Youth Justice Board
Bwrdd Cyfiawnder Ieuenctid

Young People who Sexually Abuse

Source document

Author: Roger Grimshaw

Additional research by: Mhemooda Malek, Mark Oldfield, Rose Smith, Zoe Davies, Catherine Downes, Paul Gavin and Avril Smith

www.yjb.gov.uk

Contents

Glossary of key terms

Cognitive behavioural therapy (CBT)
This is a relatively new intervention type, which has arisen from advances in our understanding about the role of internal cognition in the expression of external behaviours. CBT is based on the idea that cognition affects behaviour, and that individuals have the capacity to be aware of and adapt their ways of thinking, which can lead them to change their behaviour. In the context of treating young people who sexually abuse, the young person learns to recognise inappropriate behaviour, to take responsibility for it, and to learn rules for anticipating risks and changing behaviour accordingly.

Co-morbidity
The coexistence of two or more disorders/conditions. For instance, young people who sexually abuse may also have co-occurring problems and display characteristics associated with non-sexual disorders.

Multi-systemic therapy (MST)
MST is an intensive family- and community-based intervention designed to make positive changes in the various social systems (home, school, community, peer relations) that contribute to serious anti-social behaviour of children and young people. It is a flexible, individualised intervention and MST practioners offer 24-hour support to the families they work with. It uses evidence-based, solution-focused interventions, such as strategic family therapy and cognitive behavioural therapy.

Sexual offending
A range of sexually abusive behaviours that, at certain points defined in law, become offences for which a young person can be held legally responsible.

Background

This review was commissioned to serve as a background source document to accompany guidance produced by the Youth Justice Board for England and Wales (YJB), identifying key elements of effective practice in interventions in the youth justice context. It has not been written primarily for an academic or research audience, but for managers and practitioners working in the youth justice field who are directly involved in providing, or brokering access to, services for young people who offend and their families. The review offers an accessible guide to the current state of the evidence base on effective interventions and services, helping youth justice practitioners and managers to be aware of and deliver more rigorously evidence-based services.

The review document is divided into sections structured around a number of key themes or headings relevant to practice in youth justice services. The source document is structured to mirror the *Key Elements of Effective Practice* to facilitate cross-referencing between the two documents, and to ensure it is a useful document for the intended audience who may wish to explore the areas covered in the *Key Elements of Effective Practice* summary in more depth. These nine common sections therefore reflect what are considered to be core areas of consideration for practice and management within youth justice, and as such this structure is largely consistent across all 10 documents in this series of publications. The following *Key Elements of Effective Practice* titles and corresponding source documents are available from the YJB website (www.yjb.gov.uk):

- *Accommodation*
- *Assessment, Planning Interventions and Supervision*
- *Education, Training and Employment*
- *Engaging Young People who Offend*
- *Mental Health*
- *Offending Behaviour Programmes*
- *Parenting*
- *Restorative Justice*
- *Substance Misuse*
- *Young People who Sexually Abuse.*

Introduction

Background

Definitions

Sexual abuse has been typically defined as a form of harmful coercion, committed against victims who are unable to give informed consent, or are forced to take part in sexual activity against their will (Manocha and Mezey, 1998; Pennell, 2001; Grimshaw and Salmon, 2001). It covers a range of behaviours:

- sexual penetration
- touching parts of the body
- exposure of sexual organs
- intrusive observations
- stealing underwear
- masturbating into another's clothes
- obscene communication (such as obscene messages, sexual harassment or denigration)
- accessing child pornography or showing pornographic material
- facilitating sexual behaviour by others.

Electronic, as well as verbal or written, transmission of such messages and materials should also be considered abusive.

Sexual abuse is regulated in law by a number of statutes, chiefly the Sexual Offences Act 2003, which protects children and young people by creating age boundaries that affect the seriousness of the offence. In particular, young people under the age of 13 are considered in law to be unable to give consent to sexual activity. The law places a strict interpretation on the responsibility of those who engage in sexual activity, which means that young people over the age of 10 years who abuse are expected to take responsibility for their actions.

The significance of abuse by young people will be misinterpreted by seeking a simple 'one-size-fits-all' label. There is no clear mental health diagnosis for young people who sexually abuse. The importance of developmental factors in young people means that terms like 'disorder' must be used sparingly and based on specific evidence.

One expert has criticised what she calls:

> *…the misguided search for one all encompassing term that will cover children as young as 6 or 7 years old with persistent, over-sexualised or sexually aggressive behaviour, 11 year olds who may have committed penetrative offences and have faced criminal charges, as well as older adolescents with established sexually offending behaviour towards younger children or adults.*
>
> (Vizard, 2006:2)

There is inevitably a continuum of behaviours that, at certain points defined in law, become offences for which a young person can be held responsible.

The knowledge base

Sexual abuse by young people is a comparatively recent field of knowledge in which intervention and practice have been exploratory and evolving. The consequence is that research and knowledge are still accumulating and much remains to be confirmed. Systematic knowledge has been hampered by the fact that sharing detailed knowledge and practice across international boundaries seems to be limited, and much of the practice documented is in North America, where different arrangements governing the management of cases apply (Zimring, 2004).

Context

This report was commissioned in order to inform the Youth Justice Board of England and Wales (YJB) about research on effective practice that has emerged since 2001 (when the last *Key Elements of Effective Practice* source document and summary on *Young People who Sexually Abuse* were produced) up to 2006. The period has been marked by a number of changes in the organisation of services for children and young people and by an important change in the law. The Sexual Offences Act 2003 has redefined the offences committed against young victims and has made changes to the decision-making criteria adopted by the Crown Prosecution Service. Children's services have been reorganised in order to provide a clearer and more unified interagency structure.

Legal issues and developments

Since the last *Young People who Sexually Abuse* source document and summary were issued in relation to young people who sexually abuse, a major new Act has been introduced. The Sexual Offences Act 2003 protects all children from engaging in sexual activity at an early age, irrespective of whether or not a person under 13 may have the necessary understanding of sexual matters to give ostensible consent. A child under 13 does not, under any circumstances, have the legal capacity to consent to any form of sexual activity. The intention behind ss 5–8 of the Act is to provide maximum protection to very young children. The under-13 offences overlap to a very significant extent with the child sex offences (ss 9–15 of the Act), which are designed to protect children under 16. Moreover, the Act seeks to protect 16–17-year-olds from assault by young people in the same age category. Section 13 of the Sexual Offences Act 2003 was enacted to create a new offence to protect youths from sexual assaults by other young people. (For more details on the Act, see the Crown Prosecution Service publication *Legal Guidance on Sexual Offences and Child Abuse* and the *Sexual Offences Act 2003*.[1])

These changes should mean that, like other agencies, youth offending teams (YOTs) are expected to play a role in explaining the legal implications of reported behaviours to young people and their families, and, in particular, working closely with the Crown Prosecution Service, which takes responsibility for decision-making. It should be noted that the intention of the Act was not to criminalise young people unnecessarily, but to make sure that decisions were taken in the best interests of children. During the passage of the bill, Lord Falconer[2] said:

> *Our overriding concern is to protect children, not to punish them unnecessarily. Where sexual relationships between minors are not abusive, prosecuting either or both children is highly unlikely to be in the public interest. Nor would it be in the best interests of the child.*

[1] See http://www.cps.gov.uk/legal/section7/chapter_a.html. Accessed 19.06.08

[2] ibid

Children's services developments

As victims are identified, often through child protection procedures, the importance of inter-agency arrangements is a priority. Care and treatment services are provided by a variety of agencies, some in the voluntary sector and some in the health sector. The integration of services to meet the quantity and range of needs is therefore a challenge.

The YJB has sought to map and explore the services for this group nationally. The results of that mapping have indicated a number of service development needs that should be addressed (Hackett et al, 2003). It has given 'Pathway' status to the Assessment, Intervention and Moving On (AIM) project, a multi-disciplinary development project based in the Greater Manchester area. The initial screening tool for the AIM project has been evaluated, and the evidence shows that the project has had some effect in reducing the fragmentation of initial responses to young people's risks and needs (Griffin and Beech, 2004).

A joint departmental review has also collated information with the intention of conducting an on-going policy review (Whittle et al, 2006). The role of specialised assessment and treatment services for young people who sexually abuse makes it crucial that well-planned and co-operative relationships are maintained among all the agencies involved.

Arrangements for safeguarding children have been reorganised and Local Safeguarding Children Boards (LSCBs) have been established. It is in their remit to develop responsive work to protect children, including young people who sexually abuse (DfES, 2006). There is now a structure to make sure that Children and Young People's Plans are devised for the effective co-ordination and delivery of services to children and young people (see the 'Service development' chapter).

These developments in the field form an important backdrop to the research questions that are tackled in this source document; it uses information about the changes as a means of highlighting needs and service priorities that flow from them.

Aims and methods

Aims

The aim of this document was to identify the elements of an effective service in relation to assessing young people who sexually abuse, and providing or securing access to interventions to address their offending behaviour and increase protective factors.

This review was commissioned in order to systematically review, according to Campbell Collaboration standards, evidence about effective practice emerging in the period from 2001 to 2006.[3] The results were intended to inform guidance on best practice. The review of literature was undertaken in order to find any evidence of effective practice internationally, especially as there is a far greater number of international studies than can be found in the UK. It is important to relate that knowledge to the context of policy and practice in England and Wales. Any gaps in knowledge that are revealed should be seen as strengthening the case for giving renewed and concentrated attention to the issues.

Methods

The review began with a search through recently systematically reviewed studies and bibliographical databases. To identify unpublished literature, contacts were made with experts

[3] See http://www.campbellcollaboration.org

and specialist agencies in the UK. A special effort was made to contact international experts and practitioners in order to find new and unpublished literature (see Appendix C).

Material was found that enabled an analysis of studies, mainly on assessment and service delivery, to be undertaken. There was a scarcity of evidence on a range of the topics that were the focus of the guidance. In particular, very little robust evidence was found in relation to:

- individual need
- transition
- training
- management
- communication
- service development.

However, the need for good comparison studies of all these topics has been reinforced by the findings of the YJB's mapping of services, which identified several challenges to effective multi-agency service provision (Hackett et al, 2003). In order to highlight needs not met or not known, this source document has, where appropriate, used a small additional range of sources that refer to such evidence (see Appendix C). This is very clear in a number of chapters, especially in 'Service development', where recent policies on children's services have highlighted the importance of graduated and inter-agency responses to young people's needs and behaviours, based on shared assessment models.

Assessment

This chapter will discuss principles of assessment and evidence from the review about assessment tools that can help secure access to the most appropriate interventions. It will also discuss needs and practice priorities that should be at the forefront of attention.

Evidence from the review revealed no studies at Level 3 of the Maryland Scientific Methods Scale (see Appendix C for further explanation), which examine comparable groups with and without an intervention. However, there is evidence of useful assessment tools, such as *Asset* and the AIM model and framework. Greater progress still needs to be made in effective assessment for serious risk of recidivism, assessment of young women and of minority ethnic groups.

Principles of assessment

Assessment of young people who sexually abuse has been described as a cyclical and ongoing process with five key goals (Hackett, 2004):

1. **problem explanation:** understanding the sexual behaviour within the context of the individual young person's overall psychosexual, emotional and social functioning.
2. **risk formulation:** identifying those features that are relevant to considering level of risk.
3. **risk management:** identifying the degree of control, restriction or supervision required to manage assessed levels of risk.
4. **intervention planning:** identifying areas where change is needed and how it can be achieved to support the young person to live a non-abusive lifestyle.
5. **evaluation:** assessing how change will be evaluated and progress measured.

The process must be revisited as new information is produced and previously unknown offences are brought to light. Work with a young person during treatment is likely to reveal unknown offences (Baker et al, 2001). The goals of service delivery will then need to be reviewed and the intervention plan should be modified as appropriate.

Assessments should aim to identify and gather information from the range of systems that are significant to the young person, such as family, peer group, school and community. Appropriate in-depth assessment will support access to the right part of the system and avoid levels of intervention that are either too intense or insufficient for meeting individual needs. Some possible consequences of an inadequate initial assessment are highlighted as (Print et al, 2001):

- under or over-representation 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
- inter-disciplinary conflicts and miscommunication.

It is important to see the assessment of risks and strengths as an objective process that may lead to a number of alternative conclusions and to the consideration of different intervention options.

It is therefore crucial to ensure that any information is comprehensive and valid, and to select an assessment instrument that has been evaluated as appropriate to the key characteristics of the individual concerned.

Identification

The hidden figures of sexual abuse

The identification of young people who sexually abuse is a process that is influenced by several factors:

- capacity and willingness of young victims to understand and make the fact of their abuse known
- attitudes of families and communities
- willingness of agencies to listen to victims and record what they describe.

A long era of denial and minimisation of the harm caused by sexual abuse has meant that it is only recently that the behaviour of young people has become more widely known and recorded. However, some victims may still be ignored or neglected so that young people's abusing behaviour is left unrecorded, unchecked and unsanctioned (Masson and Hackett, 2003).

Evidence from a national sample of adults showed that experience of sexually-abusive behaviour has been far from uncommon. In a survey of 2869 young adults in the UK (Cawson et al, 2000), questions were posed about both non-contact and contact abuse. It was found that 11% (6% of girls; 7% of boys) said that they had, when aged under 16 years, suffered abuse involving sexual contact of some kind, either against their wishes or when aged 12 or under and the other person was five or more years older. Asked about behaviour against their wishes or with a person five or more years older, it emerged that 4% had experienced full sexual intercourse, 3% oral sex and 1% anal intercourse.

When asked about penetrative/oral acts committed against their wishes or when they were aged 16 or under with someone five years or more older, it was found that only 1% reported sexual abuse by a relative; brothers or step-brothers were responsible for 38% and cousins for 8% of these acts. However, the sample numbers for family abuse are too low to be conclusive. For such abuse by non-relatives, reported by 7%, 70% of these acts were committed by a boy or girlfriend and 10% by a fellow student or pupil. 'Date rape' was therefore the most common form of sexual contact abuse likely to be faced by young people, and the phenomenon of peer abuse emerged as a cause for concern. Only a quarter with sexual experience against their wishes or with someone five or more years older told anyone about it at the time; very rarely were police or other professionals told about the abuse at the time (Cawson et al, 2000).

The recording of abuse

A significant section of the group identified as abusing has been recorded by inter-agency safeguarding procedures for dealing with child abuse; a small minority of the recorded cases has come to attention again for subsequent abuse (Taylor, 2003; Masson and Hackett, 2003). A proportion of cases receiving specialist services for sexual behaviour has been found to have been recorded on Child Protection Registers (Hutton and Whyte, 2006), and many of those assessed by specialist services do not come to the attention of the criminal justice system for sexual abuse again (Hickey et al, 2006). Young people under the age of 10 cannot be found

responsible for an offence and so those processed through the criminal justice system form a selected group. In the past, cases typically have come to YOT attention through police or social services referrals (Hackett et al, 2003).

There are indications of a rising trend in the offence statistics. The YJB's published figures for 2002–03 reported 1,664 sexual offences resulting in a disposal for the young people who committed those offences. Disposals include pre-court disposal (Reprimand or Final Warning) or a court disposal. In 2003–04, the total number had risen to 1,796, while in 2004–05 it was 1,827. The YJB's figures for 2005–06 show that the number of sexual offences resulting in a disposal for the young people who committed them was 1,988 (1942 males; 46 females). The evidence points to steady increases in the sexual offences dealt with by the criminal justice system.

The process of inter-agency identification and assessment will be central in determining how cases enter the system. The Local Children's Safeguarding Boards are currently key players in any agreed processes of identification, and their interface with YOTs will therefore be crucial in ensuring that appropriate procedures are in place.

Those who are formally identified as sexually abusing are a limited proportion of the abusing population (Cawson et al, 2000) and it is not clear how typical their risks and needs may be. Any changes in policies, procedures or investigations may result in changes in the pattern of young people who come to the attention of agencies. Hence, patterns of risk and need may alter over time, and assumptions must be constantly scrutinised to allow for any significant changes to be acknowledged and understood.

Assessment of risk and need

The most effective assessments are likely to be those that identify clear risks and needs that become the subject of relevant and effective interventions. However, the evidence about risk of recidivism shows very varied findings, and the evidence about interventions that reduce the risk of reoffending for these young people is inconclusive in some key respects (see the 'Service delivery' chapter); specific assessment tools of proven effectiveness in assessing risk of recidivism among young people who abuse have not emerged. The rest of the chapter therefore discusses what amounts to 'work in progress' or promising practice.

The following evidence about assessment focused on:

- the use of the *Asset* assessment profile
- the establishment of common assessment frameworks
- the identification of risk and protective factors
- specific risk prediction instruments.

The use of the *Asset* assessment profile

The major relevance of *Asset* to the assessment of young people who sexually abuse is that it produces a comprehensive profile of the young person's risks and needs that includes both sexual and non-sexual offending.

There are specific questions about 'sexually inappropriate behaviour', registration as a sex offender, and Schedule 1[4] offences. Distinct schedules within *Asset* are designed to assess any risks of serious harm or vulnerability.

The section on emotional and mental health should be carefully considered in order to determine if an assessment by a professional service specialising in emotional or mental health is required. There are opportunities in *Asset* to comment on the harms of the behaviour and the needs of victims; sections on the young person's attitudes to victims and beliefs about offending are of key significance. Educational needs and family relationships are likely to present important topics for assessment and planning.

The sections on positive factors should bring out any strengths and supports that can encourage the young person to make progress and identify any urgent needs for additional support.

The 'What Do YOU Think?' form, which is directed at the young person, is available in both English and Welsh.

Asset is therefore a tool for case management and for the auditing of YOT caseloads, but its use should be fully integrated with local inter-agency procedures that should include a common assessment framework for young people who sexually abuse.

Details about the inter-rater reliability, measurement of change, and predictive accuracy of the *Asset* profile are provided in the *Assessment, Planning Interventions and Supervision* source document.

A common assessment model and framework – the Assessment, Intervention and Moving On model

Common assessment models are designed to obtain the maximum amount of valid information that, when synthesised, can help to shape an informed and graduated inter-agency response. A positive example is the AIM assessment model, which is anchored in a common framework of response.

The AIM assessment model and framework has undergone long-term development and now incorporates many of the features outlined in various documents as key components for an initial assessment. The model involves (Print et al, 2001):

- assigning a lead agency that identifies co-assessors, consultants and a date for completing the assessment
- applying the assessment to assist with decisions about identifying services and where to place young people
- covering four domains of assessment:
    1. sexual behaviour
    2. developmental
    3. parents/carer
    4. environment

[4] Offences against children or young persons up to the age of 18 years, referred to as 'Schedule One Offences', are listed in Schedule 1 of the Children and Young Persons Act 1933.

- applying the assessment to construct an outcome matrix that provides a framework within which to structure decision-making.

The model considers indicators of concerns that focus on:

- the individual – such as early onset of severe behavioural problems, unresolved trauma, non-compliance with supervision
- the family – such as witnessing domestic violence, experience of abuse or neglect, negative family attitudes to the victim
- the environment – such as local community hostility to the young person, previous exclusion from work or school, lack of structure in daily life.

It considers also strengths that focus on:

- the individual: such as ability to reflect and understand consequences of offending behaviour, willingness to engage in treatment
- familial factors: such as parents demonstrating good protective attitudes and behaviours, family having clear and positive boundaries
- other factors: such as living in a supportive environment, an available network offering support and supervision, having a good relationship with school or employer.

Two co-workers carry out the information collection and interviews that provide the basis for the numerical scores for strengths and concerns. The scores are then placed in an outcome matrix and translated into a judgment about the level of supervision required. The whole assessment process is divided systematically into 10 steps, beginning with a referral and ending in the presentation of a report to an inter-agency strategy meeting.

In addition to the above model that focuses on adolescents, the AIM project has developed assessment models specifically for young people with learning disabilities, children from 10–12 years of age and under 10 years of age, and assessments for the parents/carer.

An evaluation was conducted of the reliability and usefulness of the first version of the assessment framework and model for AIM. In this methodical evaluation (Griffin and Beech, 2004), it was found that the inter-rater reliability (in other words, the consistency among professionals in their responses to the questions) was high for most of the distinct sub-scales of questions within the instrument; however, it was moderate for concerns for one of the two case studies used. In terms of validity there was only 17% disagreement on strengths and 13 % on concerns.

A mathematical factor analysis was carried out to see how far the responses on the dimensions correlated with one another. The results indicated that responses for the strengths dimension were only partly independent of those for concerns, and therefore the dimensions may have been in part measuring the same things. It is important that strengths are adequately measured so that planning and practice can focus on utilising them. It is encouraging that there was 75% agreement with other strengths-focused assessment scales, the Family Assessment Measure 111 (Skinner et al, 1995) or the Behavioural and Emotional Rating Scale (Epstein and Sharma, 1998), but it was notable that there was only 35% agreement with the concerns recorded by the Adolescent Sexual Abuser Project – ASAP (van Outsem et al, 2006). The study recommended changes to improve the reliability and coherence of the instrument and to introduce a ‘medium concern’ classification. One aspect to be noted is that the evaluation obtained limited feedback from young people and their families, so more information on their views about AIM is needed.

In respect of the framework of response, a study of 75 records by the authors revealed that co-working was identified in all cases; 60% showed inter-agency working; and 72% followed all 10 steps, from initial referral to report presentation. In 81% of cases, the recommendations were implemented to some extent; for example, implementation 'in part' included a request for work by an educational psychologist after it was found that there was a three-month waiting list for the recommended family support (Griffin and Beech, 2004).

Recently, the AIM assessment model has been revised and the AIM2 model now:

- sources updated research
- has 'medium' concern and strength classifications
- introduces both static and dynamic factors
- uses a clinical judgement framework with a simple scoring system
- is linked to YJB *Asset* and the Department of Health Core Assessment Framework
- is focused on protecting victims.

There is therefore evidence to suggest that the AIM framework has been able to achieve a good level of implementation across the agencies, and that, as its reliability and coherence are improved, and the feedback of families and young people becomes fully incorporated in its development, it holds considerable promise as an effective instrument.

Initial assessment of this kind will often be conducted in a community setting, though a proportion of young people are assessed while in placements. It has been noted that practitioners report difficulties in making assessments of young people's risk and needs while they are in placements, such as custodial settings, as the placement is likely to affect their support structures (Griffin and Beech, 2004). The AIM2 model seeks to address this issue. Practitioners should ensure appropriate support is provided in these settings so that young people are not distracted by stresses in their placement, and therefore assessments can focus on future needs with clarity.

Assessment of risk and protective factors

A feature of the AIM assessment tool is the attempt to assess 'strengths' as well as 'concerns'. There is growing interest in the development of 'strength-based' interventions (Ward and Stewart, 2003). An example of a new assessment tool that focuses on strengths as well as risks is the MEGA (Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing Sexually Abusive Adolescents and Children [Ages 19 and Under]). MEGA identifies protective factors, such as involvement in treatment and a positive relationship with a parent/carer. It incorporates 'multiplex'or interleaved elements that function simultaneously to influence young people. It relies only on research data about young people and not on data about adults who abuse young people. It has been developed to be applicable to all groups, including young women, children under 12 years of age and those with developmental delay; however, the tool has not yet been validated (Miccio-Fonseca and Rasmussen, 2006).

Much attention has been paid in the literature to risk prediction instruments, which aim to determine, as far as possible, the likely risk of reoffending. All such instruments have elements of actuarial prediction, and in addition some incorporate the clinical judgements of knowledgeable sources.

- *Actuarial risk prediction* is based on information about group risk of re-offending, analysed in extensive studies of populations. Actuarial assessment of an individual measures how far

the individual shares the key characteristics of the group, such as age, gender, criminal records, etc. which are found to be associated with levels of risk.

- *Clinical judgement* is derived from 'close-up' information about an individual and draws on the knowledge of trained practitioners who deliver an informed judgement.

The fact that a risk prediction is based on analysis of a population underpins its strength as a predictor, but because there is variation within groups, it offers only a general guide towards assessing risk in an individual case (Worling, 2004).

In practice, accuracy depends on several factors:

- quality and quantity of the information about an individual
- extent to which the individual shares those group characteristics of risk measured by the instrument
- reliability and validity of the instrument itself
- extent to which the instrument has been validated externally on the populations concerned.

Specific risk assessment tools

Two specific risk assessment tools were included in this review's evaluation. (See Appendix A for more details of these studies).

- **J- SOAP** (Juvenile Sex Offender Assessment Protocol) is a checklist to assist in the review of risk factors derived from the literature; it is not intended to be used as a sole guide to assessment. There are four categories:
  - sexual drive/preoccupation
  - impulsive
  - anti-social behaviour
  - clinical intervention
  - community stability.

  Developed using a sample of inner-city youth, the instrument shows very good internal consistency, produced results correlating well with the Youth Level of Service Inventory/Case Management Inventory (Schmidt et al, 2005) and effectively distinguished between youths in community and those in residential placement. Its validity in predicting reoffending is not, to our knowledge, confirmed (Righthand et al, 2004).
- **ERASOR** (Estimate of Risk of Adolescent Sexual Offense Recidivism) is an empirically-guided checklist designed to assess short-term risk of sexual reoffence. Many of the items are derived from risk factors for adult sexual offenders. There are five categories:
  - sexual interests
  - attitudes and behaviours
  - historical sexual assaults
  - psychosocial functioning
  - family/environmental functioning treatment.

The instrument shows good internal consistency and was able to distinguish between youths in the community and in residential care, as well as between first-time offenders and recidivists. While comparisons among offenders have been undertaken, no prospective data on recidivism has, to our knowledge, been reported (Worling, 2004).

Some research has sought to apply the concept of 'psychopathy' to young people who sexually abuse. Young people with experience of custodial settings have been associated with a significant rate of psychopathic personality disorder (Gretton et al, 2001 and 2005). A diagnosis of psychopathy implies that the risk of recidivism is higher than average. The extent to which a test for psychopathy can be successfully applied to a young population has been explored in research on young people with sexually-abusing behaviour who have been assessed by a fourth-tier service designed for young people who pose significant risks to others. The results imply that 'emerging severe personality disorder' is correlated with a future career of non-sexual and violent offending (Hickey et al, 2006).While some evidence suggests that traits resembling 'psychopathy' can be discerned in young populations, it is not clear from the evidence that a consistent and predictive construct linked to risk of sexual recidivism has been established. There is no single clinical instrument that can currently identify those with psychopathic traits who possess an increased risk of sexual recidivism (Whittle et al, 2006; Loving and Gacono, 2002; Gretton et al, 2005).

Another approach is to test the distribution of psychological factors thought to be associated with risk (Print and O'Callaghan, 2004). Using a large multi-site sample, systematic research using scales developed by the Adolescent Sexual Abuser Project has also been conducted into the feelings and cognitions of young people who have abused, many currently in young offender institutions (YOIs) (Beckett, 2006). The study compared groups of young people who abuse with a sample of the general population. The findings show that there were no great differences in general empathy and cognitive distortions between the adolescents in the general population and the young people who abused, but victim empathy was higher among the adolescents in the general population. These results indicate that measurement tools need to be refined if they are to identify differences between the distribution of cognitive features among young people who abuse compared with the normal distribution in the population. More research is needed to critically evaluate theories about the attitudes of young people who abuse, using evidence from large samples, including adolescents in the general population.

Risk assessments should not assume that adult instruments will be suitable for the task of identifying risk and need, and allocating individuals to treatment programmes. Miner (2002) found that predictors of youthful sexual recidivism were not the same as those for adults. The development of adult scales relies upon the predictive power of prior offending patterns over a number of years. Data on offending patterns for young people differs from that of adults. Adolescent offending frequently fits into two patterns – 'adolescent limited' or 'life course persistent'. The former refers to a pattern of offending that spontaneously decreases and stops in late adolescence, and the latter to a persistent and often escalating pattern of criminal activity as the individual moves out of adolescence and into adulthood (Moffit, 1997). Research has indicated the difficulties of being able to differentiate such patterns for young people who offend, and this may well suggest similar patterns for some young people who abuse sexually; their sexually harmful behaviours may not necessarily be the precursors of similar activity in adult life.

There are two opposite kinds of measurement error – the failure to identify something that exists and the failure to confirm that something does not exist. The likelihood of either form of error needs to be quantified, and therefore any research information about the 'success' rate of an instrument should be carefully examined before its use is authorised. Even a very successful

instrument, as used in medical testing, would produce a significant proportion of false results when applied to an actual population of young people. Because risk assessments are not exact, they should be best expressed in terms of broad categories of risk, rather than precise measures (Worling, 2004).

There is some evidence that the prediction of infrequent events is enhanced by the incorporation of two or more risk assessment tools into one model. This, the authors suggest, draws on a wider range of predictive factors and results in more accurate prediction – and of course may also be useful in assessment (Monahan et al, 2001). In this respect, a combination of risk and assessment tools is well worth considering. In probation practice in the UK, Oldfield (1998) described the combination of two measures, which assessed severity of offending and likelihood of persistence of offending in order to structure allocation to appropriate services, and then measured change in offenders using an instrument that recorded practitioners' assessments of change on dynamic factors over three-monthly periods. Practitioner assessments of change were highly correlated with persistence and desistance, with the direction of the correlation depending on whether the assessment was positive or negative. We should be cautious, however, about extrapolating such results to young people and more work is required to link assessment, components of work and outcome measures to risk and protective factors.

Assessment tools should therefore be carefully selected with a clear awareness of their limitations. There are currently no assessment tools that 'do everything' we might ideally want.

Checklist for assessment tools

The following checklist is meant to inform discussions about the usefulness of particular instruments.

- Does the instrument refer to strengths as well as risks?
- Are the risks and strengths independent constructs?
- Has the instrument been designed to draw upon a number of sources (agency records, professional judgments, information from the young person and family)?
- Has the instrument been tested with sub-groups based on gender, ethnicity or disability?
- Is the guide to administration and analysis clear?
- What is the likelihood of test prediction failure?
- Are users of the predictive information fully trained and aware of all the implications?
- How clear is the base information available? Is it out of date? How reliable are the sources?

Particular assessment needs

Attention should be paid to clarifying the assessment needs of sub-groups, such as those from minority ethnic communities, with a disability, those with mental health problems and those abusing younger children or abusing peers (Hackett et al, 2003; Whittle et al, 2006). Assessment needs will vary depending on several aspects of the relationship, including age and level of affection. For example, intentional penetrative touching of someone under 16 years of age by a 17-year-old is a serious offence that is only mitigated by an affectionate relationship, or immaturity. Where there is coercion or the offence is within the family, the assessment needs will be different (Sentencing Guidelines Council, 2007).

Assessment in the secure estate should be well-integrated with the rest of the assessment system. The current threshold for youth custody extends across a range of cases and circumstances. It is

likely that the aggravating circumstances for cases sentenced to youth custody will be varied. They may involve obviously violent coercion, or equally, a degree of planning or subterfuge, especially in a case where consent to intercourse is not possible (*A Case* [2005] EWCA Crim. 3104). More details on the custody threshold are contained in current guidance (Sentencing Guidelines Council, 2007).

The current threshold for youth custody suggests that, owing to the variety of circumstances and needs, it will not be reasonable to develop offender assessment tools solely and separately for the cases dealt with by the secure estate. A young person's risks and needs have been found to be affected by entry into placement, which should be assessed as part of the normal induction procedure. Good support is needed at this stage to enable the young person to take part in an assessment that identifies future needs with clarity. The main goal of assessment in the secure estate should be to contribute to the findings of a common assessment framework; a process of combining information from *Asset*, the AIM screening instrument and further validated risk assessment tools should be considered. With a shared assessment, multi-disciplinary work will then be promoted so that the young person's future risks and needs after release are assessed within an appropriate timescale.

Summary

- Assessment is a cyclical ongoing process and should be updated to focus on the changing needs and risks revealed by new information.
- There are advantages in bringing together assessments that address all the component needs, risks and strengths.
- *Asset* forms a useful basis for assessment, case management and caseload audit as it collates information about all the individual needs of young people; it should be completed in conjunction with other assessments.
- A common assessment framework, such as AIM, has the advantages of pooling information collected by different agencies and making its interpretation as clear as possible to practitioners in every agency. It can ensure standards for ascertaining the views of young people and families. There is a greater likelihood that discrepancies and disagreements are identified and resolved as far as possible.
- Instruments that use specific risk predictors are so far lacking in predictive validity, owing in large measure to the low base rate of recidivism.
- To begin to shape a comprehensive assessment framework, information from *Asset*, AIM and other valid instruments should be jointly compiled, compared and analysed.
- Particular needs should be addressed through the common framework of assessment.
- More longitudinal research on assessment and outcome is required to understand how the two are related; this would help improve existing instruments and make a more accurate management of risk possible.

Individual needs

Heterogeneity of need

Referring to young people 'who commit sex offences', an extensive review of the professional literature asserted that they:

> *…differ according to victim and offence characteristics and a wide range of other variables, including types of offending behaviours, histories of child maltreatment, sexual knowledge and experiences, academic and cognitive functioning, and mental health issues.*

(Righthand and Welch, 2001: p.xi)

The heterogeneity of young people's needs has been noted in numerous studies, and emerges again in a recent systematic review (Brooks-Gordon et al, 2005).

The review sought evidence of effective practice in relation to identifying and meeting individual need. However, the needs and risk factors associated with the primary occurrence of the behaviour are hard to ascertain. As the previous discussion of the identification of abuse showed, a significant problem in linking primary risk factors with intervention is the interval between the behaviour and its disclosure. The secondary risks of sexual abuse (in other words, abuse following the primary occurrence of the behaviour) are difficult to assess because the risk of sexual recidivism is low (Caldwell, 2002).

In order to focus the review, studies were sought which dealt with needs that should be addressed by agency intervention. Personal, developmental and other factors that are likely to affect responses to interventions were important in considering evidence of effective practice.

The review revealed no studies at Level 3 on the SMS, which compare progress in meeting the needs of well-matched groups with and without intervention (see Appendix C for more information). Literature on good professional practice was therefore consulted in examining some of the key issues.

Needs of groups identified as sexually abusing

The evidence about the needs of those identified as abusing cannot be formulated in a neat and precise pattern. However, these are some of the typical observations from research:

- Young people have frequently experienced sexual, physical or emotional abuse (Burton et al, 2002; Kenny et al, 2001; Dent and Jowitt, 2003).
- A significant proportion show poor social competence and high impulsivity (Righthand and Welch, 2001; Rutter et al, 1998; Righthand et al, 2005).
- A significant proportion of young people have educational difficulties or learning disabilities (Manocha and Mezey, 1998; Hickey et al, 2006; Timms and Goreczny, 2002).
- Young people are often coping with disrupted and neglecting family backgrounds (Veneziano and Veneziano, 2002).

Understanding the links between having been sexually abused and going onto subsequent abusing behaviour is complex; research suggests that features of the abuse, such as the use of

force, as well as family experiences distinct from the abuse, each play a significant role (Burton et al, 2002; Whittle et al, 2006).

It has been found that young people who commit sexual offences are similar in a range of characteristics to non-sexual offenders from troubled backgrounds (Rutter et al, 1998; Hickey et al, 2006; van Wijk et al, 2005; Seto and Lalumiere, 2006). The evidence suggests that those identified as abusing share common characteristics with many other young people who are involved in offending of various kinds.

The extent to which the risks are offset by strengths and resilience is less often the subject of investigation, and the literature suggests that the impact of adverse experiences is filtered by the meaning given to them by the young person, and that educational levels can be protective in enabling adaptive coping (Wilcox et al, 2004).

Attempts to produce typologies of the young people have not generated practical and reliable results (Veneziano and Veneziano, 2002). It is extremely difficult to arrive at valid generalisations about the population and to produce robust information about primary risk factors for the emergence of abuse. For this reason the review focused on assessment and individual needs at the point of the behaviour coming to official attention.

Those planning interventions should be alert to the complexity of young people's needs, and their interventions should be based on understanding how several domains (sexuality, family, education, non-sexual offending, etc.) are interrelated.

Young people with learning disabilities

A significant number of young people who sexually abuse have learning disabilities or very poor educational attainments. However, it is not the case that young people with learning disabilities are more likely than others to abuse sexually (Vizard et al, 1995; O'Callaghan, 1998; Hackett et al, 2003). Also definitions and measures of disability vary and therefore it should not be assumed that a distribution of learning disabilities will be predictable or uniform.

There is evidence that young people who sexually abuse have educational needs that are common among young people who are found to offend generally. For example, in a detailed assessment of mental health needs involving 301 young people on the youth offending caseload drawn from six areas (151 in custody and 150 in the community), one in five were found to have a learning disability, measured as an IQ less than 70 (Chitsabesan et al, 2006). Similarities among the needs of young people in the criminal justice system should not therefore be underestimated.

In specific studies of young people who sexually abuse, it has been found that between a third and a half of samples in six UK studies had official statements of special educational needs (Hickey et al, 2006). However, the literature is sparse and not sufficiently empirical (Fyson et al, 2003). For example, high rates of emotional, behavioural and educational difficulties were found in a study of young people showing sexually abusive behaviour identified under child protection procedures. Nonetheless, about 30% (n= 67) were reported to have 'no difficulties whatsoever' (Taylor, 2003).

One of the most common measures of educational ability has been IQ and it is not surprising that this measure has been widely used in comparisons between samples of young people who sexually abuse and of other young people who offend. Evidence from a large meta-analysis of studies suggests that there is no difference in the IQ scores between young people who offend sexually and other young people who offend. The analysis compared recorded IQ scores for samples comprising 1398 sexual offenders, 1399 non-sexual offenders and 48 non-offenders.

There were no significant differences between scores for the sexual and the non-sexual offenders, but there were significant differences between juvenile sexual and adult sexual offenders, and adult non-sexual and juvenile non-sexual offenders (Cantor et al, 2005).

These results need to be evaluated with caution. It should be pointed out that the least able group may have been less likely to enter the study samples. Indeed studies that only reported data on 'mentally retarded offenders' were excluded (Cantor, et al 2005 – 'exclusion criteria'). It appears that these samples will reflect the selection of cases brought through the criminal justice system and may not be typical of cases where a welfare-oriented approach was thought more appropriate. The higher scores of adults compared with those of juveniles could be attributed to the effects of maturation. Also, IQ scores are a very partial test of learning disability.

The heterogeneity of study samples implies that good evidence about the proportions of young people with different learning needs is lacking. A clear evidence-based approach to assessment and meeting need is still some way from being realised (Timms and Goreczny, 2002). Problems in learning are associated with the competence of young people in interpreting communication and in social skills (Timms and Goreczny, 2002; Rich, 2003). Assessments and planning of interventions for young people with learning disabilities need to take account of social and cognitive functioning and related implications, such as shorter attention spans, experience-based learning and repetition of messages (Hackett et al, 2003).

Young people with co-morbid conditions

There is evidence to suggest that among young people who sexually abuse there is a substantial proportion that show co-occurring problems, or, in particular, display characteristics associated with non-sexual disorders (so-called 'co-morbid' conditions). Whereas a range of problems can be identified and determined by common assessment frameworks, co-morbid conditions are psychiatrically defined, assessed and evaluated.

Schizophrenia and psychotic disorders are comparatively rare among young people with sexually-abusing behaviour (Righthand and Welch, 2001). More relevant are disorders that are more frequently found among children, such as attention-deficit hyperactivity disorder (ADHD) and post-traumatic stress disorder (PTSD), which concern a lack of appropriate attention and impulse control (Lambie and McCarthy, 2004; Rich, 2003; Bladon et al, 2005).

In particular the prevalence of abuse histories among young people who sexually abuse is associated with PTSD (Hunter et al, 2003; Wilcox et al, 2004; Veneziano and Veneziano, 2002). However, it would be wrong to give a diagnosis of PTSD simply because of a known history of abuse, and careful assessment of the actual symptoms is required (Rich, 2003). Some young people are reacting strongly to a range of abusive experiences that have left a legacy of distress; some have followed the behavioural example set by others and have been sexualised at a young age.

PTSD has implications for risk and treatment outcomes, in particular, because it can be a factor leading to relapse or repetition of abusing behaviour. In a study of triggers for abusing behaviour, 47% of 40 young people in a treatment sample had been exposed to both physical and sexual abuse and PTSD was found among 84% of this group. Among the 27% exposed to both sexual and physical abuse, as well as other violence, the rate of PTSD was 100%. It was found that strong negative feelings, such as fear, helplessness and horror, associated with risk of relapse, were connected with PTSD (McMackin et al, 2002). Provided that such findings are replicated, this means that the treatment of abusing behaviour can be adversely affected if PTSD is not

recognised and treated. The research suggests that an intervention that fails to address the PTSD that young people experience will not be as successful as one that addresses those needs.

A sub-group of young people displays dissociation, marked by memory problems and fluctuations in behaviour – a condition which is trauma-related (Friedrich et al, 2001). Disavowal of behaviour is also a feature of dissociation, so engagement in treatment is affected by the condition.

Another obstacle to treatment is cognitive impairment linked to particular health conditions such as foetal alcohol syndrome (Baumbach, 2002). The cognitive deficits of such conditions mean that treatment should be adapted to the young person's particular learning style.

More information on service responses to co-morbid conditions should be sought in the *Key Elements of Effective Practice* source documents *Substance Misuse* and *Mental Health*.

Young people from minority ethnic communities

People from minority ethnic communities span a wide range of cultures and countries of origin. Applying cultural awareness and sensitivity to assessment and treatment interventions is important. Assumptions about the beliefs, needs and practices of particular minority ethnic groups should be avoided.

Assessment and treatment interventions should consider practical needs, for example translation and interpreting, as well as the need for services and staff to develop culturally-competent responses. It is suggested, for example, that appropriate ways of working with clients and families from minority ethnic communities should be an aspect of ongoing professional development for all who work with young people who sexually abuse. As well as obtaining insights from colleagues and members of minority communities, the young person and the family are likely to have something to teach the professional about their culture (AIM, Mir and Okotie, 2002). Developing professional cultural awareness and sensitivity would enable all staff, irrespective of their own ethnicity, to provide an effective service to this group (Whittle et al, 2003).

Young women who sexually abuse

Young women form a minority – less than 10% – of young people who are formally identified as sexually abusing (Kubik et al, 2002; Hunter et al, 2006).There is a lack of evidence available regarding the needs of young females who sexually abuse, and therefore it is difficult to ascertain the extent to which their treatment needs are similar or different to those of young males (Tardif et al, 2005; Calder, 2001).

Not only have young women experienced physical and sexual abuse, extensive and severe abuse involving coercion has been found to be typical (Kubik et al, 2002; Mathews et al, 1997). Indeed, a recent study of cases recorded in the child protection system found that girls, irrespective of age, were also more likely to be alleged victims of sexual abuse (Taylor, 2003). Lack of family support is identified as a background factor in the emergence of their problematic behaviour. Abusive behaviour is frequently directed at younger victims who are acquaintances or relatives.

Individual needs of young women vary, with some, for example, who appear to have been sexual experimenters, showing few signs of being disturbed. Others display more extensive abusive behaviour that mirrors their experiences of being abused. Another group engages in more

persistent or entrenched behaviour that is associated with severe emotional disturbance (Hunter et al, 2006).

Psychiatric co-morbidity, including substance misuse and PTSD, has been found to be frequent among young women who abuse; in particular, they have frequently contemplated suicide. (Kubik et al, 2002; Mathews et al, 1997). The implications of co-morbidity are that therapeutic relationships become challenging because young people feel very vulnerable. Holistic approaches that recognise the full extent of needs are therefore recommended (Scott and Telford, 2006).

The lack of attention and acceptance of females who sexually abuse in policy and research is highlighted; it is reported to impact on legal and reporting practices and act as a barrier to effective identification and response (Bunting, 2005; Denov, 2003). Attitudes to young women who abuse are found to be polarised in inconsistent ways (Scott and Telford, 2006).

Work with young females who sexually abuse should recognise patterns of experience that echo those of young men, but should take account of girls' different maturation paths and views about relationships (Vick et al, 2002). Separate provision or interventions are appropriate (Hunter et al, 2006) and assessments will identify the more specific needs. For example, interventions for the 'experimenter' cases will focus on sex education, self-esteem, social skills and family support. A more long-term approach is likely to be needed for cases with more abusive behaviour, and will include a focus on the impact of victimisation on these young people. The cases with severe disturbance will require long-term intervention and will often need 24-hour supervision (Hunter et al, 2006).

Summary

- The needs of young people are heterogeneous.
- Young people who have typically suffered abuse show poor social competence and impulsiveness, and are coping with disrupted and neglecting family backgrounds.
- The proportion of young people with learning disabilities is significant, but these needs are often shared with the wider population of young people who offend.
- The needs of young people with co-morbid conditions will impact on treatment, and therefore specialised assessment, treatment and services should be provided.
- Young people from sub-groups, such as young women, minority ethnic groups and people with learning disabilities, may have specific needs. Services should apply awareness and sensitivity in identifying and addressing such needs.

Communication

Communication pathways

No conclusive evidence about effective practice in communications was found; examples of good professional practice were therefore identified.

Effective interventions for young people who sexually abuse and their families are likely to be provided by a range of agencies and professionals; the nature of support offered is also likely to vary over time. Communication between agencies is therefore a vital aspect of effectively co-ordinating interventions and enabling young people to gain the maximum possible benefit from interventions offered.

Some pathways for communication between YOTs and other agencies already exist (YJB, 2004). These include YOTs:

- referring child protection and children in need concerns to the social services department and contributing towards child protection plans on a case-by-case basis as appropriate
- attending Local Children's Safeguarding Board meetings
- links with Child and Adolescent Mental Health Services and Primary Care Trusts
- sharing, through the MAPPA process, information on children who pose a risk to the local community.

The YOTs will need to be regularly liaising with partners in the secure estate in order to sustain the implementation of agreed plans and to help make effective transitions.

Good practice in communication – the example of Multi-Agency Protection Arrangements

The structure of multi-agency public protection arrangements (MAPPAs) is set out in guidance issued by the National Probation Service. The offenders subject to the arrangements fall into three categories:

- registered sex offenders required to register with the police
- violent and sex offenders receiving a custodial sentence of 12 months or more, a Hospital or Guardianship Order, or subject to disqualification from working with children
- others considered to pose a 'risk of serious harm to the public'.

There is a statutory duty placed on agencies to cooperate with MAPPAs.

Multi-agency public protection panels (MAPPPs) have been established to manage offenders in the community. The role of MAPPPs is to share relevant information, to assess the level of risk and recommend suitable action, and to monitor the action plan periodically.

YOTs will be expected to work together with Crime and Disorder Reduction Partnerships (CDRPs), LSCBs and Criminal Justice Boards to support the MAPPAs. In larger areas, routes for initial referral to the MAPPAs should be agreed to ensure that the central co-ordinating function is not overloaded. Attendance at meetings of the Strategic Management Boards and panels is vital if the agencies are to share information and make effective and accountable decisions (Kemshall et al, 2005). Attendees from YOTs should have the capacity and authority to allocate resources and be responsible for decisions.

In a study of the work of MAPPAs (Kemshall et al, 2005), it was noted that youth justice practitioners needed to appreciate that 'risk of serious harm' in the *Asset* form referred to the risk posed by the young person to others, and relevant guidance on dangerous offenders has been subsequently issued by the YJB. Risk management plans should be integrated with care plans for children and emphasise the protection of child victims. For example, release from a custodial sentence means that plans should be made to meet the needs of the offender and protect the victim. Adequate monitoring arrangements using suitable databases are needed to ensure that plans are implemented.

Good practice in YOTs has involved organising multi-agency risk strategy meetings as part of the management of cases identified as a 'risk concern' (Kemshall et al, 2005). Chaired by an intensive supervision team manager, the meetings have followed a core agenda that included:

- a confidentiality statement
- information exchange
- risk assessment
- discussion about the level of risk applicable and if it should be changed
- risk management strategy
- actions
- review date.

As the case of MAPPAs shows, professional and inter-agency communications help build an understanding of jointly-agreed aims and objectives.

Communications with the young person and family

In addition to effective communication between professionals and services, it is also important that there is effective communication with the young person and their family. Achieving this will require consideration of the young person's individual needs, such as those related to developmental stage, disability or ethnicity. These considerations will be important in assessment meetings and in sentence planning in which the young person and the family are encouraged to take responsibility for changes in behaviour or risk management.

A third dimension in relation to communication is highlighted by a study examining the experiences of adolescent sex offenders who had not reoffended for at least one year after completing a treatment programme and re-entering society (Franey et al, 2004). The study usefully illustrates how this sort of communication (obtaining the views of 'successful' adolescent sex offenders about their experiences, challenges and coping strategies on discharge into mainstream society) can contribute to an understanding of their experiences after treatment. This, in turn, can inform the development of relapse prevention programmes and treatment programmes that address the process of re-integration back into society.

Similarly, Lawson (2003) obtained the views of participants in an outpatient treatment programme, which aimed to generate a mid-range theory of treatment for use in monitoring treatment progress. The study illustrates how listening to respondents' views about what they learn in treatment, their goals and what is happening in their lives more generally, can facilitate the assessment of treatment progress.

Learning and gaining insights through effective communication was also highlighted by respondents participating in a study of service users (Hackett et al, 2003). Both young people and their parents/carer valued being able to talk, feel understood and be heard. They also valued the opportunity to gain insight into the nature of sexual abuse and how the child protection and criminal justice processes operated. Parents in this study also found it beneficial to communicate with, and learn from, other parents who had been through a similar process.

Summary

- No conclusive evidence on effective communication was found.
- Communication among agencies is required through formal arrangements, including the Children's Safeguarding Boards and MAPPA.
- Formal communication should be supplemented by professional communications that help build an understanding of jointly-agreed aims and objectives.
- Young people and their families gain benefits from clear and effective communication that takes account of their specific information needs.

Service delivery

The evidence base

This chapter discusses ways of providing or securing access to interventions to address young people's offending behaviour and increase protective factors. It deals with the effect of treatment on sexual offence recidivism, and examines evidence about ways of securing care, welfare, and justice outcomes. A discussion of intervention goals and components adopted by practitioners suggests that multiple outcome measures should be used to reflect the range of intervention goals that could reduce risk and increase protective factors.

While there are signs that some programmes might work to reduce recidivism among some young people, it is premature to conclude that programmes have a clearly established effect. Methodological problems and a dearth of valid studies mean that neither efficacy nor effectiveness in reducing recidivism is proven. The effectiveness of treatment, care and therapeutic placement is not well understood. It is possible that the reduction of risk factors and increase in protective factors might be achieved by the identification of multiple intervention goals that could be developed into testable intervention components, but it is not yet known how effective a further development or synthesis of current approaches might be.

Treatment approaches

It was only in the final decades of the twentieth century that the phenomenon of young people who sexually abuse became recognised as a public policy issue (Masson and Hackett, 2003). Evidence about early onset sexually abusive behaviour among adult offenders focused attention on this group. A belief grew that there were needs that could only be addressed by treatment and that early intervention was required to prevent the behaviour becoming deeply entrenched. Since then, there has been a growth in the salience of treatment as an approach for reducing risks and increasing protective factors among young people.

Treatment studies have been slowly accumulating. Many of the approaches were initially borrowed from the emerging field of adult sexual offender treatment. It was therefore necessary to ensure that the developmental needs of young people were fully addressed in all forms of intervention, including treatment (Pennell, 2001). The legacy of adult-oriented approaches is now being questioned (Hackett, 2004).

It is evident that treatment is a complex process with several goals and components. Summarising and describing treatment is made challenging by the ways in which its focus is developed in a treatment setting and crystallised in a plan. The reports that are analysed next should be seen as evidencing versions of models, rather than testing a single model in any simple sense. The problems of linking the results of studies with variant approaches and with wider applications are known as problems in establishing the external (as distinct from the internal) validity of the studies.

The treatments most often identified in the better-designed outcome evaluation studies discussed below were:

- **Cognitive behaviour therapy (CBT)** – a model of treatment in which the young person learns to recognise inappropriate behaviour, to take responsibility for it, and to learn rules for anticipating risks and changing behaviour accordingly. More details are to be found in the *Key Elements of Effective Practice* source document *Offending Behaviour*.

- **Multi-systemic therapy (MST)** – a theoretically-based treatment model that provides intensive therapy and 24/7 crisis support for young people in all the significant domains of their lives, including family and education, in order to effect change.

Other approaches are described as psycho-educational, family systems or attachment-focused.

Evaluation of treatment studies

A main purpose of the review was to uncover any clear evidence of treatment effect on sexual offence recidivism, i.e. evidence of reoffending. The measurement of officially-recorded recidivism is problematic because it is a conservative measure of further offending and is subject to unknown levels of error in the construction of arrest or reconviction rates due to definitional and procedural differences across regional and international jurisdictional boundaries. However, official records are the common basis for the evaluation of practice.

The standard for evaluatng effectiveness was to find at least one well-conducted study at Level 3 of the Maryland Scientific Methods Scale showing good statistical evidence of a positive treatment effect, with indications that the rest of the evidence was pointed firmly in the same direction (see Appendix C).

It was important to try to find a consistent pattern in the results of soundly-conducted studies. The evaluation of a large body of research work on a particular subject has increasingly become based on meta-analytical methods. Meta-analytical methods combine the results of numerous pieces of research, coding and quantifying characteristics to examine overall trends and results, often controlling for participant and design characteristics (integrity in delivering treatment; random allocation of subjects to the treatment being investigated, etc.). However, where such information is not available in the source studies, the meta-analysis itself must leave such information out of its considerations – thus limiting some of the findings.

The results of meta-analytical methods are expressed as an effect size (Lipsey and Wilson, 2000). This consists of a standardised indicator of the magnitude of the relationship between treatment and outcome. Effect sizes can be expressed statistically as correlation coefficients, as standard deviation-based measures, or as odds ratios. Where information is available, it is also possible to directly compare the proportions of participants who are reconvicted or whose recidivism is recorded by other means. Of course, to be truly meaningful, it is then necessary to also consider factors such as length of time in treatment, the level of engagement, drop-out and removal from treatment and so forth, in order to compare like with like.

For this purpose, a comparison was made of findings from systematic reviews, meta-analyses, and comparison group studies. A problem for outcome studies in this field is known to be a low general rate of sexual offence recidivism (Print et al, 2001; Reitzel and Carbonell, 2006). To illuminate the question of what effectiveness in reducing reoffending might mean, and how it might be measured, recidivism rates across outcome studies were also compared. The evaluation examined results from studies with the strongest and most comprehensive designs, first of all, before considering less well-designed studies.

Inconsistent evidence of effectiveness in systematic reviews

A systematic review is designed to evaluate the widest range of well-evidenced studies; however, the analytic procedures and criteria for inclusion can deliver rather different results.

The main lesson to be learned from the systematic reviews was that treatment and, in particular, CBT programme and MST, were not demonstrably and consistently effective.

A systematic review of sex offender treatments by MacKenzie (2006) contained a meta-analysis of seven 'CBT programme' studies, alongside meta-analysis of studies of other treatments. Only two of the seven were with young offenders; one was a randomised controlled trial ([RCT] rated as 5 on the Scientific Methods Scale (SMS) and the other was a comparison group study (rated as 3 on SMS Scale). One of the studies examined MST, and this was also the study with the highest effect size (21) of all treatment studies included. However, its sample size was only eight. The second study was of 'sex offender treatment', with an effect size (2.24) that is almost a tenth of the first. The total treatment sample in the combined analysis was 52 (8 + 44). The analysis therefore displays, at best, very modest evidence of effectiveness. The results of combining these with five other studies in a meta-analysis produce an impression of stronger evidence than is the case. It seems reasonable to question the appropriateness of aggregating the results of two rather different treatment studies, in particular, describing MST – a specific therapy within the field – as a form of CBT.

A second review by Littell et al (2005) focused on just one of the treatments – MST – and its impact on several kinds of behaviour. Eight randomised controlled trials of MST conducted in the USA, Canada, and Norway were examined, one of which was of MST for young people who sexually abuse. The results indicated that it is premature to draw conclusions about the effectiveness of MST compared with other services. Results were reported to be inconsistent across studies that vary in quality and context. There was no information about the effects of MST when compared with no treatment.

A third review of treatment for young people who sexually abuse by Brooks-Gordon et al (2005) included:

- one randomised controlled trial of cognitive behaviour therapy
- 13 non-randomised comparison group studies
- three qualitative studies.

The RCT did not report recidivism outcomes and no evidence was cited from the further 13 studies of significant differences in recidivism among the groups compared (except for one study comparing those rated as high, medium or low-risk of reoffending on the Hare Psychopathy Checklist: Youth Version [PCLR-YV] – a risk assessment instrument). There was no evidence of treatment effect on recidivism. The review's authors raised doubts about whether unproven treatment approaches, including CBT and relapse prevention, can be recommended; it was suggested that further evaluations of process and outcomes should take place.

In the same review by Brooks-Gordon et al (2005), there was qualitative evidence about the impact of positive pathways modelled for young people, as well as description of the varied characteristics and specific needs of offender sub-groups.

The findings of the different reviews produce a rather contradictory picture; while the results of the meta-analysis by MacKenzie (2006) appeared at first glance to support claims of effectiveness, the analysis by Brooks-Gordon et al (2005) suggests that, by the best design standards, there is no evidence that psychological treatments are effective. The review by Littell et al (2005) also draws into question the general efficacy of MST with young people who display behaviour problems.

Analysis of the findings of the systematic reviews casts significant doubt on the consistency of the claims for effectiveness that have been made in treatment studies.

Positive treatment outcomes identified in particular meta-analyses

Meta-analysis can be used to assess interventions reported in a more limited range of studies than is characteristic of systematic reviews.

The main lesson to be learned from the meta-analyses was that treatment could have positive outcomes, but it was not clear what treatment in this context was successful and with whom.

Three particular meta-analyses were included in the review. The first, by Walker et al (2004), included 10 treatment studies, reporting an overall effect size of 0.37. Several studies lacked control groups and there were inadequacies in the reporting of case attrition and of follow-up data. The most recent study included nine treatment studies and found an average weighted treatment effect size of 0.43 (CI=0.33-0.55) (Reitzel and Carbonell, 2006). However the studies had non-equivalent follow-up periods and treatment drop-out was handled in unclear ways.

The third contained comparisons of seven programmes for young people forming part of a large meta-analysis of sexual offender treatment studies; here the specific effect size for those studies was an odds ratio of 2.35 (CI= 1.01-5.43) (Losel and Schmucker, 2005). The percentage differences are summarised in the table below.

Table 1: Differences in outcomes for treatment and comparison groups in meta-analyses

	Treatment	Comparison
Walker et al (2004)*	32.%	68%
Reitzel and Carbonell (2006)	7.4%	18.9%
Lösel and Schmucker (2005)*	30%	50%

* calculated expected rates

The results certainly suggest that where young people have received treatment of one form or another, the outcomes are more favourable than for comparison groups. However, the handling of drop-out and removal of cases from the studies was questionable, limiting the conclusions to be drawn.

Another characteristic challenge of meta-analysis is the problem of distinguishing the impact of different interventions. In terms of programme type, the highest effect sizes were associated with MST and cognitive behavioural programmes. However, Reitzel and Carbonell (2006) reported that MST produced a larger effect size than CBT, but Walker et al (2004) found the reverse to be the case. There is some likelihood that MST is sometimes recorded in meta-analytic evaluations as being CBT. Indeed Lösel and Schmucker (2005) explicitly do so to facilitate their analysis.

The results of the meta-analyses tend to endorse positive treatment effects across the studies selected, but the difficulties in comparing the included studies from the available information mean that, as Lösel and Schmucker (2005) advise, we should remain cautious in deriving clear-cut conclusions.

Comparing intervention outcomes from a recent RCT

The most recent RCT study in the review produced interesting but inconclusive evidence (Carpentier et al, 2006). It compared 135 young people with sexual behaviour problems randomly assigned to CBT or to Play Therapy with a clinic group of 156 being seen for non-sexual disruptive behaviour. CBT was highly structured, using a teaching and learning model, identifying appropriate and inappropriate behaviour, teaching behaviour rules and self-control techniques and providing sex education. The Play Therapy group was based on psychodynamic principles; children were allowed to play, with minimal direction by therapists, who helped to

identify feelings connected with the children's play. Both interventions included sessions with care-givers.

The study reported evidence of an 8% positive difference in recidivism outcomes after CBT treatment compared with Play Therapy, but there were too few details given about the 'blinding' of assignment of cases to treatment groups (in order to reduce the possibility of bias) and there was no comparison with an untreated group. No differences were found between outcomes for the CBT and the clinic groups (Carpentier et al, 2006). (See Appendix B, Table 2: Table of Studies, where the outcome evidence from the evaluated studies is laid out in detail.)

Drop-out

Drop-out from treatment is of interest as a possible factor in recidivism (Worling, 2004; Whittle et al, 2006). According to a meta-analysis of treatment effects for sex offenders of all ages, completion of a programme doubles the likelihood of reduced recidivism compared with those who drop out of treatment (Lösel and Schmucker, 2005). Dropping-out can be a serious issue; for one programme, Whittle et al (2006) cite a drop-out rate of 51% over 10 years. Research has investigated relationships between drop-out and pre-treatment variables, but the results so far are sufficient only to produce a clinical checklist (Edwards et al, 2005).

Recidivism rates

It is hard to find evidence about the impact of treatment as comparison group data are lacking. If there was more accurate knowledge of recidivism rates for young people who sexually abuse, treatment outcomes would be better understood. It would also be possible to gauge the effects of other interventions, including innovations in justice or public protection.

For the purpose of further clarification, intervention studies with recidivism data were evaluated and compared, but the data were not adequate to support clear conclusions. Rates of recidivism fell within a wide range, from 0 to 20%, and follow-up periods varied greatly in length. The heterogeneity of the samples and follow-up periods were obvious reasons for the variations in recidivism. (See Appendix B, Table 2: Table of Studies and Table 3: Sexual recidivism in intervention studies.)

The data suggest that rates of sexual recidivism are too varied and often too low to permit treatment effectiveness to be evaluated solely by reductions in recorded reoffending.

Fortune and Lambie (2006) reviewed recidivism studies over the previous 15 years, arriving at several conclusions. Generally, young people who received treatment had lower rates of recidivism than than those who did not receive any treatment controls, indicating there may well be some treatment effect – though only a few studies included untreated or control groups in their design.

However, several problems with the research base were identified:

- scarcity of literature
- age discrepancies between study samples
- few studies included control group
- few studies included drop-outs
- diverse outcome variables.

The review by these authors concluded that recidivism rates varied; 0–40% committed further sexual offences (but there were problems in direct comparisons of treatment programmes because of the effects mentioned above).

Adolescent offending tends to fit into two patterns – 'adolescent limited' or 'life course persistent'. However research has not yet established the extent to which young people who sexually abuse fall into one category (desisting from abuse as they grow up) or the other (continuing to abuse young people or offending sexually against adults).

Summary of evidence on treatment and recidivism

The results of the analysis suggest that:

- low base rates of recidivism make it hard to measure the impact of any intervention on reoffending
- study weaknesses remain a substantial problem and good designs do not deliver clear conclusions if they are not adequately conducted and reported
- by the best standards, clear evidence of treatment effect is lacking
- meta-analysis gives more impressive indications of effective results but its findings are only as robust as the studies and treatments included
- in terms of reducing recidivism, treatment shows signs of promise, but that conclusion should be qualified by the piecemeal picture that emerges from an overview of studies and by the failure of the best designs to show clear evidence of effect.

Care, welfare and placement

Concerns about placement availability or quality were common among YOTs that took part in a service mapping study (Hackett et al, 2003). Reflecting the known gaps in the literature (Epps, 2006), only a small number of studies were found on care, welfare and placement, exploring the impact of residential, foster and therapeutic care for young people who sexually abuse. They reveal several interesting practice needs and approaches, but it is difficult to identify clearly effective practice.

Residential care and foster care (non specialist)

No conclusive evidence has been found about the effectiveness of non-specialist residential care and foster care. A small-scale study has suggested that levels of supervision, formal treatment, behaviour modification and meeting outstanding needs are factors that may be associated with positive outcomes, but more research is required (Farmer, 2004).

Therapeutic communities

Young people can be placed in a residential therapeutic community, which involves a planned and comprehensive approach to needs, with regular community meetings, group and individual work, education and work experience. Owing to a scarcity of relevant and specific studies, a lack of conclusive evidence has been found about the effectiveness of therapeutic communities. However, a recent study indicates that young people appear to make progress in addressing the problems that they had experienced prior to entering the community (Boswell and Wedge, 2002).

Therapeutic foster care

Therapeutic foster care provides specially trained and managed foster care families for young people who sexually abuse, but relevant studies are rare in the literature. The study included in

this review focused on six children and is mainly of methodological significance (Ownbey et al, 2001). No conclusive evidence has been found about the effectiveness of therapeutic foster care for such young people.

Priorities

Good practice suggests that there is a strong need to ensure that all placements are, and remain, safe for the young person and any others who share the placement or are in regular contact. Adequate support should be given to families and carers. Information needs to be co-ordinated and shared among all concerned with the welfare of abusing and non-abusing young people. Policies on sexual play and contact should be established and made clear to young people. Protective factors, such as self-esteem and self-control, can be encouraged by carers (Epps, 2006).

Innovations in justice

Evidence about one innovation – restorative justice – is available from one study below Level 3. However, the choice of interventions was not controlled and good comparison data was therefore not forthcoming (Daly, 2006). No conclusions can be drawn about the effectiveness of restorative justice in reducing recidivism.

Custodial placement

Some studies focus on the outcomes of treatment applied in a custodial setting, but from the descriptions given in the papers, it is very difficult to tease out the elements of service that could be associated with any reduction in recidivism. Custodial settings comprise far more than formal treatment services and they also typically offer education or occupational training services; their regimes affect the quantity and quality of the services from which young people can benefit. There is a lack of research on the combination of staff services that might produce effects on young people. No conclusive evidence has been found about the effectiveness of provision in a custodial placement.

Service needs, priorities and interventions

The evidence about effective practice in service delivery is not adequate, but its gaps also reflect the isolation of different service goals, targets and components, with little attempt to collate information about all the aspects of service delivery and to evaluate impact on a comprehensive range of positive outcomes.

A focus on reducing recidivism should not mean that the accomplishment of more direct intervention goals and targets is not measured. Such intervention goals can be framed as contributions to strengthening protective factors and reducing risk factors.

Intervention goals and targets

Setting intervention goals is important both from the perspective of planning interventions and for evaluating effectiveness. In a study mapping services in England and Wales, the greatest degree of consensus between practitioners regarding core intervention goals was in relation to (Hackett et al, 2003):

- helping young people understand and accept responsibility for their behaviour and develop skills to avoid offending in future
- promoting physical, sexual and emotional well-being

- ensuring community safety
- supporting carers to acknowledge their child's behaviour and take responsibility for changing the context of the family.

Within these core intervention goals, a further 15 intervention targets received high consensus; they highlight the need to achieve a balance between addressing protection issues with those of welfare:

- protection of other children and community safety
- meeting the support needs of young people who had sexually abused
- supporting the emotional and psychological development of young people who had sexually abused.

Intervention goals will vary for individual young people and should not be mutually exclusive. Neither will the goals be constant within a single intervention. For example, the main emphasis in the early stages of an intervention may be to help the young person take responsibility for their behaviour and to secure the safety of others, and once this is achieved the focus of the intervention could move more towards helping the young person to develop personal awareness and social skills.

Intervention components

Intervention components refer to the key elements of intervention programmes and will have strong links with intervention goals. The components receiving the highest consensus among practitioners were (Hackett et al, 2003):

- emotional competence skills, including management of anger and distress
- general developmental assessment
- changing cognitive distortions about sex and relationships
- pro-social, emotional, cognitive and behaviour skills
- risk assessment
- gaining an understanding of the child's cycles/pathways to sexually harmful behaviours
- sex education
- life-space work (boundaries, interaction, social skills)
- relapse prevention work
- family work
- consequences of further abuse/behaviour
- development of empathy.

From the evidence about their views, it is clear that practitioners had a concept of the goals of intervention that embraced family services and community safety, as well as developmental goals. The adoption of such goals can serve to address risks and to strengthen a range of protective factors.

More work is needed to clarify which of the components listed above are effective in accomplishing intervention goals. All components should have particular operational outcomes

to be measured. Components should be seen not just as small-scale, but as parts of comprehensive interventions that will include the treatment, care and management of young people separated from their families. In addition to custodial settings, specialist and non-specialist care provision should be integral participants in the process of specification.

In the absence of clearly conclusive evidence about effectiveness, all local interventions should be subject to a process of evaluating intervention goals and components that are aimed at reducing risks and increasing protective factors. For example, treatment programmes should be endorsed on the basis that they are addressing such goals concretely, and not simply because they are using a version of CBT or MST. Particular components will have outcome measures attached, such as change in young people's perspectives, behaviour or achievements, and these will be scaled to demonstrate degrees of progress or reveal blockages. Systematically designed research that explores the most effective mechanisms for the attainment of goals will be possible once the goals and components are operationally clear-cut and measurable.

Matching needs to levels of intervention

The evidence from the studies suggests that needs are multi-dimensional and complex. Young people show needs in the areas of sexuality, learning, care and family relationships, as well as co-morbid conditions. Much of the evidence draws comparisons between young people who sexually abuse and the population of young people who offend as a whole; therefore, service needs that are common to both groups should be clearly identified.

The AIM project has made progress in developing an assessment process that delivers a matrix of needs matched to levels of intervention. Appropriate assessments enable the agencies delivering services to assign cases appropriately to levels of intervention that are neither too intense nor insufficient for meeting individual needs.

A tiered approach to service design can offer an effective means of allocating services appropriately and more details about tiered services are discussed in the 'Service development' chapter.

Case management

In a survey of those managing services that worked with young people who sexually abuse, (Hackett et al, 2003), there was a high level of consensus about the importance of:

- establishing an agreed inter-agency framework for referral, investigation, assessment, case planning and review of all cases
- allocating a key worker, or equivalent lead worker, to each young person receiving a specialist service to co-ordinate the case management process
- offering outreach work to carers and others working with young people who are awaiting a specialist service.

Case managers are in a position to organise the process by which assessment of risks and protective factors leads to planned intervention goals, targets, and components with outcomes that are periodically measured (Oldfield, 1998).

Summary

- The evidence does not support firm conclusions about the effectiveness of particular treatment approaches, though some young people show reductions in recidivism and other benefits after going through some programmes.
- We do not yet have evidence from well-designed studies to attribute effects to the programmes themselves. Drop-out rates should be researched and evaluated as possible factors in recidivism.
- Recidivism rates appear too low and too varied to allow targets to be set for the reduction of re-offending. The variations in recidivism belie any expectation that all, or most, young people who sexually abuse have a common risk of reoffending.
- Evidence about care, welfare and innovations in justice for young people who sexually abuse was too sparse to allow general conclusions to be drawn.
- Key approaches to the treatment field have concentrated on applying the models created for adult risks and needs. As they are developing, young people have complex needs that call for multiple intervention components in sexual knowledge, offending patterns, learning needs, care and support.
- The development of more integrated services with graduated levels of response to assessed needs would make it possible to focus on the complex needs of young people more effectively.
- Effective case management enables a clear allocation of responsibilities to be made, and provides a continuing link with the individual and family.
- From a review of existing intervention goals and components, new components of service should be formulated, with operational measures of outcome attached. These components should be combined to meet identified needs, with the result that the evaluation of the achievement of all service goals will then be feasible. Until then, evidence will be disparate and inconclusive.

Transition

Co-ordination

There are several types of transitions. The type of transition recommended for a young person depends on their needs and development (such as educational changes), on planning decisions (changes of placement) and other factors that bring change. Evidence about transition was limited to a number of studies that indicate norms of good practice.

Treatment facilities are needed to help young people adjust from treatment, in particular residential treatment, back into the community and to provide ongoing support (Whittle et al, 2006). Effective co-ordination of services is as important on release as it is for assessment and treatment, and there is a need to provide ongoing support to parents when young people are discharged from treatment.

The following case of DM highlights the importance of co-ordinated decision-making and collation of information.

Case review of DM

After DM was discharged into the community from a residential treatment unit, he was later found to be responsible for the murder of a child. A case review showed a series of fundamental failures in information sharing, risk assessment, co-ordination and planning. The case involved 16 agencies and organisations over a period of 19 years spread geographically across England. The range of professional disciplines included social work, teaching, educational psychology, clinical psychology, child and adolescent psychiatry, health visiting and the police (Dent and Jowitt, 2003).

Issues to consider in relation to transition, which should be identified at the assessment stage and reinforced at each review, are:

- continuing effective involvement and multi-disciplinary work after a placement has been made
- sharing sensitive information at times of transition to make sure that assessment and planning are effective
- information collation should be co-ordinated in cases where there have been several agencies and organisations involved and many professional interventions have taken place
- disagreements among professionals about levels of risk should be openly discussed and resolved
- the agencies that are assigned responsibility for continuing supervision or services should be given all the relevant information needed to address risks
- an effective plan for after-care should be produced in time for it to be implemented
- all statutory review requirements should be adhered to
- treatment outcomes should be adequately monitored
- accurate recording practices should be maintained.

As for all placements, the issues of transition are an integral part of sentence planning for young people in custodial settings, and they should be addressed at the outset of the assessment and planning process. Transitional arrangements will be influenced by the progress of plans as the custodial period unfolds, and therefore there will be a combination of foreseeable and unforeseen needs at the critical times of transition, such as release from custody. The return of the young person to the original community setting is obviously a key option to be considered, but it may not be feasible, may create unacceptable risks or fail to meet the young person's needs. In response to updated assessments and plans, the identification of any new resources in the community – such as new placements, services, or schools – will have to be undertaken within an appropriate timescale for all the stakeholders to be fully informed and consulted, and for the transition to be effected smoothly.

In due course a young person with continuing needs will become an adult, and so planning for that young person should anticipate a transition to adult services by contacting, at an appropriate time, those who will be responsible for assessing the needs of the adult.

Summary

- Transitions are of several kinds, and the young person's social and developmental needs should play a major part in assessment and planning.
- The issues of transition will need to be addressed at the outset of the assessment and planning process for young people entering new placements and custodial settings.
- Multi-disciplinary work should continue while a young person is in a specialised placement.
- Information collation and sharing is important when responsibilities shift from one agency or set of professionals to another.
- In response to updated assessments and plans, the identification of any new resources in the community – such as new placements, services, or schools – will have to be undertaken within an appropriate timescale.
- Effective co-ordination of services is important when a period of specialised service ends.
- There is a need to provide ongoing support to parents and young people when young people finish a period of specialised intervention.
- Planning should anticipate transitions to adult services for those young people likely to have continuing needs as they become adults.

Training

Principles and practice

Evidence about training was limited in scope (Dadds et al, 2003). Nonetheless, 56% of respondents within YOTs expressed concerns about insufficient training opportunities for professionals involved in work with young people (Hackett et al, 2003).

It is recommended that training for practitioners should be developed to cover the varying levels of need and types of interventions (Whittle et al, 2006; Green and Masson, 2002). A four-tier model of provision, as outlined in the 'Service development' chapter, would involve a graduated range of educational and preventative interventions, individual advice, community-based projects and intensive support. Training should be designed to give practitioners and managers the necessary skills to deal with the demands of each tier of provision.

Greater access to training should be afforded to professionals and volunteers, such as teachers or mentors, who come into contact with young people who sexually abuse. The diffusion of training to all who come into contact can help to maintain young people in mainstream settings and reduce damaging social exclusion (Whittle et al, 2006).

The multi-agency nature of input required to address the needs of young people who sexually abuse suggests that knowledge and skills of staff need to be developed across all agencies likely to work with this group (Whittle et al, 2003)

In a survey of service providers (Hackett et al, 2003), respondents highlighted the need for training that:

- builds on basic introductory or awareness-raising courses and looks at issues in more depth or refreshes existing knowledge
- focuses on intervention approaches as well as assessment
- provides input on working with sub-groups of service users, such as those from minority ethnic communities or with mental health problems.

The survey of practitioners (Hackett et al, 2003) highlighted overall consensus on the point that professionals need to feel comfortable around issues of sexuality and be aware of both personal and professional issues they bring to the work.

Summary

- Training should be designed to support the tiers of provision.
- Training needs should build on awareness-raising to include skills of intervention as well as assessment.
- Training should extend across agencies and be available to all who come into contact with young people who abuse.

Management

Responsibilities

Little attention in the literature has been paid to the management of service provision (Hackett et al, 2003). The responsibilities of management include:

- developing effective needs-based assessment
- working towards effective inter-agency structures
- developing effective services
- promoting effective communication at all levels
- ensuring that effective training and supervision is delivered
- ensuring that services are effectively monitored and evaluated.

To ensure progress is made on all these priorities, consideration should be given to allocating specific management responsibilities within clear job descriptions and lists of duties.

In a mapping study of services (Hackett et al, 2003), managers thought that joint strategic agreements were needed in order to underpin consistent and effective provision. It was suggested that managers should be fully experienced in such work to be able to manage work with young people who sexually abuse. However, managers did not seem to feel that the work was exceptionally demanding compared with other parts of the YOT caseload.

Regular clinical supervision and support were felt to be important needs for staff and for managers alike. Where supervision is provided by external consultants, such as specialist projects or experts, it follows that these arrangements should be adequate and robust. The need for clinical supervision was also reflected in responses from the secure residential sector. Within YOTs, monitoring has been focused on YJB targets and there has been insufficient inter-agency monitoring or practice evaluation in the field of young people who sexually abuse (Hackett et al, 2003).

Summary

- Consideration should be given to developing clear responsibilities at management level in YOTs so that managers have a complete overview of all effective practice issues for young people who sexually abuse.
- The demands of clinical supervision should be factored into supervision and support allocations.
- Monitoring should be extended to include inter-agency working; practice should be evaluated more often.

Service development

Needs and priorities

There is no conclusive evidence about how service development can be effectively promoted and maintained. The evidence base is limited to studies that describe the organisation of services in particular contexts (Lambie et al, 2001; Hackett et al, 2003). There is some related evidence on the broader implementation of change in children's services, indicating that progress in developing Children's Trusts has been advancing more rapidly at a strategic level than at a procedural or frontline level (O'Brien et al, 2006). Despite the limited evidence, it is clear that there are service needs that should be priorities for attention if young people are to receive interventions that are responsive to their needs.

Co-ordination

Interventions for young people who sexually offend are currently delivered by a range of agencies that are located across statutory, voluntary and private sectors. A variety of partnerships, funding arrangements, models of provision and treatment goals are apparent among the range of services working with this group (Hackett et al, 2003). A recent study has indicated that, across the whole caseload of young people who offend, needs in the field of 'inappropriate sexual behaviour' have very frequently not been met (Chitsabesan et al, 2006).

The needs of this group overlap between youth justice and social and welfare provision. The co-ordination of services and interventions is, therefore, fundamental to the identification and comprehensive assessment of individual needs, and to the delivery of treatment that addresses the range of identified needs. Developing a shared understanding, effective partnerships and strategies for joint working between agencies is an important aspect of service development (Hackett et al, 2003; Whittle et al, 2006).

Wider reforms in children's services, introduced by the Children Act 2004 and related *Every Child Matters: Change for Children* programme, give further impetus and urgency to the development and implementation of partnership working (Home Office, 2004; Department for Education and Skills, 2004 and 2006).

Development of multi-agency partnership working

Multi-agency working applies to all levels of intervention, from identification and assessment to treatment and post-discharge services. It is recommended that the development of partnership working and co-ordination of services for young people who sexually abuse should include the following elements (Hackett et al, 2003; Department for Education and Skills, 2004; Whittle et al, 2006):

- Development of regional strategies specifically for the assessment and treatment of young people who sexually abuse. Strategies should be developed on the basis of a shared and agreed understanding about the needs of this group, what constitutes an intervention and the goals and approaches to address identified individual needs.
- Appointment of a lead agency to co-ordinate partnership working across agencies.

- Appointment of a lead professional to co-ordinate assessment and treatment interventions to individual young people.
- Ensuring the availability of assessment services to professionals in youth justice and child protection systems who work with this group.
- Development of a common assessment tool that facilitates the gathering of information from the range of agencies and social systems relevant to the young person. A common assessment tool should aim to:
  - ensure appropriate referral between agencies
  - develop a common language about the needs of this group
  - promote appropriate sharing of information
  - minimise the different assessment processes that young people need to undergo.
- Agreeing referral routes and funding places in treatment programmes.
- Developing a database of services that can be accessed by professionals. This would support co-ordination and make services more visible to staff across agencies.
- Ensuring that young people who sexually abuse gain access to interventions that are best suited to meeting their specific needs and which are delivered by trained practitioners.
- Addressing drop-out from treatment by matching interventions to address identified individual needs.

LSCBs, set up under s 13 of the Children Act 2004, are the statutory successors to the non-statutory Area Child Protection Committees, and each local authority is required to set one up. LSCBs have three main areas of responsibility:

- identifying and preventing maltreatment
- targeting particular groups
- targeting young people who are suffering from harm, including young people who abuse.

LSCBs bring together a number of partners from youth justice, education, health and social services agencies, and have a key role in co-ordinating the safeguarding and welfare promotion of children, and for ensuring the effectiveness of practice (Department for Education and Skills, 2006). Guidance on dealing with cases of abuse by children in Wales was set out by the All Wales Area Child Protection Committees (2002) and updated by the Welsh Assembly Government (2006). In Wales, as in London, the coming together of area child protection agencies in cross-boundary arrangements to address the needs of young people who sexually abuse has been perceived as helpful (Masson and Hackett, 2003). Rural areas and Wales in general, are known to be at risk of having inaccessible or overloaded services (Hackett et al 2003).

Developing local policy and guidance

Guidance relating to young people who sexually abuse is not always specifically highlighted in policy and guidance documents; it may be subsumed under general sections that relate to all abuse by young people, such as physical or emotional abuse (Hackett et al, 2003). It is suggested that local area policy and guidance documents are useful when they:

- make specific reference to specialist services available in the locality, and include agreed criteria for referral into such services
- are supported by more extensive protocols between social services, the voluntary sector and YOTs
- supplement national guidance by addressing relevant local issues
- are supported by current research findings
- address the needs of sub-groups, such as young people with learning disabilities and looked-after young people who sexually abuse
- offer guidance regarding the principles underpinning placement practice
- provide an indication of the availability of placements in the locality
- include the views of children, young people and parents regarding service provision.

Commissioning services

In a survey of services managers working with young people who sexually abuse, strong agreement was expressed that commissioning of services for this group should occur through local inter-agency planning agreements (Hackett et al, 2003).

Guidance for joint planning and commissioning, published under the *Every Child Matters: Change for Children* programme (Department for Education and Skills and Department of Health, 2006), is aimed at Children's Trusts and has relevance to services for young people who sexually abuse. The guidance can be applied to support joint planning and commissioning of services specifically in relation to young people who sexually abuse. The nine-point process set out in the guidance is:

1. Look at outcomes for children and young people (who sexually abuse). The data should provide a baseline of need, which can be used to assess current and future needs. The data may need to be accessed from a range of agencies, including the local authority, police and schools.
2. Within the overall picture, look at the needs of sub-groups, for example in relation to ethnicity, disability, deprivation and looked-after children.
3. Develop a needs assessment that includes the views of staff and service users.
4. Establish and agree on the scale of local need, identify resources available and set priorities for action.
5. Plan the pattern of services that will meet priorities and consider how resources can be increasingly focused on prevention and early intervention. Mapping of available local services will indicate which services need to be commissioned, commissioned differently, or decommissioned.
6. Develop a joint commissioning strategy that supports the efficient commissioning of services, including whether to commission services regionally or sub-regionally, and how these will be financed.
7. Commission services, using pooled budgets and other pooled resources such as staff and premises. It should be noted here that YOTs can jointly commission and pool budgets with other partners for the benefit of children at risk of offending.

8. Plan for workforce and market development. Workforce issues include skills, training, salaries, accountability, management, supervision and geographical location. Market issues include contracting out of services, service level agreements, choice of services for service users, strengthening the provider base and sustainability.
9. Monitor and review services and the process of joint planning and commissioning to assess whether the initial aims and objectives are being met.

The standardised assessment tool, *Asset*, used by YOTs provides details about the profile of young people who offend. Information generated through *Asset* can be used in the joint planning and commissioning of services.

Tiered framework of provision

There is increasing recognition of the case for applying a tiered approach to the development and delivery of services (Hackett et al, 2003; Whittle et al, 2006) for young people who sexually abuse. With reference to service development, this is described in terms of primary, secondary and tertiary prevention and as the location of services into four tiers (Whittle et al, 2006). With reference to service delivery, this approach provides a structure for allocating the level of intervention to the level of need, from prevention to treatment and aftercare.

In relation to service development, a tiered approach can assist in the mapping of provision at different levels of intervention, identifying gaps, informing priorities and commissioning strategies.

Harrington and Bailey (2004) summarise primary, secondary and tertiary prevention as:

- *Primary prevention:* refers to activities aimed at reducing the incidence of a disorder/behaviour occurring in the first place. The activities can be aimed at whole population groups, or those seen to be at high risk due to the presence of risk factors, or groups that have minimal signs of disorder. The aim here is to build resilience, and the acivities include programmes relating to family support, safe dating, coercion and substance use/misuse.
- *Secondary prevention (treatment):* refers to activities aimed at case identification and provision of standard treatment for an established disorder/behaviour. Activities can be aimed at young people known to be at risk. The aim is to break the cycle of abuse and minimise the risk of abused children going on to abuse.
- *Tertiary prevention (maintenance):* refers to activities aimed at reducing the recurrence of a disorder/behaviour and any complications arising from it. It is aimed at young people already displaying sexually harmful behaviours and should ensure that young people are allocated the intervention best suited to the level of identified need and risk. The aim is to achieve compliance with long-term interventions, reduce complications and provide aftercare.

The four-tier approach is well-established in the field of child and adolescent mental health services, and some substance misuse services. In relation to young people who sexually abuse it is described as (Whittle et al, 2006):

- Tier 1 – The provision of education regarding ‘normal’ sexual behaviour in children and adolescents. Support to parents and frontline professionals, such as health visitors, nurseries and schools, for example through the provision of information to facilitate early identification and referral to the next tier.

- Tier 2 – The provision of advice to parents and schools regarding sexually-abusive behaviour and dealing with low risk concerns, without criminalising the behaviour.
- Tier 3 – The provision of interventions through specialist community-based projects if the sexually-abusive behaviour persists
- Tier 4 – The provision of intensive support for those assessed as being too high risk for community-based intervention, or whose behaviour indicates a need to protect the public.

The tiered approach provides a framework for both the development and delivery of services to young people who sexually abuse.

The service framework is governed by national arrangements that are set out in government documents for England and for Wales (Department for Education and Skills/Department of Health, 2004; Welsh Assembly Government, 2005).

The standards in Wales include a requirement that children with urgent needs, such as those displaying inappropriate sexual behaviour, should not have to wait for a completed formal assessment before services are provided (Welsh Assembly Government, 2005).

The Health Commission (Specialist Services) ('HCW(SS)') is an executive agency of the Welsh Assembly Government. It has a responsibility for commissioning tertiary and other highly-specialised services throughout Wales, except for those services that can be commissioned by Local Health Boards.

Summary

While evidence about effective methods of service development is limited, there is recognition that co-ordination is required to effectively meet all young people's needs.

- There should be regional strategies specifically for the assessment and treatment of young people who sexually abuse.
- Strategies should be developed on the basis of an agreed understanding about needs, intervention, goals and approaches to address identified individual needs.
- A lead agency should co-ordinate partnership working across agencies.
- Lead professionals should co-ordinate interventions for individual young people.
- Assessment services and a common assessment tool should be available.
- Referral routes to properly funded programmes need to be agreed.
- Protocols are required to create databases of services, promote adequate training and ensure monitoring of outcomes.
- Local planning arrangements should be developed to provide guidance, co-ordinate inter-agency working, address the needs of subgroups and consult with young people and their families.
- Local inter-agency planning arrangements should underpin the commissioning of services based on a local assessment of needs and service outcomes.
- Local arrangements should map local services and be seeking to establish effective prevention and early intervention.
- Joint commissioning arrangements need to:

- identify the appropriate services to be commissioned at a regional and at a local level
- plan for workforce and market development
- monitor and review plans and services

- A four-tier model of services implies that young people's needs can be met by developing service elements that involve a graduated range of educational and preventative interventions, individual advice, community-based projects and intensive support.

Monitoring and evaluation

Priorities and issues

The review has shown that service evaluation is an urgent priority. The dearth of evaluation studies was highlighted by respondents to a national mapping study (Hackett et al, 2003) and was noted in comments on a serious case review (Dent and Jowitt, 2003). Given the lack of clear evidence about effective service delivery, practitioners have an increased ethical responsibility to monitor the impact of their particular practice.

Monitoring and evaluation can be applied to all aspects of service provision, including:

- inputs to the service
- process by which it is delivered
- outputs from the service
- outcomes for service users and others connected to the service.

A monitoring and evaluation exercise may focus on all of these aspects, or be more specific and look at particular areas, such as, for example, the outcome of treatment interventions or management of staff. Developing monitoring and evaluation processes, and building them in from the early stages of planning and delivering services or interventions, will maximise their potential to be a useful and informative exercise.

The development of effective practice norms and standards can only be possible if practitioners are fully engaged in the process and there is a routine process of monitoring and evaluation that enables practitioners and managers to understand outcomes better. At the moment the evidence base is inadequate to do more than point to the needs for investment in processes that will provide clear information about who receives which services and – more significantly – what happens to those young people and their families.

Clear evidence of learning linked to participation has to be generated before we can be more confident about a programme's potential, and there is scope, as Brooks-Gordon et al (2005) suggest, for eliciting young people's perceptions of the process more systematically. For example, programmes can regard their leavers, including drop-outs and transferred young people, as an evaluation resource in identifying the usefulness of their services.

In evaluating intervention outcomes for young people it is important to consider assessing outcomes in relation to all relevant areas of a young person's life and not solely their offending behaviour (Hackett, 2004). Six areas are suggested below for monitoring and evaluating change in relation to individual young people:

1. changes in non-offence related conduct
2. developmental level and functioning
3. persistence and pattern of sexually-abusive behaviour
4. networks/strengths, support and resilience factors, involvement in networks
5. relapse and self-regulation, support efficacy and inter-dependence
6. general community access and quality of life.

A process of reviewing intervention goals and components should be commenced so that measurable outcomes are attached to each component.

Service users and their families should be facilitated to provide feedback in monitoring and evaluation exercises. A practical method of recording these outcomes is by Goal Assessment Scaling, in which the practitioner and the young person or family outline potential outcomes on a scale and assess their achievement over several months (Hackett, 2004).

Fortune and Lambie (2006) include a series of suggestions for strengthening research and evaluation:

- better identification of characteristics of experimental and control groups for matching
- inclusion of treatment drop-outs
- multiple outcome measures
- large samples
- long-term longitudinal follow-ups
- taking into account the context of treatment (where it takes place, how, and exactly what is delivered, etc.).

The strongest method of research would be a randomised controlled trial with young people randomly assigned to treatment or control group; however, they note ethical issues with regard to withholding treatment.

YOTs and their partners will need to pool information in a form that will allow adequate comparison samples to be drawn, so that valid conclusions can be made about the effectiveness of interventions. For a minority of young people, for example, in custodial and specialised therapeutic settings, this will mean that regional studies need to be undertaken in order to generate the samples required.

The YJB advocates that impact and reconviction studies be conducted in accordance with joint YJB and RDS/NOMS research standards.[5]

Summary

- The review has shown that service evaluation is an urgent priority.
- Areas suggested for monitoring and evaluating change in relation to individual young people include:
  - changes in non-offence related conduct
  - developmental level and functioning
  - persistence and pattern of sexually-abusive behaviour
  - networks/strengths, support and resilience factors, involvement in networks
  - relapse and self-regulation, support efficacy and inter-dependence
  - general community access and quality of life.

[5] See Annex A of YJB Research Strategy online at http://www.yjb.gov.uk/en-gb/yjb/Whatwedo/Research/

- Service users and their families should be facilitated to provide feedback in monitoring and evaluation exercises. Goal Assessment Scaling is a practical example of such ways of assessing outcomes.
- Better evaluation will involve improvement in the design of evaluations, including well-matched comparison groups, inclusion of treatment drop-outs, multiple outcome measures, large samples, long-term follow-up of outcomes and understanding of intervention context.
- In evaluating interventions, YOTs should adhere to the YJB/RDS NOMS standards for the evaluation of programmes and pool information in a form that will allow adequate comparison samples to be drawn.

Conclusions and key recommendations

This concluding chapter brings out the main messages from this review and points towards key implications that can be formulated as recommendations.

The results of the review have been productive in some areas and much less so in others. A rigorous approach to finding, collating and evaluating evidence is an effective way of discovering which areas of practice are evidence-based and which are lacking. It has been shown that assessments and treatment have been the focus of the more rigorously designed studies and that little rigorous evidence of effective practice is available on individual need, communication, transitions, training, management, and monitoring and evaluation.

Definitions of sexual abuse vary according to the context in which they are applied. The most typical definitions focus on the power imbalance between the victim and abuser, and emphasise the harm caused by the behaviour. The legal definitions that have been incorporated in the Sexual Offences Act 2003 provide a code for interpreting evidence of behaviour and taking action.

The ways in which the abuse comes to the attention of the agencies has an influence on the characteristics of the cases that are revealed, and therefore on the dimensions of need that young people display. Only a minority of abusive experiences are disclosed to other people, and relatively few are brought to the attention of professionals. A significant proportion of known cases have been identified through the child protection system, and therefore co-operation among all the local agencies dealing with children is an important obligation. Indeed, recent trends indicate steady increases in the sexual offences dealt with by the youth justice system.

The needs of young people who sexually abuse are complex and often ongoing. Young people have typically suffered abuse, which can have important mental health consequences and may affect the impact of future intervention for their sexually abusive behaviour. They show poor social skills and a tendency to impulsiveness, and are coping with disrupted and neglecting family backgrounds. While there are a significant proportion of young people who have learning disabilities, these needs are often shared with the wider population of young people who offend. Where appropriate, their non-sexual offending needs should be fully recognised and addressed

Assessment has been interpreted as a cyclical and systematic process. The studies of assessment have revealed promising approaches that help to advance knowledge about effective practice. The development and implementation of a common assessment model and framework – the AIM Model – has indicated that there is potential to draw usefully on the contributions of agencies, families and young people.

While assessment tools, such as J-SOAP and ERASOR, are being developed in order to predict whether some young people are more likely than others to re-offend, there is no clear evidence that the tools reviewed are able to make effective predictions in practice. However, there are advantages in bringing together assessments that address all the component needs, risks and strengths. Particular needs should be addressed through a common framework of assessment. Instruments that use risk predictors are so far lacking in predictive validity, owing in large measure to the low base rate of recidivism. More longitudinal research on risk and outcome would enable the development of more accurate tools.

Individual needs should form a clear focus for practice so that sub-groups, such as young people with learning disabilities, young women and people from minority ethnic groups, are treated with

understanding and respect. A comprehensive approach should be taken to identifying individual need.

Evidence on service delivery suggests that most of the better-designed studies focus on treatment. The evidence about the impact of treatment does not support strong claims that treatment is effective in reducing recidivism, though some young people show hopeful signs of progress. Reoffending rates are too low to make it easy to draw conclusions from these studies.

A focus on treatment as the primary intervention has meant that it has been difficult to deliver and evaluate the full range of services required to meet all the needs and to deliver them continuously in a planned way. Care and welfare interventions should be given an appropriate level of importance, and this should be reflected in a greater quantity of well-designed research studies. Across the range of needs, intervention goals, targets and components should be specified with clear operational outcome measures.

Evidence about transition, communication, training, management and so on, is lacking. It is important nevertheless to consider transition from the outset of the planning process, and to develop communications that are coordinated and continuous. Training should be concerned with improving skills as well as awareness, and extend to all who come in contact with young people who sexually abuse. Clarity about management structures should go hand in hand with planned provision of sensitive clinical support for people working in the field.

Service developments should be promoted to ensure that young people have access to interventions that are adequate to their needs and the risks that their behaviour poses. Building on regional strategies, a lead agency should co-ordinate partnership working across the agencies. Changes are necessary to help provide a range of services that are tailored to primary, secondary and tertiary intervention. A number of innovations should be considered to help to attain this objective, including a tiered framework of services, organised through joint planning, joint commissioning and multi-agency professional guidance. A four-tier model of services can help deliver a graduated range of educational and preventative interventions, individual advice, community-based projects and intensive support. The role of families and young people in service development and monitoring could be significantly enhanced. Effective communication with families from the outset, and continuous case work and management, offer the means to enable them to benefit from interventions.

A much broader evaluation would be possible if services were to be developed on a more integrated basis. This dearth of evaluation should be remedied so that services are more robustly evidenced and can be confidently implemented in the long-term interests of young people, as well as of victims and the community at large.

Appendix A: Notes on risk assessment tools

Two risk assessment instruments, J-SOAP and ERASOR, were included in the evaluation.

Table 1: J-SOAP – The Juvenile Sex Offender Assessment Protocol (Righthand et al, 2005)

Sample size	Scale	Internal consistency	Concurrent validity	Discriminant validity	Predictive validity
134 youths aged 7–20 years (mean 15.9) adjudicated juvenile sexual offenders – 45 in residential placement	1. Sexual drive/ preoccupation 2. Impulsive, anti-social behaviour 3. Clinical Intervention 4. Community stability 1&2 = static 3&4 = dynamic	Excellent: high alpha scores for all scales Factor structure analysis supports internal consistency for scales	Highly correlated with Youth Level of Service Inventory/Case Management Inventory	Discriminated between youths in community and those in residential placement (p<.01)	Not confirmed. Authors recommend that J-SOAP not be used as only risk assessment instrument

Table 2: ERASOR – The Estimate of Risk of Adolescent Sexual Offense Recidivism (Worling, 2004)

Sample size	Scale (five sections)	Internal consistency	Concurrent validity	Discriminant validity	Predictive validity
n=136 aged 12–18 years Juvenile sexual offenders Community Group (45) Residential Group (91) First-time detected (56) Recidivists (80)	1. Sexual interests and behaviours 2. History of sexual assaults 3. Psychosocial functioning 4. Family environ-mental functioning 5. Treatment 6. Aim: to predict short term (1 year) sexual recidivism	Good. Alpha 0.75	Not carried out although scale items based on theoretical constructs of other tools in part.	Discriminated between youths in community and those in residential care *and* between first time offenders and recidivists.	No recidivism follow up carried out so predictive validity not tested. Not calibrated into risk levels for practitioner use.

Appendix B: Tables of studies

Table 3: Treatment studies

Author	No of studies (n), design and follow-up period	Type of participant	Recidivism (%)	Treatment and treatment integrity (TI)	Comments
Reitzel and Carbonell (2006)	9 studies (2986) Avge: 6 months–243 months	Adjudicated 7–20 yrs	Treatment 7.37% Control 18.93%	Diverse treatments Treatment integrity not known for studies included	▪ Non-comparable follow-up periods ▪ Attrition was not addressed ▪ Sample size affected effect size ▪ There was a small impact of CBT on outcomes ▪ Largest effect size was associated with MST
Walker et al (2004)	10 studies (644) Follow-up periods not available	Male adolescent juvenile sexual offenders	Recidivism: r = .26 Self-report r = .48 Arousal r = .42 Overall r = .37 (overall r calculated as equivalent to experimental – 68% control – 32% success)	Treatment integrity detail not provided Type of qualification of therapists significantly associated with effect size	▪ Large overall effect size ▪ 3 of 4 studies with effect size significant at 0.5 level of probability were CBT or MST ▪ CBT produced largest effect size but contents of CBT were not necessarily consistent across studies ▪ Several studies lacked control group ▪ Lack of attrition data ▪ Lack of follow-up data
MacKenzie (2006)	25 studies Follow-up periods vary	Males	Overall estimate of 5-7% compared with control group 15%	Studies varied in quality	▪ Positive effects in favour of treatment overall ▪ Lack of information on offender type and treatment content

Author	No of studies (n), design and follow-up period	Type of participant	Recidivism (%)	Treatment and treatment integrity (TI)	Comments
Lösel and Schmucker (2005)	69 studies (22181) No clear follow-up period data	Adjudicated Adult and juvenile sexual offenders	Difference of 6% between control group 17% and treatment group 11%	Some detail on treatment type and setting	▪ Juvenile programmes had larger effect than adult (but the difference was not significant). ▪ CBT and behavioral therapy had significant effect ▪ Positive treatment effect ▪ Only programmes designed for sex offenders had significant impact on sexual recidivism. ▪ Drop-outs had double the odds of recidivism ▪ Overall effect size of treatment versus control groups = 2.35 (CI= 1.01-5.43)
Carpentier et al (2006)	One study n=135 Random controlled trial – no information on 'blinding' allocation 10 years	Outpatients with sexual behavioural problems Ages 5–12 years	Sexual Recidivism: CBT – 2% Play therapy – 10% Non-sex offender comparison group – 3%	Random allocation Treatment integrity built into study design	▪ Concludes that young people with problematic sexual behaviours don't necessarily go on to become older ones ▪ Short cognitive behavioural programme gives low recidivism rate comparable with non-sexual offender comparison group
Seabloom et al (2003)	One study 151 families: 122 juvenile sexual offenders, including unadjudicated Follow-up 14–24 years	Wide ranging sexual behaviours – not all illegal, inc. transvestism and promiscuity	<u>Arrest:</u> 0% – completers 10% – withdrawals <u>Conviction</u> 0% – completers 8% withdrawals	Psychotherapeutic and family therapy components Lack of detail on treatment delivery	▪ Large amount of missing data ▪ Convenience sample: availability of recorded data shaped sample ▪ Non-comparable behaviours ▪ Drop outs not recorded until one-month stage ▪ No information on those who withdrew
Caldwell and Van	One study	Highly disruptive	Experimental group 10%	"Decompression" gradual relaxation of institutional	▪ Small sample size

Author	No of studies (n), design and follow-up period	Type of participant	Recidivism (%)	Treatment and treatment integrity (TI)	Comments
Rybroek (2001)	(10) Experimental group and two control groups Two years	and aggressive incarcerated offenders	Control 1 20% Control 2 70%	controls Treatment integrity not measured	▪ Atypical study population
Jones (2004) PPT presentation	One study (16) Follow-up of programme 1–32 months	Convicted Black/Hispanic sex offenders aged 12–18	Breached – 32% Non sex recon – 21% Sexual recon – 0%	Intensive case management Therapy and healing work: individual and group based Mentoring and crisis intervention CBT	▪ Juvenile sexual offeners had 83% attendance rate and 80% completion rate ▪ No details on specifics of treatment delivery etc.
Hagan et al (2001)	One study (150) Three groups of different sex offence types Follow-up after release eight years	Incarcerated adolescent sex offenders and delinquents 12–19 years	Sex assault – 20% Rapists – 16% Delinquents – 10%	Reduce denial/minimisation Victim empathy Relapse prevention Understand offending Harm to victim Pro-social behaviour No TI data	▪ All groups differed in risk of sex offending in general population – all three categories were risk factors ▪ Sample – sub-population of incarcerated population ▪ No attrition or TI detail ▪ Treatment resembles adult programmes in UK

Author	No of studies (n), design and follow-up period	Type of participant	Recidivism (%)	Treatment and treatment integrity (TI)	Comments
Waite, Keller et al (2005)	1 study (256) 10 year follow-up	Juvenile sexual offenders	Self contained 4.9% Prescriptive 4.5%	'Self contained' and 'Prescriptive' groups	▪ Included drop-outs but unable to identify whether or not they had completed treatment

Table 4: Studies with data on sexual recidivism (range of sexual recidivism: 0–20%)

Study	Sample size	Offenders	Follow-up period	Sexual recidivism	Rate of reoffending and follow-up period
Seabloom et al (2003)	122	Juvenile sexual offenders, including unadjudicated	15–24 years	0%	0% in 24 years
Carpentier et al (2006)	135	Outpatient juveniles with sexually intrusive behaviour problems	10 years	2%	2% in 10 years
Vandiver (2006)	300	Juvenile sexual offenders – juvenile at arrest	3–6 yrs	4% rearrested for sexual offence	4% in 6 years
Waite, Keller et al (2005)	256	Juvenile sexual offenders	10 years	4.9%	4.9% in 10 years
Nisbet, Wilson and Smallbone (2004)	303 (data on 292)	Juvenile sexual offenders, adjudicated as juvenile	Mean 7.3 years	5% reconvicted of sexual offences as adults	5% in 7 years
Reitzel and Carbonell (2006)	2986	Juvenile sexual offenders, 7–20 yrs	Mean: 59 months	7.37%	7.4% in 5 years
Allan et al (2003)	326	Juvenile sexual offenders – nearly all	8 years 11 months	9.5% reconvicted of a further sex offence	9.5% in 8.9 years

	(age data on 215)	first-time offenders	mean 4.2		
Caldwell and Van Rybroek (2001)	10	Incarcerated violent juvenile offenders	2 years	10% reconviction for any offence (treated group) 20% (comparison group 1) 70 % (comparison group 2)	10% in 2 years
Hagan et al (2001)	150	Incarcerated juvenile sexual offenders in two offence groups; compared with non-sexual offenders	8 years	Sex assaulters – 20% Rapists – 16% Non-sexual offenders – 10 %	20% in 8 years
Jones (2004) PPT presentation	16	Convicted juvenile sexual offenders	1–32 months	0%	0% in 2.6 years
Miner (2002)	86	Incarcerated juvenile sexual offenders	1mth–6.5yrs	8%	8% in 6.5 years
Whitemore (2005)	163	Pre-adolescents with sexually abusive behaviour problems	na	Not recorded	Data not available
Eastman (2004)	100	Juvenile sexual offenders – residential	6 months	Not recorded	Data not available
Walker et al (2004)	644	Juvenile sexual offenders	na	Overall obtained effect size equivalent to 32% of experimental group having a negative outcome compared to 68% of the control group	Data not available
MacKenzie (2006)	2623	Male adolescent and adult sexual offenders	na	5–7% sexual recidivism for the most recent outcome measure studied (predominantly criminal justice outcomes)	Data not available
Gretton et al (2005)	253	Juvenile sexual offenders	4.6 to 13.8 years	17% charged or convicted of sexual offence	17% in 13.8 years
Worling (2001)	97	Juvenile sexual offenders	2 to 10 years	11% charged with sexual offence	11% in 10 years

Appendix C: Methods and results of systematic review

Aims of the review

To help update the previous *Key Elements of Effective Practice* on *Young People who Sexually Abuse*, the aim has been to review systematically the literature from 2001 to 2006 on effective interventions for young people who sexually abuse. The interests of the YJB lie in a range of outcomes, including recidivism, treatment, welfare (education, mental health), care, and justice (orders, reparations, etc). We sought to develop our analysis of the intervention field to embrace these outcome types. We were interested in justice interventions, welfare interventions, assessment and treatment interventions and placement interventions.

From the initial search stage, we focused on studies that described needs and problems to be addressed by agencies responding to young people identified as abusive. Studies were excluded at the initial search stage if they amounted to commentary or discussion.

Independent findings

We determine if there is evidence of independent findings by clarifying the purpose of the intervention and its relationship with particular outcomes. So if the intervention is aimed to promote the health of the child, data on the child's education outcomes will not be relevant unless the aim of the study is to investigate whether or not the education is materially affected by the intervention. However, an intervention that is holistic or multi-disciplinary will be expected to address both health and education, so both outcomes are relevant. Evaluation of qualitative research is focused on examining relationships between intervention and outcome.

The criteria for independent findings are especially important where outcomes in different studies are being grouped for analysis. We decided to focus on sexual recidivism outcomes in order to compare studies that were about interventions aimed to reduce that form of recidivism.

Searching and collation

We systematically searched several well-known databases – C2-Spectr, PubMed, Embase, Ingenta, Wiley, International Bibliography of the Social Sciences (IBSS), Copac, Digital dissertations, Digital Dissertation Abstracts, Psychinfo and Zetoc – using the search strings listed in the section below. CSA, which comprises several extensive databases, was searched using key terms. The libraries of the National Society for the Prevention of Cruelty to Children and the National Children's Bureau provided additional information on sources. Material was identified on the basis of title and abstract if available. To avoid unjustified exclusion, an item that lacked detail in its abstract was, wherever possible, given the benefit of the doubt.

In order to retrieve relevant references, 'strings' of connected words were used to search the bibliographical databases. The approach to selecting the search strings was based on a similar strategy used in a recent systematic review (Brooks-Gordon et al, 2005). We developed one basic – and one much more complex – search string that combined key terms. The principles of the search are that the target group for intervention should be identified first of all. This involves combining searches for the age groups and for the behaviours – sex offending, abuse, etc. Then we searched for interventions in three

groups – treatments, care and justice. Then we searched for outcomes in two groups – core behavioural outcomes (reoffending, etc) and related outcomes (thinking skills, relapse, mental health, etc). Our outcomes also include safety of victims and public protection, and organisational outcomes, such as partnership working and service standards. Furthermore, we developed methodological search strings for randomised control trials and for other comparison studies.

We hand-searched the references in the recent NHS review of treatment, by Brooks-Gordon et al, 2005, as a starting point for the collation. It became clear that our hand and bibliographic searches were producing many duplicates. Published material was identified and then sought by electronic access or by loan requests. We were advised that some material, in particular, dissertations from North America, were difficult to obtain.

Unpublished material was sought by contacts with experts. We contacted a number of experts, listed below, both in the UK, North America, Australia, New Zealand and in Europe. Treatment organisations such as National Organisation for the Treatment of Abusers (NOTA), the International Organisation for the Treatment of Sexual Offenders (IATSO) and the Association for the Treatment of Sexual Abusers (ATSA) were the subject of enquiries. As a result, five unpublished papers entered the review.

We are conscious that reviews are subject to bias if relevant material is not identified and obtained for the purposes of classification and evaluation. The absence of dissertations and the very small number of unpublished papers obtained would seem to make the resulting review more like a standard review than might normally be the case. However, the fact that the present study was able to include the results of several recent systematic reviews and meta-analyses makes the conclusions more reliable than they might have otherwise appeared.

In order to produce a report relevant to all aspects of the guidance, we identified, from the studies known to us, or by investigating policy documents, a range of material in addition to the classification. This has been described as ‘additional material’. Some of the additional material is concerned with needs, trends and priorities identified in the policy field (e.g. DfES, 2004); some of it is descriptive, methodological or bibliographical (e.g. Lipsey and Wilson, 2000) and some of it predates our period and is used to illustrate key points in the long-term evidence base (e.g. Cawson et al, 2000; Vizard et al, 1995). The additional material is not considered to have revealed studies that would alter the classification results at the higher levels of the Scale of Scientific Methods.

Table 5: Results of the searches

NHS review	65
Bibliographic searches	110
‘Grey’ literature , internet and other means	29
Material additional to the classification	28
Total references	232

Standards

The standards of the Campbell Collaboration are the benchmark for the review. In the field of crime reduction studies, a hierarchy of evidence has been defined in the well-known Maryland Scale of Scientific Methods (SMS) (Harper and Chitty, 2005):

- **Level 1 –** Correlation between an intervention and a measure of outcome at a single point in time.
- **Level 2 –** Temporal sequence between the intervention and the outcome clearly observed, or the presence of a comparison group without demonstrated comparability to the treatment group.
- **Level 3 –** A comparison between two or more comparable units of analysis, one with and one without the intervention.
- **Level 4 –** Comparison between multiple units with and without the intervention, controlling for other factors or using comparison units that evidence only minor differences.
- **Level 5**. Random assignment and analysis of comparable units to intervention and comparison groups.

We were interested in the extent to which the studies have addressed the issues of variable control, measurement error (including subject attrition and missing data) and statistical power.

We saw benefits in a review of qualitative evidence according to rigorous standards. We have used the Global Assessment of Quality Scale (GAEQ) as the standard for this evidence.[6] For qualitative studies, it contains five relevant dimensions:

- A – specified data collection tools
- B – adequate representativeness of sample
- C – adequate sample size
- D – appropriate data capture and analytic methods
- F – external or independent evaluation.

Studies scoring 3 or higher were included. It should be noted that in some cases the study was not an evaluation, but a research investigation. In interpreting Dimension F of the GAEQ, we have scored 1 if there is evidence that the investigator was independent.

Procedures

Two reviewers conducted classifications of the material independently (see the Classification of studies section below). All studies at or above Level 3 and all qualitative studies were evaluated. Data extraction for evaluated studies was carried out by one reviewer and checked by another. The lead reviewer selected studies for planned meta-analytical outcome comparisons by a second reviewer and then checked the comparisons made.

Enquiries and search strings

1. Enquiries

The following academics and practitioners were contacted.

[6] See http://www.prb.org.uk/wwiparenting/RR574.pdf

UK

Dr Peter Misch

Prof. Barbara Maughan

Professor Helen Masson

Professor Elaine Farmer

Dr Richard Beckett

Dr Belinda Brooks-Gordon

Professor Don Grubin

Dr Caroline Friendship

Dr Jo Paton

Gill Brigden

Professor Susan Bailey

Dr Kerry Baker

Professor Hazel Kemshall

Rachel Wingfield

Professor Mike Nash

Organisations

National Organisation for the Treatment of Abusers (NOTA)

International Organisation for the Treatment of Sexual Offenders (IATSO)

Association for the Treatment of Sexual Abusers (ATSA)

International

Professor Robert Prentky – US

Dr Brenda Eastman – US

Dr Charles Borduin – US

Cathy Wood – South Africa

Dr Gary O'Reilly – Eire

Dr Michael Seto – Canada

Robin Jones – Australia/US

Patrick Tidmarsh – State of Victoria (Australia)

Jari Evertsz – University of Melbourne (Australia)

Karen Owen – Department of Justice (Australia)

Dr Judith Becker – US

Dr Heather Gretton – Canada

Professor John Hunter – US

Professor Michael Miner – US

Professor William Murphy – US

Dr James Worling – Canada

Robert Freeman Longo – US

Dr Howard Barbaree – Canada

Dr William Marshall – Canada

Catrien Bieljveld and Frank Weenman (Netherlands)

Programmes/interventions

Two programmes with evaluation material sent reports:

- SafeCare (Western Australia): www.safecare.com.au
- Counterpoint (United States): Program for Pre-Adolescent Children with Sexually Abusive Behaviour Problems (day/residential treatment programs), Morrison Center (www.morrisoncenter.org) – Contact: Erin.Whitemore@morrisonkids.org

2. Search strings

The minimum terms considered crucial in identifying any core studies for this review are:

Minimum core terms – juvenile*/ sex*/ offen*

Limits

Limit to 2001–2006

Use available limits on age: 0–17 years; or any combination 0–5, 6–10 etc.

Expanded basic key word search in non-specialist databases

The keywords should be mapped to the descriptors in the database.

Conduct searches separately and then combine.

age (youth* or young* or teen* or juvenile* or adolesc* or child*)

AND/or

problem (sex* offen* or sex* re-offen* or sex* abus* or sex* inappropriat* behav*)

AND/or

intervention a) (assess* or treat* or counsel* or interven* or evaluat* or therap* or psycholo* or psych* or program*)

intervention b) (justice* or court* or order* or diver* or warn* or reprima* or charg* or penalt* or sentenc* or tag* or monitor* or supervis* or licenc* or regist* or ban* or restor* or apolog* or repar* or refer*)

intervention c) (family home* or custody or pris* or foster* or care or residential care or residential care home* or special school* or secure unit* or secure (treatment centre* or children's home*) or care home* or family link* or welfare)

intervention d) (learn* or cognit* or cognit* behav* or (sex* and educ*))

Intervention e) (safe* or child protect* or victim* or public protect*)

Intervention f) (strateg* or policy or multi-agency or multisystem* or collabor* or partner*)

Intervention g) (profession* train* or service standard* or equal opportunit*)

Obstacle a) (sexis* or racis* or homophob* or discrimin*)

AND/or

Core efficacy (sex-offen* or re-offen* or relaps* or recidiv* or viole* or freq* or senten* or court* or viola* or breach* or re-senten* or reduc* or escap*)

AND/or

Related outcomes (resilien* or behav* or attitud* or personal development or employ* or educ* or training or course* or skill* or thinking skills or social skills or interpersonal skills or problem-solving skills or mental health or self-esteem or suicid* or self-harm or family contact* or family links or bully* or resettle* or transition* or placement*)

AND/or

method a)

(systematic review) or (randomisation or randomised or randomise or randomises or randomize or randomized or randomly) or (double and blind) or (double-blind) or (double* blind*) or (randomised controlled trials)

or (randomi* or doubl* **and** blind* or control* **and** clinical)

and/or

method b)

quasi-experim* or cohort* or longitudin* or follow-up* or survey* or control* or comparison* group*

AND (youth* or young* or teen* or juvenile* or adolesc* child*)

AND (sex* offen* or sex re-offen* or sex*abus*)

Medical databases

age (youth* or young* or teen* or juvenile* or adolesc* or child*)

AND/or

problem (sex* offen* or sex* re-offen* or sex* abus* or sex* inappropriat* behav*)

AND/or

intervention a) (assess* or treat* or counsel* or interven* or evaluat* or therap* or psycholo* or psych* or program*)

intervention b) (justice* or court* or order*)

intervention c) (family home* or custody or pris* or foster* or secure unit* or secure (treatment centre* or children's home*) or care home* or special school* or family link* or welfare)

intervention d) (learn* or cognit* or cognit* behav* or (sex* and educ*))

intervention e) (safe* or child protect* or victim* or public protect*)

Intervention f) (strateg* or policy or multi-agency or multisystem* or collabor* or partner*)

Intervention g) (profession* train* or service standard* or equal opportunit*)

Obstacle a) (sexis* or racis* or homophob* or discrimin*)

Need a) (learn* disab* or physical disab*)

AND/or

Core efficacy (sex-offen* or re-offen* or relaps* or recidiv* or viole* or freq* or senten* or court* or viola* or breach* or re-senten* or reduc* or escap*)

AND/or

Related outcomes (resilien* or behav* or attitud* or personal development or employ* or educ* or training or course* or skill* or thinking skills or social skills or interpersonal skills or problem-solving skills or mental health or self-esteem or suicid* or self-harm or family contact* or family links or bully* or resettle* or transition* or placement*)

AND/or

method a)

systematic review or (randomisation or randomised or randomise or randomises or randomize or randomized or randomly) or (double and blind) or (double-blind) or (double* blind*) or (randomised controlled trials)

or (randomi* or doubl* **and** blind* or control* **and** clinical)

and/or

method b)

quasi-experim* or cohort* or longitudin* or follow-up* or survey* or control* or comparison* group*

AND (youth* or young* or teen* or juvenile* or adolesc* child*)

AND (sex* offen* or sex re-offen* or sex*abus*)

Expand **problem** terms (such as sex* offen*) to include:

(bestialit* or bondag* or bugger* or coprophi* or exhibitionism or fetish* or frott* or incest* or indecen* or klismaph* or lewd* or masoch* or mesophi* or molest* or murder* or necrophi* or paraphi* or partialism or pederast* or (public masturbat*) or rape* or rapist* or sadis* or scatalogia or (sex* devia*) or (sex* offen*) or sodom* or tortur* or urophili* or voyeur* or zoophili*

Social service focused databases

age (youth* or young* or teen* or juvenile* or adolesc* or child*)

AND/or

problem (sex* offen* or sex* re-offen* or sex* abus* or sex* inappropriat* behav*)

AND/or

intervention a) (assess* or treat* or counsel* or interven* or evaluat* or therap* or psycholo* or psych* or program*)

intervention b) (justice* or court* or order* or diver* or monitor* or supervis* or licenc* or refer*)

intervention c) (family home* or custody or pris* or foster* or care or residential care or residential care home* or special school* or secure unit* or secure (treatment centre* or children's home*) or care home* or family link* or welfare)

intervention d) (learn* or cognit* or cognit* behav* or (sex* and educ*))

Intervention e) (safe* or child protect* or victim* or public protect*)

Intervention f) (strateg* or policy or multi-agency or multisystem* or collabor* or partner*)

Intervention g) (profession* train* or service standard* or equal opportunit*)

Obstacle a) (sexis* or racis* or homophob* or discrimin*)

Need a) (learn* disab* or physical disab*)

AND/or

Core efficacy (sex-offen* or re-offen* or relaps* or recidiv* or viole* or freq* or senten* or court* or viola* or breach* or re-senten* or reduc* or escap*)

AND/or

Related outcomes (resilien* or behav* or attitud* or personal development or employ* or educ* or training or course* or skill* or thinking skills or social skills or interpersonal skills or problem-solving skills or mental health or self-esteem or suicid* or self-harm or family contact* or family links or bully* or resettle* or transition* or placement*)

AND/or

method a)

systematic review or (randomisation or randomised or randomise or randomises or randomize or randomized or randomly) or (double and blind) or (double-blind) or (double* blind*) or (randomised controlled trials)

or (randomi* or doubl* **and** blind* or control* **and** clinical)

and/or

method b)

quasi-experim* or cohort* or longitudin* or follow-up* or survey* or control* or comparison* group*

AND (youth* or young* or teen* or juvenile* or adolesc* child*)

AND (sex* offen* or sex re-offen* or sex*abus*)

If possible explode or expand terms such as care, foster care etc.

Criminal justice databases

age (youth* or young* or teen* or juvenile* or adolesc* or child*)

AND/or

problem (sex* offen* or sex* re-offen* or sex* abus* or sex* inappropriat* behav*)

AND/or

intervention a) (assess* or treat* or counsel* or interven* or evaluat* or therap* or psycholo* or psych* or program*)

intervention b) (justice* or court* or order* or diver* or warn* or reprima* or charg* or penalt* or sentenc* or tag* or monitor* or supervis* or licenc* or regist* or ban* or restor* or apolog* or repar* or refer*)

intervention c) (family home* or custody or pris* or foster* or secure unit* or secure (treatment centre* or children's home*) or care home* or special school* or family link* or welfare)

intervention d) (learn* or cognit* or cognit* behav* or (sex* and educ*))

Intervention e) (safe* or child protect* or victim* or public protect*)

Intervention f) (strateg* or policy or multi-agency or multisystem* or collabor* or partner*)

Intervention g) (profession* train* or service standard* or equal opportunit*)

Obstacle a) (sexis* or racis* or homophob* or discrimin*)

AND/or

Core efficacy (sex-offen* or re-offen* or relaps* or recidiv* or viole* or freq* or senten* or court* or viola* or breach* or re-senten* or reduc* or escap*)

AND/or

Related outcomes (resilien* or behav* or attitud* or personal development or employ* or educ* or training or course* or skill* or thinking skills or social skills or interpersonal skills or problem-solving skills or mental health or self-esteem or suicid* or self-harm or family contact* or family links or bully* or resettle* or transition* or placement*)

AND/or

method a)

systematic review or (randomisation or randomised or randomise or randomises or randomize or randomized or randomly) or (double and blind) or (double-blind) or (double* blind*) or (randomised controlled trials)

or (randomi* or doubl* **and** blind* or control* **and** clinical)

and/or

method b)

quasi-experim* or cohort* or longitudin* or follow-up* or survey* or control* or comparison* group*

AND (youth* or young* or teen* or juvenile* or adolesc* child*)

AND (sex* offen* or sex re-offen* or sex*abus*)

Aim to capture articles such as 'The impact of imprisonment for young people who sexually abuse', as well as terms for community sentencing options to capture articles with titles such as 'Young people who sexually abuse in the community'/'family or

community treatments for young people who exhibit sexually inappropriate behaviours'.

Classification of studies

Adult abusers

Authors	Date
Craissati et al	2002
Di Fazio et al	2001
Dunsieth et al	2004
Falshaw et al	2003
Friendship et al	2003
Hill et al	2003
Hosser and Bosold	2006
Mailloux et al	2003
Marshall et al	2002
Petrunik	2002
Schweitzer and Dwyer	2003

Case review

Authors	Date
Dent and Jowitt	2003
Fyffe et al	2004

Description

Authors	Date
Ayland and West	2006
Bremer	2003
Bryan and Doyle	2003
Cesaroni	2001
Fyson et al	2003
Hedderman	2004
Hughes	2002
Jones	2004
Judd and Beggs	2005
Katner	2004
Kawahara	2002
Kolko et al	2004
Lambie and McCarthy	2004
Lambie et al	2001
Longo	2004
Martens	2004
Miccio-Fonseca and Rasmussen	2006
Myers	2002

Myers	2005
Nahum and Brewer	2004
NCSBY	2004
Newbauer and Blanks	2001
O Reilly et al	2001
Parsons et al	2002
Poole and Dickinson	2005
Prescott	2004
Print et al	2001
Rich	2003
SAFECARE	2006
Scott and Telford	2006
Turoff	2001
Ward and Stewart	2003

Discussion

Authors	**Date**
Bartol	2006
Brownlie	2003
Bunting	2005
Flanagan	2003
Hackett	2004
Pennell	2001
Rich	2006
Wilcox et al	2004

Evaluation (formative)

Authors	**Date**
Berg	2004

Evaluation (impact)

Authors	**Date**
Kemshall et al	2005

Evaluation (process)

Authors	**Date**
Maguire et al	2001

Evaluation (system change)

Authors	**Date**
O'Brien et al	2006

Evaluation (tool)

Authors	**Date**
Griffin and Beech	2004
Righthand et al	2005

Worling	2004

Literature review

Authors	**Date**
Andrade et al	2006
Bailey and Boswell	2002
Becker and French	2004
Becker and Hicks	2003
Bentovim	2002
Borduin and Schaeffer	2002
Caldwell	2002
Efta-Breitbach and Freeman (1)	2004
Efta-Breitbach and Freeman (2)	2004
Faniff and Becker	2006
Flitton and Braga	2002
Fortune and Lambie	2006
Gerardin and Tibaut	2004
Grimshaw and Salmon	2001
Harper and Chitty	2005
Kurtz	2002
Letourneau and Miner	2005
Lowenstein	2006
Rasmussen	2004
Ray et al	2004
Righthand and Welch	2001
Righthand and Welch	2004
Timms and Goreczny	2002
Veneziano and Veneziano	2002
Vizard	2006
Whittle and Kurtz	2003
Whittle at al	2006
Zankman and Bonomo	2004
Zimring	2004

Meta-analysis

Authors	**Date**
Cantor et al	2005
Losel and Schmucker	2005
Reitzel and Carbonell	2006
Seto and Lalumiere	2006
Walker et al	2004

Qualitative

Authors	Date
Aldernen	2001
Allan	2006
Boswell and Wedge	2002
Eliasov	2004
Franey et al	2004
Green and Masson	2002
Hackett et al	2003
Hall	2006
Lawson	2003
Myers et al	2003
Scheela	2001
Steen	2001

Review (system)

Authors	Date
MAPPA	2006

Review (protocol only)

Authors	Date
Mishna et al	2006

Review of issue

Authors	Date
Denov	2003
Epps	2006
Grant et al	2006
Hunter et al	2006
Longo and Calder	2005
Loving and Gacono	2002
Pratt et al	2001
Prescott	2001
Print and Callaghan	2004

SMS 1/2

Authors	Date
Abel et al	2004
AIM, Mir and Okotie	2002
Allan et al	2003
Allan et al (1)	2002
Allan et al (2)	2002
Ashkar and Kenny	2007
Aylwin et al	2005

Baker et al	2001
Baker et al	2003
Baumbach	2002
Bijleveld and Henriks	2003
Bladon et al	2005
Brandon et al	2006
Burton et al	2002
Butler and Seto	2002
Caldwell and van Rybroek	2001
Campbell and Lerew	2002
Carpentier et al	2005
Cauffman et al	2004
Chitsabesan et al	2006
Dadds et al	2003
Daly	2006
Duane et al	2003
Edwards et al	2005
Farmer	2004
Freeman et al	2005
Friedrich et al	2001
Gretton et al	2001
Gretton et al	2005
Hagan et al	2001
Hendriks and Bijleveld	2004
Hickey et al	2006
Hunter et al	2004
Hunter et al	2003
Hutton and Whyte	2006
Kenny et al	2001
Knight and Sims-Knight	2004
Kubik et al	2002
Langstrom	2002
Letourneau et al	2004
Masagutov et al	2003
Masson and Hackett	2003
McMackin et al	2002
Miner	2002
Miner and Munns	2005
Morris et al	2002
Moultrie	2006
Murphy et al	2001
Nisbet et al	2004

O' Halloran et al	2002
Ownbey et al	2001
Parks and Bard	2006
Rayment-McHugh and Nisbet	2003
Richardson	2005
Richardson et al	2004
Seabloom et al	2003
Seto et al	2003
Shapiro et al	2001
Silovsky and Niec	2002
Smith et al	2005
Soothill et al	2005
Sperry and Gilbert	2005
Steel and Herlitz	2005
Stefurak et al	2004
Tardif et al	2005
Taylor	2003
van Outsem et al	2006
van Wijk et al	2007
van Wijk et al b	2005
van Wijk et al a	2005
Vandiver	2006
Vandiver and Teske	2006
Vick et al	2002
Waite et al	2005
Walker and McCormick	2004
White and Smith	2004
Whitemore	2005
Whittaker	2006
Woodhams et al	2007
Worling	2001
Zolondek at al	2001

SMS 3

Authors	**Date**
Eastman	2004

SMS 5

Authors	**Date**
Carpentier et al	2006

Systematic review

Authors	**Date**
Brooks-Gordon et al	2005

Littell et al	2005
MacKenzie	2006

Evaluations

Quantitative studies

Authors/date Brooks-Gordon et al, 2005
Design Systematic review of psychological treatment studies for young people who had been convicted or cautioned for a sexual offence. Seventeen quantitative and qualitative studies included in the period 1996 to 2004.
Area Not stated
Interventions Included studies: ▪ One randomised controlled trial of cognitive behaviour therapy ▪ 13 non-randomised comparison group studies ▪ Three qualitative studies ▪ No meta-analysis. No summary of quantitative search results.
Participants Randomised control trial – 93 young people aged 6–12 years completed 16 weeks of a 32-week CBT programme. No clear data on allocation to relapse prevention or expressive therapy. Non-randomised comparison group studies – 893 young people (mean: 69) completing programmes of which six are reported to involve CBT or relapse prevention. Qualitative – three samples (7; 7; 127) totalling 141 young people in treatment
Outcomes RCT – Child Sexual Behaviour Inventory Scores (CSBI-3). No data on outcomes at programme end. Evidence of more successful outcomes for ‘highly traumatised, non-symptomatic abuse-reactive children’ compared with aggressive children. Non-randomised group studies – various measures including recidivism. No evidence is cited from these 13 studies of significant differences in recidivism among the groups compared, except for one study comparing those rated as high, medium or low risk of reoffending on the PCLR-YV. Differences in recidivism between sex and non-sex offenders found in two studies.

Qualitative studies

1. Interviews with 'successful' treatment cases identify learning processes that assist young people to avoid 'messing up' and highlight role of family and community support.
2. Interviews with treatment participants articulate narratives of an 'uphill journey' that leads to becoming a 'whole new person'.
3. Typology of young people – sexually reactive, abuse-reactive, non-symptomatic, rule-breaking, and highly traumatised.

Follow-up periods and outcomes

No evidence of treatment efficacy. No evidence of recidivism effects. Qualitative evidence about the impact of positive pathways modelled for young people. Qualitative evidence of the varied characteristics and specific needs of offender sub-groups.

Comments

Methodological problems and dearth of valid studies mean that neither efficacy nor effectiveness in reducing recidivism is proven.

Authors doubt that unproven treatment can be recommended on ethical grounds. They recommend more evaluation of process and outcomes.

Authors/date

MacKenzie, 2006

Design

Systematic review of sex offender treatment.

Meta-analysis of seven CBT programme studies was included, alongside meta-analysis of studies of other treatments. Two of the seven were with juvenile offenders.

Study 1 – RCT Study (rated as 5 on SMS Scale)

Study 2 – Comparison group study (rated as 3 on SMS Scale)

Area

Interventions

Two juvenile sex offender programmes stated to be offering CBT.

Study 1 – multi-systemic therapy

Study 2 – sex offender treatment group

Participants

Study 1 – treated 8; control 8

Study 2 – treated 44; control 31

Outcomes

Recidivism measures

Study 1 – reoffending (sex and non-sexual); arrests (sex and non-sexual).

Effect size : 21.00

Study 2 – rearraignments. Effect size: 2.24

Comments

One of the studies was of MST – a specific therapy within the field – and the one with the highest effect size of all included treatment studies. However its sample size was only eight.

The second study was of 'sex offender treatment', with an effect size that is almost a tenth of the first. The total treatment sample in the combined analysis was 52.

The analysis therefore displays, at best, very modest evidence of effectiveness. The results of combining these with five other studies in a meta-analysis produce an impression of stronger evidence than is the case.

Authors/date

Littell et al, 2005

Design

Systematic review of MST – a multi-faceted, short-term, home- and community-based intervention for families of youth with severe psychosocial and behavioural problems.

Area

USA, Canada, and Norway

Interventions

Eight randomised controlled trials of MST conducted in the USA, Canada, and Norway. One trial was of MST for young people who sexually abuse. Intent-to-treat analysis with unstandardised follow-up period. (Another study contained only unpublished data.)

Treatment is for four to six months. Treatment teams consist of professional therapists and crisis caseworkers, who are supervised by clinical psychologists or psychiatrists. Assistance is given on a 24/7 basis.

Participants

Study of sex abuser treatment: Sixteen male adolescents who had been arrested. Mean age: 14.

Outcomes

Sixteen young people were followed up over mean 37 months. In all, six studies of MST treatment showed arrest data.

The group study mean effect size was as follows: g=0.46. MST (sexual abusers): g=1.27. Overall not signficiant, but approaching significance.

Comments

Results indicate that it is premature to draw conclusions about the effectiveness of MST compared with other services. Results are reported to be inconsistent across

studies that vary in quality and context. There is no information about the effects of MST compared with no treatment.

Authors/date

Griffin and Beech, 2004

Design

Evaluation of reliability and usefulness of the Assessment Framework and Model for AIM (Assessment, Intervention, Moving On) – a 10-step, multi-disciplinary framework for initial assessment.

Area

Greater Manchester

Interventions

Implementing AIM Assessment Framework. Collation of multiple research data from records, practitioners, AIM meeting chairs, other professionals, young people and parents. Inter-rater reliability test. Subscale reliability test. Factor analysis of scales.

Comparison with results of similar questionnaire scales for 'concerns' (ASAP) and 'strengths' (BERS and FAM 111).

Participants

Sample of 75 cases in 10 YOT areas.

96 % were male and 4 % female. Age range: from 11 to 17 years.

90 % of young people were White, 7% were Asian, 1% were Black, 1% were Mixed Race and 1% were Other. One-third with learning disabilities.

Qualitative feedback: from practitioners: and in addition four other professionals; 13 meeting chairs; AIM co-ordinator; five young people and two carers.

Outcomes

Implementation

Records – co-working was identified in all cases; 60% showed inter-agency working; 72% followed all 10 steps. In 81% of cases, the recommendations were partly implemented.

Practitioner perspectives – welcomed multi-disciplinary process but questioned the existing timescale for process

Chairs and other professionals – also made positive comments

Instrument evaluation

Inter-rater reliability – 55 % reliability on concerns for one of the two case studies used. Otherwise reliability was 75–100 %.

Validity – 17 % disagreement on strengths and 13 % on concerns

Factor analysis – strengths dimension only partly independent of concerns.

Comparison with similar scales – 75 % agreement with FAM111 or BERS (strengths);

35% agreement with ASAP (concerns)

Temporary placements for the young people were reported to make it more difficult to assess strengths and concerns.

Justice – Prosecution: 41% high concern/low strength; 35% low concern/high strength

Recidivism – One case reoffended sexually over 12–18 months and this one had been assessed as high concern/low strength. Three others reoffended non-sexually.

Impact on young people and families

Young people felt that their thoughts and feelings were listened to and felt that the assessment had made them realise what was done was wrong. Both carers felt that their thoughts and feelings were listened to.

Comments

The evaluation shows that the AIM assessment was implemented mostly as intended.

It was accepted by practitioners and found useful. It was able partly to discriminate strengths and concerns among cases. It showed an indication of effectiveness by identifying the sole sexual re-offender in the sample.

The findings were very largely relevant to males, since the proportion of young women and minority groups was low. Responses from young people and families were limited by sample size.

The study recommends changes to improve the reliability and coherence of the instrument and to introduce a 'medium concern' classification.

Authors/date

Baker et al, 2001

Design

SMS 1/2

Area

USA New York

Interventions

Interviews with clinicians to determine the extent of prior offence disclosure to treatment providers, compared with those recorded at entry.

Participants

Clinicians working with 47 male sex offenders.

Offenders' mean age 14.64; 60% White; 23% African-American; 6% Hispanic; 10% Other. Mean IQ 88.18. DSM 1V diagnosis: 46% acting out; 22% ADHD/impulse; 16% mood/bipolar/dysthymia; 16% Other.

Outcomes

Baseline: Pre-admission report data extracted by research assistants blinded to hypotheses of study.

Follow-up: Six to 30 months into treatment. Clinician interviews about new

information revealed since treatment. Clinicians were blind to the interview hypothesis and were asked about many items.

Results: 53% reported either a new offence or a new victim or both ($p<.01$). An additional 15% reported having been physically abused ($p<.001$). Reports of maternal domestic violence victimisation, maternal sexual abuse victimisation, paternal domestic violence perpetration, witnessing domestic violence and sexualised environment increased (all $p<.05$).

Comments

The authors conclude that family systems perspective should be addressed in therapy. While the sample was small, the increase in reports of both abuse and abusing was significant. The treatment periods ranged from six to 30 months so that the length of time for new information to emerge varied from case to case. It is not possible to attribute the new disclosures to the effect of treatment but it is reasonable to suppose that disclosure will increase as treatment goes forward.

Authors/date

Ownbey et al, 2001

Design

SMS 1/2 Temporal change observed in one group

Area

USA

Interventions

Professional Parenting Intensive Program. A treatment foster care service for children with sexual behaviour problems. Program manager support to families recruited and trained for work with this group. Community-based ‘safety’ planning. Parent group meetings. In-service training.

Participants

Six eight to 12 year-olds placed after experiencing abuse. Three male; three female. Three were European American; three were African American. All with sexual behaviour problems, two having been adjudicated as sex offenders.

Outcomes

Measures – reports of behaviour reported by caregivers and others

Baseline – retrospective interviews with pre-placement respondents, asking about behaviour in the year prior to placement. In practice these were ‘most often’ social workers.

Follow-up – interviews with placement care-givers at three month intervals for two years about behaviour frequency and also propensity to behave in ways reported by pre-placement caregivers if an opportunity were available.

Results

Weekly behaviour frequency declined from baseline and extinguished by 24 months. Propensity decline on a 10 point scale of judgement was steady but less precipitate.

Inter-rater reliability: for frequency, mean r=.87 p<.05; for propensity r=.705 p<.05
Comments The effort to involve care-givers in monitoring behaviour within placement is clearly worthwhile. However, the conclusion that the less precipitate decline in propensity (compared with the change in behaviour frequency) supports long terms of treatment fails to take into account the conjectural element in the interview questions about propensity. Clearer data on 'propensity' would be needed to corroborate the conclusion.

Evaluations of qualitative papers with GAEQ score above 3

Authors/date Allan, 2006
Total GAEQ score – 4
Design Qualitative
Area Australia
Interventions Semi-structured interviews with practitioners working with children, aged 14 years or under, who had sexually assaulted another child.
Participants Thirty-six participants who were social workers, psychologists, counsellors, psychiatrists and therapists, identified by a snowball sampling process. Of the 36 participants, eight worked in private practice, two were private practitioners, 26 in public sector health or charitable agencies. The least experienced participant had worked as a counsellor for five years and the most experienced for 23 years in child and adolescent psychiatry.
Outcomes The study investigates experiences of practitioners.
Comments The paper aims to highlight the relative inattention given to structural disadvantage, such as poverty, in the treatment of sexual offences. Child clients from poor backgrounds are said to be the most difficult and worrisome for study participants, yet counselling is unable to address structural disadvantage. Individualised case-based approaches to intervention and social policy are said to minimise the continuing and persistent problem of poverty.

Authors/date Boswell and Wedge, 2002
Total GAEQ score – 4

Design

Qualitative research

Area

United Kingdom

Interventions

Residential therapeutic community specialising in work with young male sexual abusers in their late teens. The approach applied is broadly described as psychodynamic.

A staged assessment process informs the individual treatment plans, which incorporate a range of therapeutic approaches. The therapeutic approaches include individual counselling, groupwork, on and off-site work experience, creative arts, drama, optional education and leisure activities and a specialist Relapse Prevention Programme.

Staff and clients attend meetings at the beginning, middle and end of each day to review behaviour; the meetings are seen as opportunities to both nurture and challenge behaviour. On-going risk assessments are provided by staff. Levels of supervision are high and gradually reduced on the basis of risk assessments.

Family contact is encouraged where appropriate and work undertaken address difficult relationships. A gradual move towards independence includes living for a period in more independent accommodation in the grounds with minimal staff support and the provision of an after-care support facility.

A final risk assessment is undertaken when residents leave the community to inform the after-care process of the referring or new Authority.

Participants

Ten ex-residents were who had left the Community between two to five years prior to interview and a) should have either completed the programme or b) left in a planned way (i.e. by way of agreement between all concerned that they had completed the necessary work). Seven participants described themselves as White British or English, two according to the region of England they came from and one as mixed race. At the time of interview four were aged 20, three aged 21, two aged 22 and one aged 23 years.

Ten young people were selected as a control group and their social workers/probation officers were interviewed about their progress. The young people in the control group had been referred to the Community but had not become residents either because they were deemed unsuitable by the Community, the young people themselves deciding they did not wish to participate, their social workers or probation officers deciding they should not attend or their supervising authorities being unwilling to pay for them to participate. Details of age, ethnicity and so on not given in paper.

All 32 Community staff were invited to participate, 16 completed and returned anonymous questionnaires.

Outcomes

It is suggested that the holistic nature of the therapeutic experience equipped ex-residents the most in relation to coping with living in the wider community.

Nine of the 10 control group members had reoffended ‘mainly non-sexually’

compared to two of the 10 ex-residents who had 'reoffended in this way'.

Sexual conviction of ex-residents post-departure reduced dramatically.

Ex-residents are described as 'typically unloved, unwanted, abused young men with low self-esteem' who came to recognise and appreciate a structured and professional regime of care provided by the Community.

Ex-residents reported fewer problems two or more years after leaving the Community compared to before being admitted. They are described as having acquired the necessary techniques to cope with difficulties arising after their departure from the Community.

- Recognition that more direct linkage with work prospects on return to the community would be useful to the young people.
- Recognition of the need for a befriending service that offers sustained support
- Post-departure.

Recognition of the need to achieve greater ethnic diversity in the staff group.

Comments

- Interviews were conducted with ex-residents but feedback about the control group was obtained from professionals most recently in contact with them.
- It is acknowledged that the control group may have differed in significant ways from the ex-resident group, though they were the closest match that could be obtained.
- The research is described in a monograph and it is unclear how the data collected were analysed.
- The research and evaluation exercise is described as a pilot and provides a useful basis from which to develop future work on evaluating outcomes of interventions such as this.

Authors/date

Franey et al, 2004

Total GAEQ score – 4

Design

Qualitative

Area

United States of America – San Diego

Interventions

Review of criminal records of all participants who had left a day treatment programme at least one year prior to start of this study (n=51). Records reviewed were juvenile court, probation, Department of Justice database, clinical records and assessment data. Seven participants were selected for the main study from this initial review. Questionnaire addressing components of adolescent development, mental health, criminal behaviours and substance abuse was administered to the seven selected participants. In-depth qualitative interviews conducted with the seven selected participants to gain an understanding of life experiences of participants.

- Children resident in the homes
- Residential workers
- Social workers
- Managers

Outcomes

Aim of study is not to assess effectiveness of the treatment program but to describe life experiences of study participants.

Revisiting the past in relation to their sexually abusive behaviour is described as distressing for the study participants.

Participants described peer support, structure and therapeutic relationships as helpful elements of the treatment programme.

The concept of accountability was identified by participants as the most important element of treatment they utilised after discharge from the programme.

It s suggested that the scope of treatment must be extended beyond offence-specific behaviours to include modules on aspects such as relationship skills, money management and life skills.

Comments

The study presents an approach to understanding young people through qualitative research. The time period between leaving the treatment and participating in the study is relatively short and study participants may re-offend in future. This, combined with the small sample size, does not allow for substantial or generalisable conclusions to be made about factors that contribute to abstinence from sexual and non-sexual re-offending. Nevertheless, the study illustrates how listening to the views of service users about the challenges they face on re-entering society generates valuable information that can be used in the development of services.

Authors/date
Hall, 2006

Total GAEQ score – 5

Design
Qualitative

Area
United Kingdom

Interventions
The study focuses on a small social services department that has no specialist provision for this group within the organisation. Data for the study was collected in two stages:

- Information gathering about referral procedures, examination of participant case files and cross-referencing of case file data with data held by social services child protection unit.
- Semi-structured interviews with social workers who undertook assessment of young people in the study sample.

Participants

- All 14 referrals made during a randomly selected 12-month period, where issues of young people's sexually harmful behaviour were recorded.
- All 14 social workers who had assessed young people in the study sample.

Outcomes

The objective of the study, undertaken as part of an academic degree, was to provide managers with information about social services activities, in particular the implementation of Department of Health guidance *Working Together* (1991).

Comments

The study concludes that the Department of Health guidance was being adhered to and makes the following points:

- Assessment of children had proceeded in different ways with some social workers interviewing the young person in some depth and others gathering information about the young person from other agencies and parents/carers.
- Reports compiled for case conferences did not, on their own, provide a full description of case management. A fuller description of activities would be gained from social workers reports and case conference minutes.
- Department of Health guidance was actively used and found to be helpful.
- The social workers participating in this study were generic child care workers but able to respond effectively in the early stages of case management.
- Co-working and supervision were described as helpful to undertaking effective assessments.

The study is small, based on one social services office and though it includes all referrals made over a 12-month period, the number of referred cases is small.

Authors/date

Lawson, 2003

Total GAEQ score – 4

Design

Qualitative

Area

United States of America

Interventions

Study participants were due to complete an outpatient treatment programme for sexual behaviour problems. The programme is a multiple systems model focusing on addressing four general vulnerabilities:

- social/environmental
- family structure
- individual personality/genetic factors

- family origin.

The following interventions apply to this study: chart review to obtain demographic data including family relationships, characteristics, adjustment factors and offence characteristics.

Participants asked to provide written answers to 10 questions that asked for their perspectives on treatment.

Face-to-face interviews were conducted to discuss the written answers.

Participants

Seven boys aged 14 to 18 years (mean =16, SD 1.46), charged with various offences and due to complete group, individual and family treatment at an out-patient facility. Two boys were African-American and five Caucasian. No females were completing treatment at the time of the study.

Outcomes

Study designed to generate a mid-range theory of treatment which can be used in practice to monitor progress in treatment.

Communication and support from families and communities were highlighted as important by young people in helping them to avoid ‘messing up’.

Listening to how respondents talk about what they are learning, their goals and what is happening in their lives more generally, is said to facilitate the assessment of progress in treatment.

Comments

The study supports the practice of identifying and building on patient strengths rather than focusing on offenders’ deficiencies.The study sample is small and does not have any female participants.

Authors/date

Scheela, 2001

Total GAEQ score – 4

Design

Qualitative

Area

United States of America

Interventions

Unstructured face to face interviews, tape recorded and transcribed.

Outcomes

The study seeks to ascertain experiences and perceptions of therapists working with sex offenders in an outpatient sexual abuse treatment programme.

Therapist perceptions of positive and negative impacts of working with sex offenders

are reported, along with coping strategies. Separating work from personal life, mutual support and supervision were perceived as helpful. It is suggested that knowledge about the positive effects of such work may help avoid burnout and facilitate therapists to be more therapeutic with clients.
Comments The study sample is small, participants are from one treatment programme and the researcher is also a member of staff.

Authors/date Steen, 2001
Total GAEQ score – 5
Design Qualitative
Area United States of America – Washington
Interventions Observation in sex offence probation unit over a six-week period. Observation of range of activities, such as court hearings, interviews with juvenile sex offenders and group therapy sessions. Fifteen hours courtroom observation and 30 hours outside courtroom. Interviews with court personnel, such as judges, prosecutors, police and non-court personnel such as therapists and program co-ordinators (n=17). Range of written documentation including legal statutes, professionals' reports for the court and newspaper articles from 1995–1996.
Participants No specific sample, range of participants interviewed/observed in different settings.
Outcomes Study examines medical and legal perspectives regarding juvenile sexual offending and not effectiveness of treatment interventions. Study illustrates the medicalisation of juvenile sexual offending as a result of legal requirements to make treatment as a central goal for this group. Tensions between the medical and legal perspectives are highlighted and the medicalisation of delinquent behaviour within a legal system is examined.
Comments The study is based on one county in the United States and professionals involved in the management of juvenile sex offenders are relatively few.

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