risk and complicating factors found among young sexual abusers is continually expanding, although almost exclusively among those who have been convicted of an offence. This knowledge indicates the importance of preventive and treatment approaches aimed at ameliorating these factors, and that this will go much of the way to preventing further abuse. The ability to identify those at risk of sexually offending among children in need is an important requirement of all services that work with children and families in all sectors: health, education, social care, and voluntary agencies.

- 8.3 The knowledge about holistic needs of young sexual abusers also highlights the need for robust assessment instruments that can identify key components of a young person's problems, and distinguish those young people most at risk of serious complications and offending behaviours.
- 8.4 This knowledge should allow the development of programmes of intervention that are likely to meet individual young people's needs effectively and appropriately, and to reduce rates of recidivism. A number of specialist services have been developed and have begun to accumulate considerable experience in working with young sexual abusers.
- 8.5 So far, evidence for the effectiveness of these programmes is limited but there are good indications of the requirement for holistic intensive and long-term interventions, tailored to the needs and circumstances of each individual child and family, based on detailed and holistic assessment. Good outcomes should be seen to include improvement in the child's emotional and behavioural state and overall functioning, although reduced offending is likely to follow.

9. Issues of concern and recommendations

9.1 Unhelpful assumptions may bedevil appropriate service responses, e.g. all sexually inappropriate behaviour is the result of psychopathology; once a sex offender, always a sex offender; all juvenile sexual offenders can easily be distinguished from other young people (Epps, 2003). The key principles in draft guidance (drafted June, 1994) for child protection and youth justice agencies, prepared by a joint sub-group of interdepartmental groups on sexual offending and on child abuse, are as relevant nearly ten years later (see section on Treatment Approaches at 5.4 for specific key principles).

9.2 Strategy and commissioning

9.2.1 At present, intervention with young people who sexually abuse is offered by different agencies and services, with different models of provision, with aims to reduce their offending behaviour and address their physical and mental health and emotional needs. Effort is needed to develop effective regional strategies along with a network of specialist regional centres that are able to offer a range of services, including residential, secure, specialist foster care and community placements. As far as possible, young people should be treated effectively and supported safely within their local communities. As services are now seeing a considerable number of young people under the age of 10 who are displaying sexually abusive behaviours, there is evidently a need for early intervention programmes that can be longitudinally followed up. If a subset of young people at higher risk of continuing these behaviours can be identified early, it would be possible to channel resources with the aim of preventing them from re-offending and ending up in specialist residential placements. Diversity in intervention responses is a key issue as they must reflect the complexity of this behaviour. As the majority of sexually abusive behaviour does not come to the attention of youth justice services, the basing of responses simply on a youth justice model would be a grave mistake (Hackett, Masson & Phillips, 2003).

- 9.2.2 It is also important for decisions to be made as to who should take the role of lead agency and hold the funding for the assessment and treatment of each young person. Without this decision being made, simply providing the assessment is likely to lead nowhere. These decisions should be made through opening a dialogue between service providers both on a local and national level in order to address the levels and distribution of relevant funding. Decisions made in this area should only be made after consultation with all the relevant agencies, including the Youth Justice Board, the Probation Service, Social Services, treatment providers, the NSPCC as well as those who actually use the services. Services are currently patchy and most services exist within the voluntary sector. There is therefore a need for a national database of services that can be securely accessed by professionals, giving these services more visibility and thus increasing the chance of access for those young people who need them.
- 9.2.3 A major issue in the provision of treatment services for young people who display sexually harmful behaviours is the availability of funding for places in treatment programmes (Edwards, 2003) and the lack of beds, and court diversion schemes have been raised as a prominent issue for the Home Office (Gibbs, 2004).
- 9.2.4 Thomson (2003) identified that the Youth Justice Board currently does not have a strategy in place for dealing with young people convicted of a sexual offence and that secure establishments lack experience in supporting programme interventions. Once within the secure estate there is a need for a central placement system in order to ensure that these young people gain access to the most suitable intervention and that the intervention programmes are delivered by trained practitioners (*ibid*).
- 9.2.5 Findings from the SWAAY programme indicate that the likelihood of drop-out can be predicted from pre-treatment

variables. Thus, there is a need to develop a screening tool to predict whether or not young people will complete the treatment programmes that are made available to them (Edwards, 2003). The treatment needs of young people who currently drop out of services need to be addressed, tailoring services to meet these needs and thus reducing drop out rates.

9.3 Identification and assessment

9.3.1 The assessment tool developed by AIM and G-MAP is developed from advances in research, and draws upon information provided by the young person, their family and all the relevant social systems within the young person's life, including education services. This informs multi-disciplinary teams supporting frontline workers. Professionals regard valid comprehensive assessment as the key to implementing the appropriate treatments. Such an assessment tool should demystify the referral process within multi-agency working as many children slip through the net due to the lack of comprehensive assessments and an inconsistent approach to referrals within the service system. Multi-agency working should be extended into treatment services and post-discharge services.

9.4 Service provision

9.4.1 It was widely reported that children with serious psychopathology and presenting risk related to sexually abusive behaviour are being missed by local services. There is a collective responsibility that these children are identified and appropriate service responses delivered, among universal health and education services and social services assessment of children in need. This collective responsibility is in accordance with the Government's approach within the Green Paper *Every Child Matters* (HMSO, 2003) and the influential CAMHS Strategy Document, *Child and Adolescent Mental Health Services*:

Everybody's Business (National Assembly, 2001), as well as current consultation documents. These should encourage the development of appropriate assessment tools to identify problems, as well as multifaceted approaches to early intervention. The Identification Referral and Tracking (IRT) system should incorporate specific attention to young sexual abusers alongside other vulnerable children.

- 9.4.2 There is a need to develop more widely the knowledge and skills that are being shown to be required to meet the needs of young sex abusers effectively – even in specialist services, such as Tier 3 Child and Adolescent Mental Health Services (CAMHS). A national strategy is required in order to develop effective services that are both comprehensive and tiered (Hackett, Masson & Phillips, 2003). Studies quoted by Bentovim (2003) show that looking at children's behavioural difficulties, oppositional behaviour and psychiatric problems in general, indicate that adolescent perpetrators seen in the community are more disturbed than normal controls but rather less disturbed than psychiatric clinic controls. This may mean that child and adolescent psychiatrists may be reluctant to become involved in treatment of these young people because their presentation is through their perpetrating behaviour rather than a more general psychiatric disturbance.
- 9.4.3 Guidance based upon current research and literature covering the best practice for working with young people who display sexually abusive behaviours should be produced and distributed across the United Kingdom. Central government and local guidance needs to be reviewed in order to ensure that it accurately reflects the current knowledge of the likelihood of young people who have displayed sexually abusive behaviours repeating this behaviour, with an emphasis on careful risk assessment (Hackett, Masson & Phillips, 2003). There should also be consideration given to the development and identification of different levels of accredited training that will improve practice standards (*ibid*).

9.5 Evaluation and Research

9.5.1 As in the whole field of forensic mental health, there is a lack of information about the organisation, legal powers and treatment, management and ongoing rehabilitation programmes that have been shown to impact on re-offending and relapse. Any future research should be designed to improve:

- The efficacy of models of service organisation;
- The efficacy of treatment management and rehabilitation programmes;
- The efficacy of the inevitable, multiple and changing components of the treatment management and rehabilitation programmes with regard to the level of risk, need and developmental stage of the child or adolescent.

Any treatment programme, from inception, should integrate ongoing risk assessment of the sexually abusive behaviour and any other antisocial behaviour encompassing substance misuse, mental disorder and risk to self.

9.5.2 Services are currently struggling to evaluate their projects. Thus evaluation of treatment should be built in from the start of the programmes and be ongoing throughout, using standardised evaluation measures. There is currently a window of opportunity to implement 'no-treatment' control groups in research into the treatment of young people displaying sexually harmful behaviours and such comparative studies are needed in order to reliably test the validity of treatment programmes (Beckett, Gerhold & Brown, 2003). The best form of evaluating treatment programmes would be to carry out randomised control trials linked to recidivism, to show if the assumed treatment effects are a result of the treatment programmes and not other extraneous variables, although the ethicality of withholding treatment to create control groups makes this a near impossible means of studying this group of young people.

- 9.5.3 Longitudinal studies are needed in order to follow up young people over as long a time period as possible and identify important long-term outcomes for children who sexually abuse; it may be possible to link into the Millennium Cohort Study for this purpose. Sampling children born between the 1st of September 2000 and 2001 (1st of December in Scotland and Northern Ireland) selected from a random sample of electoral wards, the Millennium Cohort Study aims to further the understanding of social conditions that surround birth and childhood fundamental in studying developments throughout the life course. The sample of the Millennium Cohort Study exceeds 18,000 children.
- 9.5.4 Systematic evaluation of specialist services and their components is required in order to identify good practice. Good practice should be seen in terms of positive outcomes in all domains of the young person's life and not solely in their offending behaviour. Interventions should also be assessed on how they meet a child's broader developmental needs. Further research is needed on the influence of the effectiveness of group dynamics on drop out from treatment programmes.
- 9.5.5 The overall social and economic costs to the individual, society and adult services, arising from those young people displaying sexually harmful behaviours who go on to become adult abusers, should be further investigated, utilising extant and developing health economic cost benefit analysis.
- 9.5.6 There is a need for a better understanding of the construction of resilience in victims of sexual abuse, not only to develop preventive approaches for sexual abusive behaviour but also for other risk behaviours and suicide.
- 9.5.7 As well as researching the effectiveness of treatment services in terms of recidivism rates and the meeting of mental health needs, research should be undertaken that focuses on the views and experiences of service users, their families and carers, thus

informing the further development of these services and subsequent compliance. It is important to build concerted, consistent and meaningful ways of gaining service user feedback (Hackett, Masson & Phillips, 2003).

9.5.8 All professionals working with these young people should have access to good quality and appropriate supervision and consultation, as concerns have been raised that many practitioners and managers feel that they are not adequately supported. Further work should be undertaken to identify best practice within these areas and disseminate them accordingly (*ibid*).

9.5.9 The impact of legislation surrounding sexual offences should be regularly reviewed, with representations made to government when the impact of legislation is felt to be counter-productive (*ibid*).

References

- AIM (2001). *Working with children and young people who sexually abuse: Procedures and Assessment*
- AIM, Mir, B & Okotie, E. (2002). Study of the experiences of Black and Asian young people whose behaviour is sexually harmful to others. NSPCC Report
- Atwood R. Gold M. Taylor R. (1989) Two types of delinquents and their institutional adjustment. *Journal of Consulting & Clinical Psychology*, **57**(1): 68-75
- Barnardo's (2003). Comments from the *Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03*
- Barry, S. (2003). Comments from the *Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03*
- Becker, J.V. & Stein, M. (1991). Is sexual erotica associated with sexual deviance in adolescent males? *International Journal of Law & Psychiatry*, **14**: 85 – 95
- Beckett, R., Gerhold, C. & Brown, S. (2003). *Adolescent Sexual Abuser Project*. Paper presented at the Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03
- Beech, A.R., Fisher, D.D. & Thornton, D. (2003). Risk Assessment of Sex Offenders. *Professional Psychology: Research and Practice*, **34**(4): 339 – 352
- Beech, A.R. & Ward, T. (2004). The integration of etiology and risk in sexual offenders: A theoretical framework. *Aggression and Violent Behavior*, **10**: 31 – 63
- Beech, A.R. & Mitchell, I.J. (2005). A neurobiological perspective on attachment problems in sexual offenders and the role of serotonin re-uptake inhibitors in the treatment of such problems. *Clinical Psychology Review*, **25**: 153 – 182
- Benoit, J.L. & Kennedy, W.A. (1992). The abuse history of male adolescent sex offenders. *Journal of Interpersonal Violence*, **7**: 543 – 548

Bentovim, A. (2002). Preventing sexually abused young people from becoming abusers, and treating the victimisation experiences of young people who offend sexually. *Child Abuse & Neglect*, **26**: 661 – 678

Bentovim, A. (2003). Update on research with young sex offenders. Who needs residential treatment and does it work? *Paper given in June 2003, at the Royal College of Psychiatrists AGM*

Borduin, C.M., Henggeler, S.W., Blaske, D.M. & Stein, R.J. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology*, **34**: 105 – 113

Borduin, C.M. & Schaeffer, C.M. (2002). Multisystemic Treatment of Juvenile Sexual Offenders: A Progress Report. *Journal of Psychology and Human Sexuality*, **13**(3/4): 25 – 42

Borum, R., Bartel, P. & Forth, A. (2003). *Manual for the Structured Assessment of Violence Risk in Youth (SAVRY)*. University of South Florida

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press

Brotherston, S. (Head of Integrated Services, The Lucy Faithful Foundation) (2004) – Personal Communication

Bunting, L. (2005). *Females who sexually offend against children: responses of the child protection and criminal justice systems*. NSPCC

Burk, L.R. & Burkhart, B.R. (2003). Disorganized attachment as a diathesis for sexual deviance: Developmental experience and the motivation for sexual offending. *Aggression & Violent Behavior*, **8**: 487 – 511

Burton, D.L., Miller, D.L. & Shill, T.S. (2002). A social learning theory comparison of the sexual victimisation of adolescent sexual offenders and nonsexual offending male delinquents. *Child Abuse & Neglect*, **26**: 893 – 907

- Butler, S.M. & Seto, M.C. (2002). Distinguishing Two Types of Adolescent Sex Offenders. *Journal of the American Academy of Child & Adolescent Psychiatry*, **41**: 83 – 90
- Cann, J., Falshaw, L. & Friendship, C. (2004). Sexual offenders discharged from prison in England and Wales: A 21-year reconviction study. *Legal and Criminological Psychology*, **9**(1): 1 – 10
- Caplan, G. (1964). *Principles of Preventative Psychiatry*. New York: Basic Books
- Cooper, P.E. (1997). *Residential treatment program criteria affecting the length of stay of adolescent sex offenders*. Dissertation Abstracts International Section A: Humanities and Social Sciences, **58**, (4-A): 1452. In Edwards, R. (2003) – see below.
- Cosentino, C.E., Meyer-Bahlburg, H.F.L., Alpert, J.L., Weinberg, S.L. & Gaines, R. (1995). Sexual Behaviour Problems and Psychopathology Symptoms in Sexually Abused Girls. *Journal of the American Academy of Child & Adolescent Psychiatry*, **34**: 1033 – 1042
- Craissati, J., McClurg, G. & Browne, K. (2002). The parental bonding experiences of sex offenders: a comparison between child molesters and rapists. *Child Abuse & Neglect*, **26**: 909 – 921
- Denov, M.S. (2003). The myth of innocence: Sexual scripts and the recognition of child sexual abuse by female perpetrators. *Journal of Sex Research*, **40**(3): 303 – 314
- Doreleijers, T. (2005). *Screening and diagnostic assessment of juvenile offenders on request of the court*. Presentation at the University of Modena, Bologna, Italy for the European Association for Forensic Child and Adolescent Psychiatry, Psychology and other involved Professionals, April 2005
- Dolan, M. (2004). Psychopathic personality in young people. *Advances in Psychiatric Treatment*, **10**: 466–473

- Doreleijers, T.A.H. & Spaander, M. (2002). The development and implementation of the BARO: A new device to detect psychopathology in minors with first police contacts. In Corrado, R.R. (Ed) *Multi-problem violent youth: A foundation for comparative research on needs, interventions and outcomes. Series I: Life and behavioural sciences*, pp. 232 – 240 . Amsterdam, Netherlands Antilles: IOS Press
- Edwards, R. (2003). *Predicting Dropout from a Residential Programme for Adolescent Sexual Abusers using Pre-Treatment Variables and Implications for Recidivism: Towards the development of a scale*. Presentation of the paper Predicting Dropout from a Residential Program for Adolescent Sexual Abusers using Pre-Treatment Variables and Implications for Recidivism (Edwards, R., Beech, A., Bishopp, D., Erikson, M., Friendship, C. & Charlesworth L. (2003)) at the Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03
- Epps, K. (2003). *Sexual Aggression in Adolescent Offenders*. Paper presented at the Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03
- Epps, K. (Consultant Forensic Clinical Psychologist, Birmingham South Mental Health Trust) (2004) – Personal Communication
- Farmer, E. & Pollock, S. (2003). Managing sexually abused/abusing children in substitute care. *Child and Family Social Work*, **8**: 101 – 112
- Fisher, P.A. (2000). Multidimensional Treatment Foster Care: A Program for Intensive Parenting, Family Support, and Skill Building. *Journal of Emotional and Behavioral Disorders*, **8**(3): 155 – 164
- French, L. (2003). Comments from the *Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03*
- Frick, P.J. & Ellis, M.L. (1999). Callous-unemotional traits and subtypes of conduct disorder. *Clinical Child and Family Psychology Review*, **2**: 149 – 168

Garnezy, N. & Masten, A.S. (1994). Chronic adversities. In Rutter, M., Taylor, E. & Hersov, L. (Eds.), *Child and Adolescent Psychiatry: Modern Approaches*. Third Edition: pp. 191 – 208. Oxford: Blackwell Scientific

Gibbs, J. (Mental Health Unit, Home Office) (2004) – Personal Communication

G-MAP (2003). *A Guide to Assessment & Therapeutic Services*. March, 2003

Grant, A. (2000). The Historical Development of Treatment for Adolescent Sex Offenders, Trends and Issues in Crime and Criminal Justice. *Trends and Issues in Crime and Criminal Justice*, **145**. Australian Institute of Criminology

Gretton, H.M., McBride, M., Hare, R.D., O'Shaughnessy, R. & Kumka, G. (2001). Psychopathy and recidivism in adolescent sex offenders. *Criminal Justice and Behaviour*, **28**: 427 – 449. In Vizard, E., French, L., Hickey, N. & Bladon, E. (2003). *Juvenile sexual offending: a developmental framework*. Paper presented at the Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03

Grimshaw, R. & Salmon, S. (2000) *Adolescent sexual abusers and offenders in Inner London: a review and audit of need and provision*. Draft report for Inner London Youth Justice Services. October 2000, The Centre for Crime and Justice Studies, King's College, London

Grubin, D. (1998) 'Sex Offending Against Children: Understanding the Risk' *Police Research Series Paper. Policing and Reducing Crime Unit, Home Office Research*

Haarbosch, V. (Norfolk Youth Justice Services) (2003) – Personal communication

Hackett, S. (2001). Working with parents of young people who have sexually abused. *Conference address to NEXUS conference 'Working with young people who sexually abuse'*. October, 2001

Hackett, S. (2003). Comments from the *Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03*

Hackett, S. (Lecturer, Centre for Applied Social and Community Studies, University of Durham) & Masson, H. (Reader in Social Work, School of Human & Health Sciences, University of Huddersfield) (2004) – Personal Communication

Hackett, S. & Masson, H. (2003). *Mapping and exploring services for young people who have sexually abused others: Findings from a two year research programme into policy, practice and services delivery across the UK and ROI*. Paper presented at the Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03

Hackett, S., Masson, H. & Phillips, S. (2003). *Mapping and exploring services for young people who have sexually abused others: Findings from a two year research programme into policy, practice and services delivery across the UK and ROI*. University of Durham

Hanson, R.K. & Slater, S. (1988). Sexual victimisation in the history of child sexual abusers: A review. *Annals of Sex Research*, **1**: 485 – 499

Harrington, R. & Bailey, S. (2004). *The Scope for Preventing Antisocial Personality Disorder by Intervening in Adolescence*. Expert paper for the NHS National Programme of Forensic Mental Health Research and Development

Hawkes, C. (2002). Accreditation of Work and Workers Involved in Providing a Service to Children and Young People who Sexually Abuse. Ch. 8 in Martin C. Calder (Eds) *Young People who Sexually Abuse*. Russell House Publishing, Dorset, pp 125 – 138

Hendriks, J. & Bijleveld, C.C.J.H. (2004). Juvenile sexual delinquents: contrasting child abusers with peer abusers. *Criminal Behaviour and Mental Health*, **14**: 238 – 250

Henniker, J. (2003). Comments from the *Home Office and DoH Conference on Young People who Sexually Abuse* – 17/10/03

HMSO (2003). *Every Child Matters*. HMSO: Crown copyright

Hunter, J., Lexier, L., Googwin, D., Browne, P. & Dennis, C. (1993). Psychosexual attitudinal and developmental characteristics of juvenile female sexual perpetrators in residential treatment setting. *Journal of Child & Family Studies*, **2**, 317 – 326

- Hunter, J.A., Figueredo, A.J., Malamuth, N.M & Becker, J.V. (2003). Juvenile Sex Offenders: Toward the Development of a Typology. *Sexual Abuse: A Journal of Research and Treatment*, **15**(1): 27 – 48
- Hyde, C., Bentovim, A. & Monck (1995). Some clinical and methodological implications of a treatment outcome study of sexually abused children. *Child Abuse & Neglect*, **19**: 1387 – 1399
- Jessor, R., Van Den Bos, J., Vanderryn, J., Costa, F.M. & Turbin, M.S. (1995). Protective factors in adolescent problem behavior: Moderator effects and developmental change. *Developmental Psychology*, **31**(6): 923 – 933
- Knight, R.A. & Prentky, R.A. (1993). Exploring characteristics for classifying juvenile sex offenders. In: Barbaree H.E., Marshall, W.L. & Hudson, S.E. (Eds.), *The Juvenile Sex Offender*, 45 – 103. Guilford Press
- Langstrom, N (2001). *Young sex offenders: A research overview*. Expert report, Socialstyrelsen: The Board of Health and Welfare
- Langstrom, N. (2002). Long-term follow-up of criminal recidivism in young sex offenders: Temporal patterns and risk factors. *Psychology, Crime & Law*. **8**(1): 41 – 58
- Lawson, L. (2003). Becoming a success story: how boys who have molested children talk about treatment. *Journal of Psychiatric and Mental Health Nursing*, **10**: 259 – 268
- Letourneau, E.J., Schoenwald, S.K. & Sheidow, A.J. (2004). Children and Adolescents with Sexual Behaviour Problems. *Child Maltreatment*, **9**(1): 49 – 61
- Lovell, E. (2002). *"I think I might need some more help with this problem...": Responding to children and young people who display sexually harmful behaviour*. NSPCC Publication

Marques, J. K., Day, D. M., Nelson, C., & West, M. A. (1994). Effects of cognitive behavioral treatment on sex offender recidivism: Preliminary results of a longitudinal study. *Criminal Justice and Behavior*, 21(1), 28-54. Quoted by Edwards, R. (2003). *Predicting Dropout from a Residential Programme for Adolescent Sexual Abusers using Pre-Treatment Variables and Implications for Recidivism: Towards the development of a scale*. (Edwards, R., Beech, A., Bishopp, D., Erikson, M., Friendship, C. & Charlesworth L. (2003)) paper presented at the Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03

Masten A.S. & Powell J.L. (2003). A resilience framework for research, policy and practice. In Luthar S.S. (ed.) *Resilience and vulnerability: adaptation in the context of childhood adversities*. Cambridge: Cambridge U Press, 2003. Adapted by O'Callaghan, D. (2003). *Young People with Sexual Behaviour Problems: Adopting a resilience informed approach*. Paper presented at the Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03

Matthews, R., Hunter, J.A. & Vuz, J. (1997). Juvenile female sexual offenders: Clinical characteristics and treatment issues. *Sexual Abuse: A Journal of Research and Treatment*, 9(3): 187 – 199

Misch, P. (2003). Comments from the Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03

Monck, E., Bentovim, A., Goodall, G., Hyde, C., Lewin, R., Sharland, E & Elton, A. (1996). Child sexual abuse – a descriptive and treatment study. *Studies in Child Protection* HMSO: London

Morrison, T. (2001). Surveying the terrain: Current issues in the prevention and management of sexually abusive behaviour by males. *Journal of Sexual Aggression*. 7(1): 19 – 39

Mutale, T. (2003). *Adolescent sexually abusive behaviour – subtypes and the influence of mental health, poor parental care and childhood abuse*. Paper presented at the Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03

- National Academy of Sciences (1994). *Reducing the Risks for Mental Disorders: Frontiers for Preventive Intervention*. Washington, DC: National Academy Press
- National Assembly for Wales (2001) Child and Adolescent Mental Health Services: Everybody's Business – Strategy Document, Cardiff, NafW.
- National Institute of Corrections (2000). *Changing Offender Behaviour to Promote Public Safety*. US Department of Justice
- O'Callaghan, D. (1998). Practice Issues in Working with Young Abusers who have Learning Disabilities. *Child Abuse Review*, **7**: 435 – 448
- O' Callaghan, D. (2003). *Young People with Sexual Behaviour Problems: Adopting resilience informed approach*. Paper presented at the Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03
- Ownbey, M.A., Jones, R.J., Judkins, B.L., Everidge, J.A. & Timbers, G.D. (2001). Tracking the Sexual Behavior-Specific Effects of a Foster Family Treatment Program for Children with Serious Sexual Behavior Problems. *Child and Adolescent Social Work Journal*, **18**(6): 417 – 436
- Prentky, R.A., Harris, B., Frizzell, K. & Righthand, S. (2000). An actuarial procedure for assessing risk with juvenile sex offenders. *Sexual Abuse: A Journal of Research & Treatment*, **12**: 71 – 93
- Print, B., Morrison, T. & Henniker, J. (2001). An inter-agency assessment framework for young people who sexually abuse: Principles, processes and practicalities, in M. Calder (Ed.) (2001) *Juveniles and Children who Sexually Abuse: Frameworks for Assessment (Second Edition)*. Lyme Regis: Russell House Publication
- Rasmussen, L.A. (1999). Factors related to recidivism among juvenile sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, **11**(1): 69 – 85

Rayment-McHugh, S. & Nisbet, I. (2003). *Sibling Incest Offenders as a Subset of Adolescent Sexual Offenders*. Paper presented at the Child Sexual Abuse Conference: Justice Response or Alternative Resolution, 1 – 2 May, 2003

Righthand, S., Prentky, R., Knight, R., Carpenter, E. Hecker, J.E. & Nangle, D. (2005). Factor structure and validation of the Juvenile Sex Offender Assessment Protocol (J-SOAP). *Sexual Abuse: A Journal of Research and Treatment*, **17**(1): 13 – 30

Ryan, G. (1999). Treatment of abusive youth: The evolving consensus. *Journal of Interpersonal Violence*, **14**(4): 422 – 436. Cited by O'Callaghan (2003). *Young People with Sexual Behaviour Problems: Adopting a resilience informed approach*. Paper presented at the Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03

Ryan, G. & Lane, S. (eds.) (1997). *Juvenile Sexual Offending. Causes, Consequences and Corrections*. Lexington, Massachusetts/Toronto, Lexington Books

Salter, D., McMillan, D., Richards, M., Talbot, T., Hodges, J., Bentovim, A., Hastings, R., Stevenson, J. & Skuse, D. (2003). Development of sexually abusive behaviour in sexually victimised males: a longitudinal study. *Lancet*, **361**: 471 – 476

Skuse, D., Bentovim, A., Hodges, J., Stevenson, J., Andreou, C., Lanyado, M., New, M., Williams, B. & McMillan, D. (1998). Risk factors for development of sexually abusive behaviour in sexually victimised adolescent boys: cross sectional study. *British Medical Journal*, **317**: 175 – 179

Smith, D.K. (2004). Risk, reinforcement, retention in treatment, and reoffending for boys and girls in multidimensional treatment foster care. *Journal of Emotional and Behavioural Disorders*, **12**(1): 38 – 48

Taylor, J.F. (2003). Children and young people accused of child sexual abuse: A study within the community. *Journal of Sexual Aggression*, **9**(1): 57 – 70

- Thomas, D. & Singh, T. (1995). Offenders referred to a learning disability service: a retrospective study. *British Journal of Learning Disability*, **23**: 24 – 27
- Thomas, T. (2003). The sex offenders register: the registration of young people. *Childright*, **194**: 10-11
- Thompson, D & Brown, H. (1997). Men with intellectual disabilities who abuse: A review of the literature. *Journal of Applied Research in Intellectual Disabilities*, **10**: 140 – 158
- Thomson, I. (2003). *HM Prison Service. Juvenile Estate: Young People Who Sexually Abuse*. Paper presented at the Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03
- Vandiver, D.M. & Teske, R. (2006). Juvenile Female and Male Sex Offenders. *International Journal of Offender Therapy and Comparative Criminology*, **50**(2): 148 – 165
- Vandiver, D. & Walker, J.T. (2002). Female sex offenders: An overview and analysis of 40 cases. *Criminal Justice Review*, **27**(2): 284 – 300
- Vizard, E. (2002). The Assessment of Young Sexual Abusers, in M. Calder (Ed.) *Young People who Sexually Abuse*. Russell House Publishing, Dorset. Ch 12: 176 – 195
- Vizard, E. (2004). Sexual offending in adolescence. In Bailey, S. & Dolan, M. (eds.) *Forensic Adolescent Psychiatry*. Arnold Publishing . Ch. 17: 228 – 246
- Vizard, E., French, L., Hickey, N. & Bladon, E. (2003). *Juvenile sexual offending: a developmental framework*. Paper presented at the Home Office and DoH Conference on Young People who Sexually Abuse – 17/10/03
- Ward, T., Hudson, S.M. & Marshall, W.L. (1996). Attachment style in sex offenders: A preliminary study. *The Journal of Sex Research*, **33**: 17 – 26
- Ward, T. & Beech, A.R. (2004). The etiology of risk: A preliminary model. *Sexual Abuse: A Journal of Research and Treatment*, **16**(4): 271 – 284

Weinrott, M. (1996). *Juvenile Sexual Aggression: A Critical Review*. Boulder, CO: University of Colorado, Institute for Behavioral Sciences, Center for the Study and Prevention of Violence.

Witt, P.H. (2003). Manual for the Structured Assessment of Violence Risk in Youth. *Journal of Psychiatry & Law* **30**(4): 599 – 603

Worling, J.R. (1995). Sexual abuse histories of adolescent male sex offenders: Differences on the basis of the age and gender of their victims. *Journal of Abnormal Psychology*, **104**(4): 610 – 613

Worling, J.R. (2001). Personality-based typology of adolescent male sexual offenders: Differences in recidivism rates, victim-selection characteristics and personal victimization histories. *Sexual Abuse: A journal of Research and Treatment*, **13**(3): 149 – 166

Worling, J.R. (2004). The Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR): Preliminary psychometric data. *Sexual Abuse: A Journal of research and Treatment*, **16**(3): 235 – 254

Worling, J.R. & Curwen, T. (2001). The “ERASOR” Estimate of Risk of Adolescent Sexual Offense Recidivism. In M.C. Calder (Ed.), *Juveniles and children who sexually abuse: Frameworks for assessment*, pp. 372 – 397. Lyme Regis, England: Russell House

Worling, J.R. & Langstrom, N. (2003). Assessment of criminal recidivism risk with adolescents who have offended sexually: A review. *Trauma, Violence & Abuse*, **4**(4): 341 – 362

Youth Justice Board (2005). *Youth Justice Annual Statistics 2003/04*. Youth Justice Board

Appendix 1

Youth Justice Board figures for sexual offences resulting in some sort of disposal by age, gender and ethnicity

Age	10	11	12	13	14	15	16	17	Total
Number of sexual offences resulting in a disposal	11	52	90	253	369	333	409	279	1,796

Ethnicity	Asian or Asian British	Black or Black British	Chinese or other ethnic origin	Mixed	White	Not known	Total
Number of sexual offences resulting in a disposal	123	158	18	70	1,375	52	1796

Gender	Male	Female	Total
Number of sexual offences resulting in a disposal	1,766	30	1,796

Appendix 2: Service descriptions

In preparation of this report a number of services for young people displaying sexually abusive behaviours were contacted and asked to complete a brief questionnaire describing their service. Information was collected on the location and type of service, when established, the team make-up, inclusion and exclusion criteria, what they do and the evidence base for it. However, since this piece of work was undertaken the Victims of Violence and Abuse Prevention Programme within the Department of Health have carried out an extensive mapping exercise of services for these young people, therefore what will follow will be an overview of the types of services currently available.

Of the services that responded they were based either within the National Health Service, the justice services or were voluntary or independent services and ranged from secure treatment facilities to community treatment and assessment services. Many of the teams were made up of a number of different professionals that included psychiatrists, teachers, social workers, occupational therapists, psychologists and other senior practitioners specialising in learning disability nursing, youth offending, family therapy and child care. Such a multidisciplinary approach seemed common across the services.

The age range seen by these services varied greatly. Some services focused primarily on adolescents, while others simply stated that they took referrals of young people under the age of 18. A small number of services specifically stated that they accepted referrals of young people below the age of criminal responsibility, although the majority did not. Interestingly one of the services that saw young people below the age of criminal responsibility was situated within a youth offending team. The remaining inclusion criteria also differed greatly between services. Some services focused only on males, some stipulated that the IQ of those referred had to fall within the normal range and one service specifically stated that it would not work with young people who were known to have set fires that endangered life or those with significant and current delinquent behaviours.

The treatment and assessment procedures differed between services and as such so did the evidence bases for the services provided. Some services had developed and validated their own assessment procedures, which have since been adopted by other services (for example, the AIM assessment). Other services used validated research and best practice as the basis for their own work.

It was clear from the responses received for the purpose of this report is that there is great variation in the services currently offered to young people displaying sexually behaviour problems. This highlights the need for and importance of the service mapping exercise that is currently being carried out by the Victims of Violence and Abuse Prevention Programme.



© Crown Copyright 2006

Produced by COI for Department of Health
276451 1P Oct 06

www.dh.gov.uk/publications