THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Report by - Dr JENNY DWYER – 2005 Churchill Fellow

ADOLESCENTS WITH SEXUALLY HARMFUL BEHAVIOURS: CURRENT DIRECTIONS IN THE UNITED STATES AND UNITED KINGDOM AND IMPLICATIONS FOR VICTORIA

Investigation: To study programs in the United Kingdom and United States in relation to adolescents with sexually harmful behaviours, with particular focus on family reunification

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Jenny Dwyer

7 July 2006
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1.0 INTRODUCTION

Working in the area of sexual abuse can be confronting, rewarding and enormously challenging. But for families who live these experiences, words are inadequate to convey their pain and distress. As a family therapist I have worked in many situations where both the offender and the victim are family members. While this is always complicated and difficult for families, it is particularly difficult when the offender is an adolescent, often the sibling of the victim. Parents frequently feel a kind of Sophie’s choice as they struggle to respond to the needs of both their children. As a mother, I couldn’t imagine having to make such choices.

As a worker my role is to assist families with compassion and care, and to find solutions to their dilemmas in ways that maximise the possibility for healing for all concerned. Working with families after sibling sexual abuse led me to be interested more generally in adolescents who perpetrate abuse on others. That in turn led me to the Churchill Trust, and the opportunity to explore this difficult area overseas.

The problem of adolescents and children with sexually abusive behaviours is now well recognised. Estimates of incidence vary, but in Victoria in 2000, 10% of sex offences were committed by juveniles (Victoria Police, 2002). Internationally, a range of studies have found that around one third of sexual offences are perpetrated by juveniles (Monck and New, 1996). The treatment of young people with problematic sexual behaviours arose from the recognition that many adult offenders began their offending in adolescence, and early treatments relied on applying adult models and practices to young people (Ryan and Lane, 1996). However the last decade has seen an emerging understanding of the unique characteristics of adolescent offenders. Indeed adolescents committing sex offences have been found to have more in common with adolescents committing other offences, than with adult sex offenders (Ryan, 2006). In response, the emerging developmental and contextual models have recognised that prematurely labelling young people as “sexual offenders” is inappropriate. The current preference is to focus on the “sexually harmful behaviours” (SHB’s) rather than labelling the young person him/herself, and this is a term used widely in the UK.

When I first began my Fellowship, my major focus of research was to investigate programs working with juveniles with SHB’s, in particular those that may enhance the possibility of family reunification. This was in recognition of the challenges that these young people posed to agencies in providing out-of-home care, the dilemmas involved in ensuring the needs of both victims and perpetrator were met, and the importance of family support in adolescent development. As the project progressed I realised that issues related to family work or alternative care could only be understood in relation to the broader conceptual frameworks that are currently gaining currency. I therefore shifted my focus to look at four major themes:

- What are the current directions in treating young people with sexually harmful behaviours?
- What are the characteristics of an optimum context of care for them?
- How can conceptual models and clinical practices best be disseminated across the service networks
- What opportunities are there for early intervention with these young people?

It would be rather ambitious to expect to definitively answer these complex questions in the limited time available for observation and research. However, I hope that this report can contribute to the emerging dialogue about the needs of young people, many of whom have experienced severe early trauma and loss in their own lives, who go on to harm others. In particular I hope that this report can contribute to development of a shared conceptual
framework across service networks, so that we can establish a more holistic response to this
difficult and challenging problem.

1.1 ACKNOWLEDGEMENTS

Travelling overseas for two months on a Churchill Study Fellowship was an enormous
privilege and would not have been possible without the support of many people, both at home
and overseas. I would like to thank the Churchill Trust for the opportunity to explore this
difficult area of work and hope that I can repay their faith by making a worthwhile
contribution to our field. The Trust continues to choose innovative and often brave projects
to explore and I am proud to be associated with them. In my travels I met many new friends
and colleagues and was overwhelmed by their extraordinary generosity. I thank each of them
for their contribution and hope this is reflected in the report. There are several people who
are owed particular recognition for the support they gave me.

- On the home front, the Bouverie Centre generously allowed me study leave and
colleagues carried my share of the housework in my absence. An additional thanks
to Banu Moloney, who made herself available to support clients in my private
practice.
- Michael O’Connell and Sharon Lacy provided loving care for my two beautiful
children and allowed me peace of mind. For their part, Jack and Seamus were always
proud and delighted at their Mum going overseas to study, and their sharing in this
made it possible for me to leave them for so long.
- Robyn Miller, as friend and colleague has shared the journey of understanding the
lives of young people who harm others. I thank her for the ongoing intellectual and
personal support and her unrelenting optimism.
- Gail Ryan from the Kempe Centre in Denver not only shared her deep wisdom and
experience, but very generously gave me permission to use her curriculum and
resources in training other professionals. On a personal front her gentle mothering,
including warmth, concern and home-cooked lunches was much appreciated by a
traveller missing her own kids and friends.
- In the UK, a very lucky find via email led me to Michael Sheath at the Lucy Faithfull
Foundation. He not only shared his own considerable knowledge with humour and
humility, but acted as my “Agent” and was responsible for much of my itinerary in
the UK. Most generously, Michael and his wife Jan shared their home, delightful
children and assorted pets. A good time was had by all!
- Isobel Cravato and Rowland Coombes also took me into their home as well as their
clinical work. We all became inspired by the possibilities of family work with young
people and hope our brief contact was the start of something bigger.
- Kevin Gibbs from NSPCC South Wales deserves thanks for his assistance in
contacting other programs and his sharing of ideas, time and enthusiasm for our joint
endeavour.
- Another Churchill Fellow in Belfast, Isobel Reilly was her usual generous self,
sharing her home, ideas and family. We continue to be inspired by the overlap of
our work in different hemispheres and different contexts and look forward to further
collaboration.
2.0 EXECUTIVE SUMMARY

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2.1 PROJECT DESCRIPTION
The problem of adolescents with sexually abusive behaviours is now well recognised. However the field has undergone rapid review and innovation as models of treatment and assessment more appropriate to adolescents, replace those derived from treating adult offenders. In April and May 2006 I travelled to the USA and UK. The study tour focussed on four major themes:
- Current directions in treating young people with sexually harmful behaviours
- The characteristics of an optimum context of care for them
- Dissemination of conceptual models and clinical practices across service networks
- Opportunities for early intervention with these young people.

2.2 FINDINGS
There is currently considerable debate and controversy in the field about which framework and interventions are most valid with sexually abusing youth. With a strong emphasis on evidence based practice, as well as the need for innovation, workers in the field are attempting to develop appropriate treatment programs based on available and emerging knowledge. I concluded that current best practice includes the following elements:
- Individual assessment and treatment planning based on appropriate developmental frameworks
- Assessment and treatment of underlying trauma impacts, including an understanding of the neurological consequences of maltreatment.
- Family treatment and context management
- Offense specific assessment and treatment

The current directions in practice with adolescents recognise the multiple pathways to the development of sexually abusive behaviours and the necessity to intervene in ways that address the underlying impacts of adverse life experience. There are both challenges and opportunities for Victoria to respond to the needs of these young people, in ways that draw on current best practice innovations. Changes to the legislation governing child protection services through The Children, Youth and Families Act (2005), provide opportunities to consider innovations in relation to network development, training and education, and early intervention.

2.3 OUTCOMES
My plans for dissemination and intervention have focussed on the three themes identified above: network development; training and education; and early intervention. These include establishment of an inter-sectorial study group, made up of senior practitioners to promote knowledge sharing; provision of training and supervision to early intervention services; participation in a cross-sectorial interest group to consider opportunities for collaboration; dissemination of this report through appropriate channels in DHS and the treatment network.

3.0 PROGRAMME

April 1: Travel to Denver Colorado
April 3 - April 8
April 10
- Denver Children’s Homes: Meetings and observations, Dr Jerry Yager and Kathy Johnson
April 11
- Kempe Centre: Meeting and tuition with Gail Ryan, Perpetration Prevention Program

April 12: Travel to New York City
April 13
- New York University: Meeting Dianne Mirabito. Orientation
- Confirmation of visits and negotiation of itinerary
Friday April 14 – Monday April 17 Easter break

April 18 –April 21
- Ackerman Institute for the Family:
  o Meetings with Fiona True, Clinician and trainer, Relational Trauma Project; and Marcia Sheinberg, Director of Training, Relational Trauma Project
  o Attendance at a multi agency forum in relation to cross cultural issues in training family therapists
  o Attendance at a one-day workshop by Dr Judy Grossman; Parenting Stress: Causes, consequences and clinical implications
- Andrus Centre, Yonkers: Therapeutic residential treatment for at risk children. Meeting and observation of ‘Sanctuary Model’ of care with Sarah Yanosy and the children’s services team

April 22 : Travel to Atlanta
April 23 –April 26
- Attendance at National Adolescent Perpetration Network (NAPN) Conference
- Post conference meetings

April 27: Travel to Washington DC
Friday April 28
- Proposed meeting and site visit cancelled due to unforeseen circumstances. Time used for research and follow up of contacts from Atlanta Conference

April 30: Travel to London
May 1
- Arrival in United Kingdom and travel to Worcester

May 2
- Lucy Faithfull Foundation: Meeting with Michael Sheath, Co-ordinator of Family Team
- Travel to Cambridge

May 3 –May 4
• Carlford Unit: Visit unit for serious adolescent offenders, observations and participation in therapy sessions; Isobel Cravato and Rowland Coombes
• Return to Worcester

May 5
• University of Bristol: Meeting with Professor Elaine Farmer, School for Policy Studies

May 6–May 7
• Belfast: Meeting with Isobel Reilly, Churchill Fellow, Queens University and Family Trauma Centre
• Participation in presentation of seminar on Family Approach to Trauma with Isobel Reilly

May 8
• NSPCC Black Country Service: Visit and Meetings, Cathy Small, Manager and staff

May 9
• NSPCC Shropshire: Discussions with Colin Watt, Manager

May 10
• Birmingham: Participation in training forum for foster parents dealing with children with sexually harmful behaviours. Run by Rob Tucker, Lucy Faithfull Foundation

May 11 Travel to London

May 12
• Cardiff: Meeting with Kevin Gibbs, Manager South Wales, NSPCC

May 13 Depart England
This report addresses four major themes that were the focus of investigation:

- What are the current directions in treating young people with sexually harmful behaviours?
- What are the characteristics of an optimum context of care for them?
- How can conceptual models and clinical practices best be disseminated across the service networks
- What opportunities are there for early intervention with these young people?

4.1 DEFINING THE PROBLEM

The problem of adolescents and children with sexually harmful behaviours is now well recognised. While historically the seriousness of such behaviours was minimised, current responses take account of the grave harm that can occur for both victim and perpetrator.

There are a handful of services in Victoria dealing with young children displaying sexualised behaviours, adolescents who have sexually abused, and court-mandated treatment for some young people convicted of offences. Demand is high, with long waiting lists for some services. Children and young people with special needs, particularly intellectual disability, generally require separate intervention and treatment. Services and agencies that may be involved with these children include Child Protection, specialist therapeutic services, the Children’s Court, Juvenile Justice, out-of-home-care, mental health and drug and alcohol services, to name a few. While assessment and treatment of adolescents who exhibit SHB’s is undertaken by specialist services, these young people are typically involved with a range of agencies prior to and after these problems being identified.

In recognition of the seriousness of sibling sexual abuse, current practice in Victoria focuses on removal from home of the young person with the harmful behaviour. While this may be effective in terms of safety, processes for family reunification are less well established. In addition, anecdotal evidence suggests that many families who are not mandated to receive treatment may refuse to attend such services, and opt to manage safety with both victim and perpetrator living at home. When young people are removed, the out-of-home-care system faces huge dilemmas in adequately catering for them because of the risks they may pose to other children and their own needs for care and support (Farmer, 2004). The provision of individually designed placements involves considerable cost and resources, and carers are not always trained to manage such behaviours in children.

Traditionally there has been a distinct separation in the therapeutic treatment of victims of sexual abuse and offenders, which is evident in the different funding structures, theoretical influences and clinical practices associated with offender and victim services. While it was always recognised that childhood sexual victimisation may be one contributing factor to adults’ sex offending, the link between the two was not well theorised. It was frequently pointed out that most childhood victims did not go on to offend, and most offenders did not have histories of childhood sexual abuse. Therapeutic intervention with offenders has therefore traditionally focussed on the abusive behaviour, and any focus on a perpetrator’s own victimisation was seen as a distraction from this task (Ryan, 2006). As a consequence,
despite some authors encouraging cross over between offender and victim treatment (for example Salter, 1988; Dwyer and Miller, 2006), the two service networks have traditionally developed in parallel universes.

As greater knowledge about the complexity of sexual abuse has developed, the idea that victims and offenders are distinctly separate is now open for challenge, and this in turn has led to new dilemmas for services. When it comes to children and adolescents, this delineation between victim experiences and ‘offending’ has always been difficult to maintain: Sexual victimisation may be a precursor to “sexualised behaviours” and some children, even as young as 4-years-old have exhibited “sexually aggressive” behaviours toward other children (Araji, 1997). The anecdotal evidence is that even in adult services the delineation between the construction of “victim” and “offender” has begun to break down. Many workers with victims have reported cases where clients commence therapy for their childhood victimisation, and after several sessions, disclose earlier sexually inappropriate behaviour toward others. Clearly then, understanding the mechanism by which some victims may become offenders may provide important directions for clinical intervention (Ryan and Associates, 1999). The service response to this issue has been somewhat piecemeal and the research required to direct service responses has been slow to emerge (Araji, 1997). Services have attempted to recognise the seriousness of sexually aggressive behaviours in children and adolescents, while not prematurely labelling them.

It has also been recognised that many young people who sexually abuse have no history of sexual abuse themselves. Indeed, as a group, juveniles with SHB’s have not been found to have a significantly higher incidence of childhood sexual abuse than other juvenile offenders (OJJDP, 2001). The commonality of experience between young people exhibiting SHB’s and other juvenile offenders has led to a focus on shared risk factors. While research has indicated for some time that young people who develop SHB’s are likely to have been subject to significant trauma, including witnessing violence, being physically abused and suffering severe attachment disruption, the mechanisms by which this may translate into problematic sexual behaviours is only now beginning to be theorised (Ryan and Lane, 1997; Araji, 1997; Ryan et al., 1999). This has led to the development of a more integrated approach to treating adolescents who exhibit SHB’s, including attention to a range of other abusive behaviours they may exhibit; a focus on the impact of early trauma; specific treatment in relation to sexual behaviour problems; and intervention with carers, including family members and residential care staff.

4.2 CURRENT DIRECTIONS IN THE USA AND UK

Many authors have argued for multi-theoretical frameworks in responding to the problem of sexual abuse, since no single theory is likely to account for the complexity of the problem, nor adequately guide responses (Friedrich, 1995; Briere, 2002; Dwyer and Miller, 2006). The evidence from the current directions in the US and UK is that this is particularly true in working with adolescents with sexually harmful behaviours. However, the field is in a state of flux, with considerable debate and controversy about which framework and which interventions are most valid with sexually abusing youth. There is as yet little empirical research on treatment approaches, to provide definitive answers to these questions. With a strong emphasis on evidence based practice, as well as the need for innovation, workers in the field are attempting to develop appropriate treatment programs based on available and emerging knowledge. From discussions with services I visited, conference presentations I attended, follow up discussions and research, current best practice includes the following elements:

- Individual assessment and treatment planning based on appropriate developmental frameworks
• Assessment and treatment of underlying trauma impacts
• Family treatment and context management
• Offense specific assessment and treatment

4.2.1 Individual assessment and treatment planning based on appropriate developmental frameworks

The use of appropriate developmental frameworks to assess and treat adolescents with SHB’s has long been advocated (Ryan and Lane, 1997; Friedrich, 1995). These emerging developmental models have also begun to highlight the different pathways to sexual behaviour problems for children and young people. In particular, the role of early life experiences, such as trauma, neglect and attachment disruption, in placing children at risk of sexual behaviour problems is becoming clearer (Lindstrom, 1999). Since there are multiple risk factors that have been identified, and these interact in complex ways in different children’s lives, any assessment and treatment needs to take account of the unique characteristics of the individual young person and his/her context. This signals a discernible shift away from fitting young people into treatment packages, many of which evolved from adult models, and an emphasis on the need to tailor treatment to meet specific needs and goals of individuals.

Individual assessment of a young person’s experience and development that goes beyond the offending behaviours has many implications for practice. One of these is the recognition of the early trauma and attachment history of the young person, and the need to address the impacts of these in treatment. This may lead to the questioning of older, entrenched practices that have hitherto been accepted as treatment of choice. Two such examples are group treatment and relapse prevention programs. Longo (2006) stated, “The Relapse Prevention model is no longer a viable model” and Creeden (2006) noted the limitations of relapse prevention as the major method of treatment. He argued that, while very widely practiced, relapse prevention was not based on appropriate developmental models and left little room for assisting young people to attain normal developmental skills, such as engaging in intimate relationships and distinguishing appropriate forms of touch. As such it may or may not be appropriate for some young people. Similar questions have been raised about group work. As Perry (2006, p. 48) noted, “A 17-year-old boy in the juvenile justice system may only have the relational skills of a 3-year-old. To expect this boy to function well in a group is unrealistic; such an expectation will only lead to problems in the group, and there will be no true therapeutic impact…. No 3-year-old could manage a complex, insight oriented group – and neither can the 17-year-old with the relational skills of a toddler.”

4.2.2 Assessment and treatment of underlying trauma impacts

As developmental and contextual frameworks have gained influence, the role of early trauma in the lives of young people has become a focus of interest, and the critiques above have significantly drawn on trauma frameworks. Those working primarily with victims have been familiar with these concepts through the work of people like van der Kolk (1996), Rothschild (2000) and Briere (2002). Araji (1997) noted aspects of a trauma framework with children with sexually aggressive behaviours and Friedrich (1995) argued for an integrated framework with this population, that took account of their trauma and attachment history. Similarly Greenwald (2002) highlighted the incidence of trauma in populations of delinquents. Trauma frameworks are now beginning to be more widely incorporated in work with adolescents with sexually abusive behaviours. In particular, the work of Bruce Perry, and his research into the

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1 This doesn’t mean that group work and/or relapse prevention may not be useful interventions. Rather, it indicates that all interventions need to be assessed for their individual applicability.

neurological consequences of early trauma is now exerting an influence on treatment in this area (Perry, 1999, 2006).

Perry’s “neurosequential model of therapeutics” (NMT) is based on an understanding of the malleability of the developing brain, which reacts and adapts to conditions in the environment. This means that both the structure and biochemistry of the brain are highly influenced by experience; and that neural circuits are modified by the adverse or protective nature of that experience. The enduring consequences of these impacts can be seen in emotional, behavioural, cognitive, social, and physiological domains of a child’s functioning. NMT requires that therapists and other treatment staff develop a familiarity with the way in which the brain functions and develops, since therapeutic intervention is designed to change these negative impacts through development and stimulation of new neural pathways (Perry, 2006).²

An understanding of the brain and its development allows for thorough assessment of a child and the effects of early maltreatment. This includes all aspects of their early life experience, not just a history of sexual abuse. Assessment of a child’s developmental age in relation to key functions, is central to providing appropriate care and therapy. To make an adequate assessment, as much as possible needs to be known about a young person’s history, particularly the nature of care provided during early childhood.

There are four principles underpinning intervention based on the NMT:

- the young person’s individual needs must be met via a program of restorative experiences and activities that target the developmental deficits identified
- the activities take place in a safe relational context
- they must be repetitive and of sufficient duration to change the neural systems
- the activities must be rewarding and pleasurable (Perry, 2006).

While the NMT targets neurosequential processing, other trauma treatments have also focussed on ways of integrating and de-sensitising traumatic experiences, and these are beginning to be incorporated into treatment of young people with SHB’s (Anguili, 2006; Burton, 2006; Fentress, 2006). Perry’s work sits comfortably alongside other developmental frameworks and trauma treatment approaches which, when used together, provide insight into mechanisms that may be underlying the development of abusive behaviours and provide directions for assessment and treatment.

Since children who are traumatised and suffer attachment disruption may not attain the normal developmental competencies that healthy adults require, several of the services I encountered overseas advocated that attainment of these developmental competencies should be a major goal of therapeutic intervention (Creeden, 2006; Jager, 2006; Ryan, 2006). For example, Strayhorn’s (1988) psychological health skills axis has been used by Ryan (2006) to set practical goals for young people that are developmentally appropriate and universal. The major developmental competencies he identifies include capacities related to:

- Closeness, trusting and relationship building
- Handling separation and independence
- Handling joint decisions and interpersonal conflicts
- Dealing with frustration and unfavourable events

² The model is complex and beyond the scope of this paper to discuss in detail. For further information, readers are referred to the excellent ChildTrauma Academy website established to distribute research and make it accessible to workers in the field. The website, which can be found at www.ChildTrauma.org includes online courses that can be undertaken to gain an understanding of the major concepts.

• Celebrating good things, feeling pleasure
• Working for delayed gratification
• Relaxing, playing
• Cognitive processing through words, symbols, images
• An adaptive sense of direction and purpose (Strayhorn, 1988, 28-9).

Several innovative programs in the US are now using an approach that incorporates both developmental frameworks and treatment of trauma (Anguili, 2006). These included the work of the Denver Children’s Home and the Andrus Centre, neither of which work specifically with SHB’s, but deal with other forms of abusive behaviour. One of the programs working with adolescents with SHB’s that is illustrative of these new directions is the Whitney Academy in Massachusetts, as represented in presentations and follow up discussion at the NAPN conference in Atlanta. As already noted, Kevin Creeden presented a powerful argument for changing from a relapse prevention model to a trauma-informed developmental model; David Burton presented on trauma focussed cognitive behavioural therapy with children and adolescents; and David Fentress explored the use of a specific trauma treatment (EMDR) with this population (Creeden, 2006; Burton, 2006; Fentress, 2006).

These programs represent significant attempts to develop an integrated approach to treating young people with abusive behaviours, which takes account of the complexity of the young person’s life experience, the dangers of offending behaviours and the developmental needs of children and adolescents. However, as the people I spoke to from the above programs were at pains to point out, these treatment approaches with sexually abusing young people are in the very early stages of development, and while clinical outcomes are promising, they have not yet been empirically validated.

4.2.3 Family treatment and context management

In both the USA and UK there is a strong recognition of the need to work therapeutically with a young person’s context, including family and/or an alternative care arrangement. Attention to context is required for adequate monitoring and supervision, as well as to ensure that care is provided in a way that meets the therapeutic goals. This therefore requires an integration of therapy and care, rather than keeping them as totally separate and private domains. That is not to say that a young person does not need a confidential therapeutic space, but rather that the broad or specific goals need to be familiar to carers, and they need to be trained to adequately respond to the young person’s complex needs (Sheinberg and Fraenkel, 2001; Robichaud-Smith, 2006; Tucker, 2006; Ryan, 2006).

Many children with sexually harmful behaviours do not reside at home. This may be due to child protection or juvenile justice involvement, and places of care range from institutional settings to foster care or residential units. All programs encountered, whatever the model, advocated careful attention to the context of care. Training of caregivers was a feature of a range of services, for both out-of-home and family based care. Training needs varied depending on the nature of the care provided, but there were general themes. Most of the training for caregivers included aspects of the following:

• Normal sexual development in children and adolescents
• The impact of trauma and abuse on children
• Understanding sexually harmful behaviours in young people
• Management of behaviours and promotion of safety
• Understanding treatment goals for individual young people and intervening to support these goals

The impact of the work on carers, and management of their own distress (Ryan, 2006; Tucker, 2006; Jager, pc. 2006).

The inclusion of trauma and developmental frameworks into residential settings has enormous implications for daily care. For example, most institutions have policies that closely regulate touch between staff and residents. However when the importance of nurturing touch for healthy development is taken into account, institutional policies and appropriate training around use of touch with young people may need to be reconsidered (Thomas, 2006).

Some programs encountered overseas had specific training they required all staff to attend, and though this did not happen in all programs, it was generally considered optimum. Several programs were involved in managing a conceptual shift in treatment models, and ensuring that staff were part of the process of change was essential to this. In particular, there was agreement about ensuring that residential staff shared the conceptual model underpinning treatment, were clear about how to enact this in every day contact with young people, and were assisted to understand their own responses.

Training in what Ryan (2006) calls “informed supervision” could be seen as the minimum required for caregivers. Informed supervision is summarised in 6 guiding principles:

- Keep the community safe
- Hold young people accountable for abusive behaviour
- Minimise reinforcement of deviance and dysfunction
- Maximise normalising experiences
- Model new experiences of non-abusive behaviour
- Assist in attainment of appropriate developmental competencies

Colleagues I met overseas were very generous with their training resources. Gail Ryan from the Kempe Centre gave me permission to use her curriculum to train carers for young people with SHB’s, Rob Tucker from Lucy Faithfull Foundation in the UK shared his training curriculum for foster care parents and Fiona True at the Ackerman Centre gave me copies of a resource CD for family therapists in the field of sexual assault.

Despite a recognition that informed supervision is a basic requirement of a care context, provision of adequate information and training for caregivers was not universal. Farmer (2004) observed that caregivers in the UK were sometimes not given adequate information to ensure they were aware of the risk that some children in their care may pose to others. Unfortunately, it appears that this is still the case on occasions, with some reports that workers could be reluctant to provide information about a child’s SHB’s for fear a carer may refuse the placement. While this could be seen as a problem of individual workers, it is more likely that it represents a lack of appropriate options for young people who may be a risk to other children.

While there were generally shared views about what would constitute optimum care, few people felt that it had been adequately achieved in most areas. One significant barrier to this was recruitment and maintenance of appropriate caregivers. In the UK the development of private residential providers was one attempted solution. The private providers would recruit caregivers who would be trained, supported and paid an appropriate wage for providing fostercare. Referring authorities utilised these placements for particularly complex cases that could generally not be accommodated elsewhere. The placements were supported by a multidisciplinary team including teachers, caseworkers and carers, but generally no therapeutic staff were employed by the providers. Views about the value of these private
providers were mixed, and no longer-term evaluations of them are yet available. However, the carers I met were positive about receiving ongoing training and being paid a reasonable wage for the care they provided.

The other important context of care for children and adolescents is their family, whose needs can be multiple. Not only may the family be the context of the early trauma or the acting out of the sexually harmful behaviours, family members may constitute the young person’s major supports. In addition, parents may provide the supervision that will underpin future safety. As a family therapist I was particularly interested in the role family work played in treatment. In both the US and UK, family therapy was seen as an essential part of the work with young people. The need for parents to be educated about their child’s sexual behaviour problems, and when appropriate to be “informed supervisors” was universal.

While all programs advocated family involvement, the models of family work were variable in their creativity and focus. Generally, families were seen to be an important resource to a young person’s recovery and future management. Therapy tended to focus on exploring unhealthy dynamics that may have underpinned aspects of offending, development of secure attachments and appropriate relationships, and on limiting risk and enhancing safety. Family reunification was also an aim of many programs, though not all provided the family work for this process to occur. There were a variety of reasons for this. In part, it appeared due to the challenging nature of the work, and the complexity of engaging with multiple agendas and views. For some, the family work was an additional role they undertook, on top of their primary role in supporting individual young people. When workers did not provide the family work as part of their programs, they tended to cite lack of resources and training as the major impediments.

In many instances family work was an “add on”, an intervention that sat alongside other interventions, but was not the central model. As noted previously, victim and offender services have developed in ‘parallel universes’, and for this reason, family work with victims and perpetrators, when it exists, tends to focus on the needs and interests of their particular client. Certainly therapists providing family work with perpetrators are sensitive to and aware of the need to privilege safety of victims, but involvement of the victim is generally in the service of the perpetrator’s treatment needs. For example, when it is seen as appropriate for the young person to have a confrontation session, this may be arranged via the victim’s therapist. While this approach is workable, it may subtly mirror old patterns whereby the perpetrators needs were primary, and in my view it misses opportunities to harness relationships in a process of healing for all family members.

This can be differentiated from the approach we developed at the Bouverie Centre, where family therapy is an overarching and central organising feature of the work. In dealing with the complexities of sexual abuse, what I call a systemic relational approach recognises the interconnection of family members, even when their interests may appear to be in conflict. In particular it recognises the difficulty parents often face as they attempt to care for the victim and the perpetrator. They are encouraged to care for both, but to do so in a way that disrupts old patterns and creates an appropriate nurturing context for all of their children. The approach holds that family recovery cannot occur unless the victim can heal, and recognises that support and changes in family relationships will be a primary vehicle for recovery. All family members are engaged in a process that keeps the victim recovery as central to healing, and recognises the hurt that has occurred.

In this approach the work with the perpetrator covers the same issues and tasks that other individual treatment models do, but the individual work is done in dialogue with the victim.
Victims generally share at least one goal with the perpetrator’s therapist; they want to make sure this young person does not hurt anyone else again. In many ways this holds the therapy accountable to the victim, who is kept informed and participates in assisting with the progress of the treatment to ensure her interests and concerns are addressed. In a paradoxical way, this process of accountability also assists reconciliation, as it allows the perpetrator multiple opportunities to express his remorse, to demonstrate that he is facing up to his abuse and to make necessary changes.

This is subtly but substantially different from an approach that generally only includes a victim in the gathering of information about the offence and in the apology, or confrontation sessions. An approach that holds family relationships as central to healing tends to ensure that there is careful integration with the treatment provided to individual family members, rather than just liaison between individual treatment providers (Dwyer and Miller, 2006).

Some programs in the US also advocated a close connection between the treatment of different family members. For example, Lamb (2006) drew attention to the common themes in therapy for victims and perpetrators, and called for closer “clinically facilitated dialogue” in treatment. She saw this as aiding in the recovery of both. At the Ackerman Centre in New York, Fiona True and colleagues have also developed a family approach to “relational trauma” (Sheinberg and Fraenkel, 2001). Like the Bouverie Centre, the Ackerman is primarily a family treatment centre, with a focus on clinical work, education and research. The model they describe is very similar to that which my colleagues and I have developed, which is perhaps not surprising given our shared theoretical ‘family of origin’, and orientation to family work.

In my meetings with other therapists I was inspired by meeting many people who shared my passion, and who were trying to develop creative family work models for assessment and intervention. Some of these people worked in extremely challenging contexts and were often lone family therapists in their workplace. Several family therapy colleagues overseas expressed an interest in collaborating on future presentations to highlight the possibilities of a broader and more integrative model of family therapy in this area, and it is hoped these opportunities can be pursued in the future.

4.2.4 Offence specific assessment and treatment

As noted, adolescents with SHB’s share a lot in common with other delinquents and frequently their sexually abusive behaviour is one manifestation of a range of other abusive behaviours they exhibit. However, the sexual nature of the abuse requires specific assessment and treatment. This includes assessment of risk of further harm, since decisions need to be made about where the young person should reside and what protection is required for the community. However, in line with the broad directions in the field, the areas of risk assessment and sex offense treatment are also undergoing review.

Recognising that normative adolescent development includes sexual development, Ryan and Lane (1997) argue that it is not the sexual aspect of the adolescent’s behaviour that differentiates it from normal adolescence; rather it is the abusive nature of it. Current treatment programs for young people who have sexually abused, tend to be both “abuse specific” (intervening in the tendency to abuse in multiple ways) and “offense specific” (dealing with the sexual nature of the abuse) (Ryan and Lane, 1997; Robichaud-Smith, 2006; Yorkely, 2006).

Abuse specific treatment must deal with those developmental competencies that adolescents need to attain, and which assist them to develop non-abusive behaviours. While language
may vary, most programs encountered focus on what Ryan and Lane (1997) call the “universal deficits” of all abusers; problems in communication, empathy and accountability. Treatment therefore assists in developing appropriate skills in language, emotional expression and interpersonal communication; empathy for others; and appropriate attribution of responsibility. However young people who have sexually abused also need adequate assessment and treatment for the sexual nature of the behaviour.

Offense specific treatment assesses risk associated with sexual behaviours, and intervenes in the pattern of offending. While this sounds like a relatively straightforward task, risk assessment is complex, and an area of current development and critique. Prescott (2006, p.24) describes risk as “…a long-term underlying vulnerability or predisposition to engage in a constellation of behaviours. Certain factors may temporarily mitigate or aggravate that disposition.” These factors are generally seen as “static/ stable” (they are not subject to fluctuation, such as historical events) and “dynamic” (which are subject to change, such as the nature and impact of current stresses).

However, in determining the level of risk it is also important to assess “assets”, that is, those factors that are protective in function. Assets, like risks, may be stable or dynamic. Risk assessment therefore entails a review of dynamic and stable risks and assets, and since adolescents can be unpredictable and changeable, should be undertaken with a recognition of the limitations of any assessment. It is generally argued that risk assessments for adolescents should be reviewed after six months, or as one observer described it, “should be written in disappearing ink” (in Ryan, 2006).

Both the treatment and risk assessment field are moving to embrace more complex understandings of adolescent sexual abuse. As Prescott (2006, p.1) notes; …it appears that “risk assessment” comes from simple and innocent questions, such as is an individual going to do it again…. (A) more worthwhile question might be, “What do we need to do to help this young person refrain from further harm?” This question addresses the specific needs, the tasks to be undertaken, and how these tasks can occur. To this end it may actually be more productive to move past the term “risk assessment” to a more comprehensive understanding of a young person’s development and ecology.

Actuarial risk assessment tools are commonly used, but do not measure dynamic risks. They have also been criticised as being biased away from incest offenders (Sheath, 2006). Many observers have cautioned against over reliance on actuarial risk assessment scales (Hart, Kropp and Laws, 2003; Prescott, 2006). The combination of both actuarial risk assessment tools and clinical judgement informed by research, are commonly utilised, but there is currently no empirically validated way of predicting a young person’s likelihood of re-offending. As Hart et al (2003, p.13) note, “There exists no method for making precise estimates of the probability that an individual will engage in specific acts in the future with any reasonable degree of scientific or professional certainty …. The search for such a method may be akin to the quest for the Holy Grail ….”

With a focus on crime and community safety, risk assessment and monitoring is often seen as the answer to community concerns. In the UK the Multi Agency Public Protection Arrangements (MAPPA) represent one attempt to ensure community safety. Registered sex offenders are monitored by community panels comprised of relevant community agencies such as police and probation services. The level of intensity of management and monitoring in any case varies, depending on ongoing assessment of current risk.

While these panels were initially set up in relation to adult offenders, they also have responsibility to monitor adolescents who have been registered as having committed a serious sexual offence. However, not all areas have a designated youth panel, and the degree to which adult panels have access to expertise in relation to adolescents, is variable. This is an example of the way in which the growing understanding of the need for developmental models of risk assessment and treatment, may be slow to be integrated into public policy responses to the problem.

These findings all suggest that risk assessment is a different task from therapy, that good therapy needs to be mindful of risk and safety, and paradoxically, that risk assessment must not overshadow efforts to assist healing and recovery. Best practice in the area currently requires recognition of the limitations of our state of knowledge.

5.0 CONCLUSIONS AND IMPLICATIONS

The current directions in practice with adolescents recognise the multiple pathways to the development of sexually abusive behaviours and the necessity to intervene in ways that address the underlying impacts of adverse life experiences on young people. The simplicity of this statement hides a complexity of implications. Some of these implications have already been alluded to, but will be expanded upon here.

5.1 NETWORK DEVELOPMENT

As noted, the service networks that interact with young people with SHB’s are numerous, however the relationship between them is variable. While there may be liaison around particular cases, there is often little shared conceptualisation of the problem and its potential solutions. This is despite the evidence that young people involved with child protection, juvenile justice, and mental health services are highly likely to have a history of significant trauma at a young age, and to exhibit a range of behaviours that may cause harm to others (Dwyer and Miller, 2006).

There are particular challenges to the way we have traditionally delineated our service streams, if we resist the temptation to see young people as either “victims” or “perpetrators”, and seek to gain a complex understanding of their unique needs and strengths. While there is no doubt that separate, specialist victim and perpetrator services need to exist, there is clearly room for dialogue and collaboration. How we share our knowledge and ensure collaboration between our services needs to be a primary focus of our attentions. Opportunities to develop shared conceptualisations must be created to ensure that these interacting services do not operate as “silos”.

The treatment requirements of young people vary according to the nature of the early life experiences, the impact of these on developmental progress, the detail of abusive sexual behaviours, their changing levels of risk, and progress in therapy. This means that young people need access to a continuum of services to cater to different needs, as well as responding to their progress through treatment and recovery. A continuum of services includes community based care options with informed supervisors in foster care and residential units, as well as secure units for those who are unable to remain in the community. In addition, Ryan and Lane (1996) recommend a “continuum of care” for young people with SHB’s. This means a consistency of care and approach across treatment. As far as possible this should include a continuity of relationships. Clearly this cannot occur without a shared conceptualisation and consistency of approach across those services involved with young people.

5.2 **HOLISTIC TREATMENT**

Holistic treatment can only be based on a thorough and integrated assessment that takes account of the young person’s developmental history, problematic behaviours and current context. As noted, current best practice with young people with SHB’s includes: individual assessment and treatment planning based on appropriate developmental frameworks; assessment and treatment of underlying trauma impacts; family treatment and context management; offense specific assessment and treatment.

It is still common for young people to be assessed according to their symptoms or behaviours, and to have separate services involved to deal with each of these. For example, a young person who has a history of sexual abuse and who exhibits self-harming and substance abuse problems, may be referred to a mental health service, a specialist sexual assault service and for drug and alcohol treatment. If s/he then discloses sexual abusive behaviours they may be referred to yet another service to deal with this behaviour, and may in some cases not be permitted to continue with the victim service.

While a multidisciplinary approach is valuable and is consistent with best practice principles, these services need to be complementary and integrated, not coming from competing paradigms. It some cases the best integrated response may come from resourcing and supporting a worker already involved with a child, through provision of consultation or supervision, rather than including yet another person into treatment. In other cases it may be appropriate to provide separate assessment or treatment. An essential element of holistic treatment is knowing when additional specialist input is required, and how to best provide it.

5.3 **EDUCATION AND TRAINING**

Not surprisingly, the current conceptual influences I have identified in the treatment of young people with SHB’s are also influential in other service areas. For example, as noted, those working with victims have been incorporating a trauma framework for some time. It is possible now to identify minimum training requirements for all services working with young people who have been subject to maltreatment in childhood. If one looks at the Take Two service in Melbourne that was set up by the Department of Human Services to provide therapeutic intervention to child protection clients, the depth and scope of training provided to staff has been thorough and targeted. All staff are trained in relation to trauma and attachment and the developmental consequences of maltreatment. While their role requires that they have therapeutic skills in these issues, other workers involved with children and adolescents may benefit from carefully targeted training that focuses on the relevance of these concepts to their roles. For example, workers in residential care will not need the same set of intervention skills as therapists, but they will need to know how to respond to the behaviours in a way that assists treatment goals. In relation to sexualised behaviours, workers in all service networks need to be educated in how these behaviours relate to normal child development, and the different pathways to SHB’s.

Since training and collaboration is central to network development, one model of training would be to identify key people across service networks, and train them to jointly deliver training. A “train the trainer” model, such as that developed by Gail Ryan and colleagues at the Kempe Centre, which includes development of a core curriculum and resources, could assist in embedding the training within the service networks.

At the undergraduate level, courses in social work, psychology, psychiatry and nursing need to ensure that graduates have a workable understanding of these major conceptual
frameworks. The responses need to be at every level of policy and service provision, and the shared conceptualisation and understanding will enhance this.

5.4 EARLY INTERVENTION

Recognition of the pathways to sexually abusive behaviours provides opportunities for early intervention. The current policy context in Victoria, based on the *every child, every chance reforms*, also provides an opportune time with the introduction of the new Children, Youth and Families Act (2005). The Act recognises the cumulative harm that can occur for children who are maltreated and seeks to ensure appropriate services are utilised as early as possible. It also specifically addresses the problem of children with sexualised behaviours. Children exhibiting sexually abusive behaviours may be deemed in need of therapeutic treatment. Some of these may be subject to Therapeutic treatment (placement) order. This provides opportunities for early intervention, but also poses challenges in training sufficient staff to assess and provide treatment.

There are a range of other initiatives that target early intervention with at-risk families and children. For example, the Innovations projects across Victoria have gone some way to breaking down barriers between services that had often been competitors for funding under previous programs. While their success and stage of development is variable, in most cases they have resulted in cross-sector collaboration and sharing of expertise in dealing with these vulnerable families. Given the association between development of abusive behaviours in children and a history of maltreatment or trauma, these services may be well placed to intervene early with those children at risk of developing SHB’s.

6.0 OUTCOMES: PLANS FOR DISSEMINATION AND INTERVENTION

Discussions have been held with a range of organisations as I consider how the findings from my trip may be utilized. In addition I have been able to incorporate some of the lessons into other activities that I undertake as a normal part of my work. My plans for dissemination and intervention have focussed on the three themes identified above: network development, training and education, and early intervention.

6.1 Network Development

- I have met with a number of key people in the service networks to consider opportunities for collaboration. Meetings have been held with Take Two Manager of Research, Principal Child Protection Practitioner for the Department of Human Services, CEO Parkville Youth Residential Centre (Juvenile Justice). Further meetings are planned with the Children’s Protection Society and South Eastern Centre Against Sexual Assault.
- Negotiations are underway with senior practitioners across the service networks to set up an advanced practice study group to explore the literature, consider implications for services and provide a peer forum for challenge and support.
- I have been part of a small group meeting with representatives from a specialist service dealing with victims of sexual assault, a treatment provider for adult sex offenders and a family support service for offenders. This group is exploring areas of joint interest across networks and ways of influencing inter-sectorial collaboration.

6.2 Training and Education

- Providing monthly supervision to clinical staff at the Gatehouse Centre, including setting up processes for exploring recent developments in practice and theory.
• I am in the process of negotiating training in relation to the impacts of trauma on children and adolescents with a CAMHS team and a post graduate training course for psychologists.
• Incorporation into training curriculum in post graduate courses run by the Bouverie Centre. Immediate examples include teaching sessions on trauma, sexual abuse and risk assessment for students undertaking a Graduate Certificate.

6.3 Early Intervention
• Since my return from overseas I have been invited to provide supervision to a number of early intervention and prevention services. This provides opportunities for education as well as service development. I am currently providing clinical supervision for the following: four Maternal And Child Health Services; two Family support teams; two Enhanced home visiting services; a drug and alcohol service.

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