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**CHILDREN AND YOUNG PEOPLE WITH HARMFUL,  
ABUSIVE OR OFFENDING SEXUAL BEHAVIOURS:  
A REVIEW OF THE LITERATURE**

**Constructed around some emerging issues from  
the review of residential services for children and young people  
with harmful sexual behaviours  
conducted by the Social Work Inspection Agency,  
Care Commission and HMIE**

**Linda Hutton  
CJSW Development Centre for Scotland  
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**[www.cjsw.ac.uk](http://www.cjsw.ac.uk)**

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## SUMMARY OF MAIN FINDINGS

### Defining ‘sexually harmful behaviour’

Factors deemed important to consider when determining whether sexual behaviour is harmful or not include:

- Disparities in age, size and/or developmental status of the children involved
- Use of force or coercion
- Context and location of behaviour
- Frequency and intensity of behaviour
- Level of preoccupation with sexual behaviour
- Persistence of behaviour despite intervention

A term considered as a useful definition for this group is ‘young people who sexually harm, abuse, or offend’.

### Describing ‘sexually harmful behaviour’

- There is a great deal of heterogeneity across the behaviours, characteristics and backgrounds of young people with problem or offending sexual behaviour
- Some studies suggest a difference between the problem sexual behaviours displayed by children and those displayed by adolescents
- While some interesting typologies for describing sexually harmful behaviour have been proposed, none are used consistently
- The terminology applied to the young person in relation to their problem sexual behaviour may have an impact on treatment and outcomes

### Profiling young people with problem or offending sexual behaviours

- The heterogeneity of this group is a significant factor in profiling these young people
- Different profiles are proposed for those who abuse children younger than themselves and those who attack peers or adults. Different profiles are also proposed for those who commit only sexual offences, and those who commit both sexual and non-sexual offences
- Differences in the profile of males and females have been found, with the issue of ‘double standards’ often relevant in considering differences in behaviour between the sexes
- The type of behaviour displayed by young people with problem or offending sexual behaviours that also have a learning disability has been found not to be significantly different from behaviours in those within the normal range of ability. However, a potential lack of understanding around, or resistance to acknowledging what constitutes normal sexual behaviour in the learning disabled may have an impact here
- Young people with problem or offending sexual behaviours do not always come from abusive and chaotic backgrounds, nor have they all been victims of sexual abuse
- There is some evidence to suggest that, for those who have been sexually abused, the circumstances of the abuse will be repeated in their own abusive behaviour

### Placement issues

- There is no explicit evidence to suggest that secure residential settings have any benefits over open settings for housing young people with problem sexual behaviours or juvenile sex offenders. In fact, providing issues such as treatment and supervision are fully addressed the evidence suggests that only those young people with the most serious and persistent of behaviours will require any form of residential care

- There is evidence to suggest that staff in residential settings lack the required knowledge and training to adequately manage young people with problem sexual behaviours
- The ‘care’ environment is not always a safe one

### **Aims and objectives of treatment**

- Both needs and deeds require to be addressed – treatment should be tailored to the individual, based on sound assessment and an extensive history of the young person

### **Treatment issues**

- Treatments should be tailored to the individual, with positive outcomes dependent on the aims of the treatment
- Cognitive behavioural and multi-systemic therapies are considered to be the best approach in treating young people with problem or offending sexual behaviours
- A ‘horizontal’ approach to treatment would appear to be the most effective, with all concerned with the welfare of the child being aware of their needs and behaviours
- Involvement of the family in the treatment process, where appropriate, is considered important
- Multiple placements, a lack of coherent philosophy/practice aims and deficits in staff training are believed to contribute to potentially poor physical and mental health care for children in residential settings
- It is proposed that a more positive and constructive approach towards education in the care setting, such as providing support, encouragement and adequate study resources could lead to improvements in educational outcomes
- A resistance to ‘labelling’ a child as displaying problem sexual behaviours, particularly in the learning disabled group, can hinder appropriate treatments and interventions. In particular, a reluctance to ‘label’ problem sexual behaviour in the learning disabled, along with an occasional reluctance to acknowledge normal sexual behaviour in this group, can be barrier towards effective interventions
- Early and appropriate interventions are recommended to best facilitate change, taking into account that the internalising coping strategies of some sexually abused young people may be wrongly interpreted as resistance to change
- Juvenile sex offenders are not the same as adult sex offenders and therefore caution should be used in applying knowledge of the later, particularly in treatment terms, to the former

### **Assessing and managing risk**

- There are no currently validated actuarial tools for evaluating risk in young people with problem or offending sexual behaviours. The ‘AIM’ framework appears to be the most consistently used in Scotland, while progress is being made with J-SOAP and ERASOR in the U.S.A.
- There is little evidence to suggest that the majority of juvenile sex offenders will continue to sexually offend into adulthood, although the relatively low detection rate for some sexual offences may be a factor in this
- Non-sexual offence history is more relevant to the risk of any future recidivism (sexual and non-sexual) than are sexual offences; also, juvenile non-sexual offenders have higher recidivism rates than do juvenile sex offenders
- Risk should not be considered at the expense of protective factors and the strengths the individual (and family) can bring to treatment and change
- The age of the young person and the motivation behind the problem/offending sexual behaviour should be taken into account when considering risk
- Factors that stand out in the literature as being associated with risk of sexual harm against others include: interfamilial violence; care rejection; maternal history of abuse and the severity of any sexual abuse the young person has suffered
- Some factors used in defining problem sexual behaviours, such as context and intensity, are also useful when considering risk

## CHAPTER ONE INTRODUCTION<sup>1</sup>

1.1 In the last twenty-five years there has been growing awareness and acknowledgement of the incidence of sexually harmful behaviour by children and young people. Researchers have estimated that between a third and a quarter of child sexual abuse is committed by young people aged under 18 years. For example, the 2004 criminal statistics for England and Wales [98] showed that of the 6400 individuals cautioned for or found guilty of sexual offences, approximately 17 per cent were between 10 and 17 years of age. With regard to Scotland, the only relevant data that could be traced were figures related to criminal proceedings in Scottish courts [103]. However, all that can be gleaned from this publication is that, of the 785 persons against whom a charge related to a crime of indecency was proved in 2004/05, 14% were aged under 21 years [103]. Also, in recent official statistics from America [85] for 2003 it is stated that of all those arrested for rape during this year, 16% were juveniles, as were 20% of all those arrested for other sexual offences (excluding prostitution). The most commonly represented age group in both instances were those aged 13 or 14. Of all the juveniles arrested during 2003 in America, only 1% were arrested for sexual offences; of all the juveniles in a residential placement during 2003, 8% were there in relation to sexual offences [85].

1.2 However, in contrast to adult sex offenders there is still relatively little literature on children with harmful sexual behaviours. Also, much of the work that can be found tends to focus on young people dealt with in a judicial or criminal context. There is also the quality of available literature to consider. While a number of studies report interesting findings, on closer reading many lack the detail required to assess their usefulness in a full review (e.g. 7, 8). Aside from small sample sizes (e.g. 3), it is often the case that a general lack of information on the backgrounds of those included in the study is reported (e.g. 15), or the sample will be very specific to a certain context (e.g. 14), making it more difficult than usual to generalise the findings. Also, in literature reviews it is often the case that findings from various studies are simply reported, with no critique made or overall conclusions drawn (e.g. 16). A study [37] that particularly stood out during this review was one that purported to assess treatment efficacy via an examination of pre- and post-treatment outcomes. On the surface, this seemed like a very useful study; however, on closer examination it was found that the subjects in the pre- and post-treatment groups were not the same, and therefore no assessment of treatment efficacy could actually be made. These examples emphasise the very important point of considering the reliability and validity (or quality) of research findings, as a course of action based on poor research is possibly more detrimental than one based on no research at all.

1.3 Nevertheless, in this current exercise an extensive review of the literature around young people with problematic or offending sexual behaviour has been conducted. This review has been constructed around some of the emerging issues identified in the review of children and young people with harmful sexual behaviour in residential settings by the Social Work Inspection Agency ('SWIA'), the Care Commission and HMIE [121], which can be summarised as being:

1. Defining "sexually harmful behaviour"
2. Describing "sexually harmful behaviour"
3. Profiling young people with sexually harmful or offending behaviour
4. Placement issues: Concentration versus dispersal? Open versus secure?
5. Aims and objectives of treatment: Address needs (welfare), deeds (youth justice) or both?
6. Treatment issues: Generalist and/or specialist approaches to treatment, the theories underpinning such approaches and whether to take a horizontal (collaborative working with all participants signed up to the same aims and objectives) or vertical (sequencing) approach. Also assessing the readiness of young people for change, setting realistic timetables and targets for change, and identifying outcomes for young people. Health and education issues for children in residential care
7. Assessing and managing risk

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<sup>1</sup> Given the high volume of literature utilised for this review, a slightly unorthodox approach has been used towards referencing within the text, although this method has been observed in other work. Instead of referencing full author information in the text, a number referencing system has been employed in order to improve the flow of the work. Also, those articles read during the course of the review, but not referenced within, are included in a traditional-style bibliography at the end of the paper.

1.4 Given this structure, there may be information in one section that could be relevant to another. However, repetition of material has been avoided where possible. Of course it is not presumed that all of these questions will be answered fully, but this review should help in at least beginning to address some of these issues. Although some concluding remarks will be given in the final section of this paper, the summary at the start of this document is presented in place of a full section on conclusions as this was believed to be a more useful format for considering the main findings of this exercise.

1.5 During the course of the review SWIA made a request to the CJSW Development Centre for Scotland ('the Centre') to make use of a client monitoring form created by their National Development Group for Children with Harmful, Inappropriate and Problematic Sexual Behaviours to collect information on children with harmful sexual behaviour. The client monitoring form is comprised of 50 questions, in multiple-choice/tick box format with free text space for 'other' responses where required, and a free text space for comments at the end of the form. It includes 5 sections. The first section covers general information on the client, such as date of birth, details of any involvement with social work services (other than that for problem sexual behaviour), accommodation status and education/employment status. The second section gathers data on referral to the specialist service (e.g. referral date and source), while the third covers factors related to risk, such as assessment tools used, level of risk awareness, legal status at referral and any previous referral or convictions. The fourth section covers trauma and needs relevant to the client, such as abuse, neglect, exposure to inappropriate environments, concerning non-sexual behaviours and current living environment. The fifth and final section relates to the sexual behaviour displayed by the client, including the nature of this behaviour, location at which it took place, and victim/incident details. Use of the form was agreed, and in due course information was collected on 36 children. This data was collated and analysed by the Centre with findings presented in the SWIA report [121].

1.6 Before continuing, it should be noted that the terminology varies widely across the literature, with the 13 to 18 year old group variously referred to 'adolescents' or 'juveniles'. However, when referring to sexual offending both of these terms are sometimes used in relation to younger children, this being dependent on the varying age of criminal responsibility in different jurisdictions. For the purposes of this paper, those young people who have been adjudicated of a sexual offence will be referred to as 'juveniles'; where extreme age disparities are recorded, these will be explicitly mentioned. For those with problem sexual behaviour who have not been charged/convicted of an offence, 'juvenile' will still refer to those aged 13 or over, while the term 'children' will be used for those 12 and under.

## CHAPTER TWO      DEFINING “SEXUALLY HARMFUL BEHAVIOUR”

2.1 It is perhaps most constructive to begin by considering what is ‘normal’ sexual behaviour in children and young people, although there does appear to be a dearth of knowledge in this area [46; 72]. The field is also considered to be somewhat hampered by carers, in both family and professional contexts, viewing themselves as ‘protecting’ children from sexual knowledge as childhood sexuality “is seldom treated as a strong or healthy force in the development of a child’s personality” [66]. No matter the cause, a general lack of information on normal sexual behaviour in children is certainly an issue when it comes to defining problem sexual behaviour [72]. However, it is known that sexual responses are present from birth, and that genetics and biology are a factor in sexual development [84].

2.2 A useful description of normal sexual behaviour in children can be found in Cavanagh-Johnson’s work (1998; in 36), where this is described as occurring when:

- The children involved are of similar age, size and developmental status
- Participation is mutual and voluntary
- The sexual play behaviours are not excessive or harmful
- The sexual play behaviours are limited in type and frequency, and by the child’s interest in sex
- Sexuality is balanced by curiosity about other aspects of the child’s life

2.3 One definition of sexual abuse, couched in similar terms to those used above, has been found in a number of studies (e.g. Graham, 1996; in 21), which states that sexual abuse can be signified by one or more of the following behaviours:

- Forced sexual contact of any kind
- Sexual contact with a person who is unable to give consent
- Victim being forced, bribed or coerced into sexual contact
- Age-appropriate sexual exploration or experimentation is replaced by dynamics of fear, secrecy, confusion, intimidation and/or domination
- Preoccupation with sexual issues

2.4 As part of the background work to an American study [49], the limited research available around sexual behaviour in young children was reviewed; although this area requires further work, some consistent findings did emerge:

- While children are naturally curious about their own/others bodies, this overt interest decreases with age and development; it is therefore the frequency and/or intensity of such interests that is important to consider when determining whether the behaviour is problematic or not
- Behaviour resembling adult sexual activity can be observed in children, although the actual content of this behaviour was not described in the report; however, the behaviour will be of very low frequency in normal sexual development and tends only to be of high frequency in children who have been sexually abused
- Normal sexual play is spontaneous, light-hearted and mutual
- It is common for a child to experience feelings of arousal/excitement within normal sexual play.

2.5 Other factors found to be relevant when considering problematic sexual behaviour in children have been reported in a review of the common misconceptions around this group and the current evidence to refute these [83]. A child’s sexual behaviour was considered problematic if:

- It interfered with normal social or cognitive development
- It was repeated, occurring in secrecy, even after adult intervention.

2.6 The context of the sexual behaviour [97] should also be taken into consideration when making assessments of normalcy/harm. For example, some studies report that the majority of normal sexual exploration by children will take place in or around the home [62]; the same behaviour in a more public setting would be less appropriate. Another important factor is the consideration of co-morbidity in terms of mental health issues or conditions such as autistic spectrum disorders, as acts which may be defined as deviant under this umbrella are much different from those influenced by deviant sexual arousal [19].

2.7 It is proposed that a useful term for these children and young people is to refer to them as having “sexual behaviour problems” [32]. This is not, of course, to negate offence-related work or to underestimate the risk some of these children will pose to others. Perhaps a more useful definition is proposed in a U.K. study [43], which suggests the term “young people who sexually harm, abuse, or offend” (p. 307)

## CHAPTER THREE      DESCRIBING “SEXUALLY HARMFUL BEHAVIOUR”

3.1 Given the heterogeneity of the group, defining a typology of juvenile sexual offenders or children with problem sexual behaviour is a difficult task, and one that has found many approaches in the literature. These typologies tend to be driven by offence/behaviour type and/or relationship to the victim rather than any particular characteristics or background of the perpetrators [77], with one particular difficulty being that sexual development is something that continues beyond adolescence and is therefore not a solid and definable construct [19] that judgements can be made on [21]. This means that an optimal method for classifying juvenile sex offenders or children with problem sexual behaviour is yet to be established.

3.2 In describing sexually harmful behaviour, it is perhaps important to bear in mind some distinctions that are reported in the literature. For example, some studies draw a comparison between juveniles who molest children and those who assault peers or adults [9; 14; 50; 54], with the former more likely to have been molested themselves and the latter having much in common with juvenile offenders in general. It is also noted that the intentions and motivations behind problem sexual behaviour in young people may not be related to sexual gratification [84], and that sexual aggression is not necessarily related to sexual deviance [97], so this should also be considered.

3.3 Work by Cavanagh-Johnson (30; 31) on children aged 4 to 13 who sexually abused younger children ultimately led to the development by Cavanagh-Johnson and Gil (1993; in 36) of a continuum to describe a range of behaviours in children from normal and healthy sexual expression to sexual molestation. This typology continues to be used (Cavanagh-Johnson, 1998; in 36) and appears to be a useful one, with this particular age group at least. The rationale behind this typology is that different manifestations of problem sexual behaviour have different contributing factors, and therefore may require different intervention and treatment responses [36]. The four types of sexual behaviour identified in the continuum are as follows:

- **Normal Sexual Exploration:** Age-appropriate curiosity about bodies, sexuality and play that explores each other's bodies (playing doctor); exploring gender roles and behaviours (playing house).
- **Sexually Reactive Behaviours:** Age-inappropriate knowledge about sex and sexual behaviours is reflected in the behaviour; such behaviour is often considered to be a re-enactment of experienced inappropriate sexual contact or exposure to adult sexual activities, pornography, etc.
- **Extensive Mutual Sexual Behaviours:** A more pervasive and focused sexual behaviour pattern is displayed than in sexually reactive children, with participation in the full spectrum of adult sexual behaviours. While these children may use persuasion in eliciting sexual contact with others, they typically do not use force or coercion.
- **Children who Molest:** Such children demonstrate sexual behaviours that go far beyond what is developmentally appropriate childhood exploration/play and are often preoccupied with sex, have poor impulse control and are physically and sexually aggressive. They also engage in adult sexual behaviours and typically use force, coercion, threats or manipulation and trickery to elicit participation from children the same age or younger.

3.4 A typology for younger children with problem sexual behaviour, aged 6 to 12, has also been proposed in a study examining assessment and treatment for this age group [32]. In this work, a 3-fold typology is suggested:

- I **Sexually inappropriate children** – behaviour is non-contact in nature
- II **Sexually intrusive children** – sexual contact is transitory in nature
- III **Sexually aggressive children** – sexual contact is sustained, involving coercion and/or aggression

3.5 However, the lack of detail presented in this study makes it difficult to assess the usefulness of this typology. For example, while findings across the whole sample are consistent with findings in other studies, few differences between the individual groups are discussed. The main differences between the groups appear to be that the children in Group I were less likely to have experienced physical and/or emotional

abuse, or neglect, while the levels for Groups II and III were comparable. The only other difference cited was that those in Group III appeared less likely to have experienced sexual abuse, while the levels for Groups I and II were comparable. Given that the distinctions between the Groups may be slight, it is perhaps not surprising that no differences in treatment completion or outcome were found in this study.

3.6 A number of typologies for juvenile sex offenders have been proposed; however, the lack of empirical support for these makes it difficult to assess the efficacy of these typologies. One that may be useful, and has some support in the literature, is that proposed by Seto and Barberee (1997; in 4), which is as follows:

**Sexual offender Type 1:** Persistently antisocial; history of early, chronic and extensive conduct problems in the manner of criminally versatile offenders; more likely to be angry and hostile, and have more pro-criminal attitudes and beliefs.

**Sexual offender Type 2:** No early onset of behaviours; not overtly antisocial in the sense that the individual will have more in common with non-offenders; more likely to have deviant sexual interests.

3.7 Overall, at this stage it would appear that typologies suggested in much of the literature are descriptive in nature, rather than having any utility as tools relating to prediction of future behaviour or assessment of risk. However, they do serve to illustrate the fact that these young people should not be considered as a homogenous group and thus highlights the need for practitioners to approach each case individually.

3.8 In describing the young person themselves, it has been suggested that negative terminology can have a detrimental effect on outcomes for that individual [96]. Two different terms and the ‘messages’ that can be associated with those are usefully described by Hackett (2001; in 96, adapted from p. 6):

**Term 1**

‘You are a sexual abuser’

**Messages it may convey**

- All you are is an abuser
- You are still an abuser
- You will always be an abuser
- I am only interested in you as an abuser

**Term 2**

‘You are a young person who has sexually abused’

**Messages it may convey**

- You are a young person first and foremost
- You have done something wrong but this doesn’t mean to say you will always be an abuser
- You could change
- I am taking your behaviour seriously – it is abuse, but I am interested in you as a young person as well

## CHAPTER FOUR PROFILING YOUNG PEOPLE WITH PROBLEM OR OFFENDING SEXUAL BEHAVIOURS

4.1 Profiling juvenile sexual offenders and children with problem sexual behaviours is not a task that can be accomplished in a straightforward fashion. The variation between studies in terms of sample size, sample origin, focus of the study etc. makes developing a consistent profile all but impossible; one of the few factors agreed across all studies is the heterogeneity of the group. Also, a major inadequacy in the research is a lack of comparison of juvenile sex offenders with other offending/non-offending groups, and even where this work has been done there remains a great variation in findings. Although some consistencies, as well as notable findings from a number of studies, have been reported it is difficult to say what, if any differences exist between this group and society in general. However, some of the more salient findings are reported below.

4.2 Some studies make a distinction between juveniles who abuse younger children and those who assault peers or adults [9; 50; 53; 54; 91]. Differences in characteristics have been found between the two groups, with those who abuse younger children scoring higher in neuroticism, being more frequently bullied, having poorer peer relationships, having a poorer self-image, beginning the abusive behaviour at an earlier age, having relatively more victims and having more emotional/behavioural problems [14; 50; 91] than those who assaulted peers or adults. They were also more likely to have been victim to sexual abuse themselves [67]. In contrast, those who assault peers or adults have been found to have a higher proportion of female or stranger victims, be more likely to commit other simultaneous non-sexual offences<sup>2</sup> and use more force<sup>3</sup> during a sexual assault than those who abused younger children [53].

4.3 There is evidence to suggest that juvenile sex offenders actually display fewer behavioural problems and are less delinquent than juveniles who commit other types of offences [4; 95]. One study [4] found that while young sex offenders did not differ from non-sex offenders in terms of conduct problems in primary school (ages 6 to 11), those who committed only sexual offences had fewer conduct problems than those who committed both sexual and non-sexual offences. In this study LSI scores were found to be lowest for those committing sex offences only and highest for those committing both sexual and non-sexual offences. Scores related to risk for future delinquency followed a similar pattern, with those committing only sexually offences scoring the lowest.

4.4 There are also a number of myths around juvenile sexual offenders which have no support in the empirical literature. For example, the idea that these juveniles come from chaotic and disrupted families and have suffered sexual abuse seems to be a common one; however, the evidence suggests that there is no definitive family profile for juvenile sexual offenders. Also, while some have indeed suffered sexual abuse, many have not [33; 34; 35; 83]; in fact, physical abuse is more commonly reported [12; 55; 83]. However, while rates of sexual victimisation on young sexual abusers/offenders vary across studies, the incidence has been almost always found to be higher than that in the general population [28; 32]. U.K. estimates of sexual abuse in the general population are cited as being between 12% and 24% of all females and between 7% and 11% of all males, equating to 16% of the whole population [35]. Levels of sexual abuse found in the literature during this exercise ranged from 15% [64] to 86% [67].

4.5 A number of studies have in fact identified a group of children with problem sexual behaviours who have been sexually abused themselves [99], with those who had been sexually abused likely to show the first signs of sexually aggression at a much younger age than those who had not [29; 34]. Such manifestations of behaviour are often linked to Social Learning Theory (Bandura, 1986; in 28). In simple terms, under this theory those children who have been sexually abused at a young age ‘learn’ that this behaviour is normal

<sup>2</sup> The volume of prior or concurrent non-sexual offending reported for juvenile sex offenders varies widely from study to study, from none [17] to 86% (Jacobs et al, 1997; in 17).

<sup>3</sup> However, it is worthy of note that, in this rather extreme sample of young people, the highest level of ‘force’ was used by child who ultimately murdered their younger victim.

(e.g. much like an average child would learn that wearing shoes outdoors was normal behaviour); therefore, expressing sexually abusive behaviours towards others would not be viewed by the child as something they should not do. This could imply that the behaviour can be ‘unlearned’ via interventions with the child.

4.6 The findings from some studies appear to imply that the experience of sexual abuse in juvenile sex offenders does have an impact, however, as differences between those who have/have not been sexually abused have been found. For example, one study [34] found that those juvenile sex offenders who had been sexually abused had a higher number of victims, fewer non-family victims and were more likely to victimise both males and females than were those who had not been sexually abused. Another study found that juvenile sex offenders were more likely to have experienced sexual and/or physical abuse than had juvenile non-sexual offenders [89].

4.7 There is some evidence to suggest that, for those young people who have been sexually abused that go on to sexually abuse others, the acts perpetrated on their victims are highly likely to be the same acts perpetrated on them. For example, one study [28] found that of the 90% of juveniles in their sample that had been abused by exhibitionism, 82% went on to abuse others in that manner. Also, of the 89% of juveniles who had been abused by penetration, 77% went on to abuse in this way. In addition, the juveniles in this sample were most likely to abuse the particular sex that they had been abused by [see also 91]. Another study [91] also reported that juvenile sex offenders who had been abused by fondling were 7 times more likely to abuse in this way than those who had not been fondled. Also, those juvenile sex offenders who had been abused by anal penetration were 15 times more likely to abuse in this way. They were also twice as likely to abuse children who were around the same age at which their own abuse had begun. These studies may indicate that while sexual abuse does not necessarily predict future sexual behaviour problems, it does have some impact on that behaviour when it occurs.

4.8 Few studies have comparison groups, and so it is often difficult to state which of the factors apparently related to problem sexual behaviour are actually present in children who do not display such behaviour. One study that does employ a comparison sample [32] compares a group of children with problem sexual behaviour with others who, while they have a number of behavioural issues, these are not sexual in nature. In this study it was found that a higher proportion of children with problem sexual behaviours (59%) had experienced abuse/neglect than had the children in the other group (48%). This was true for sexual, physical and emotional abuse. These factors, along with family dysfunction, are also reported to be of higher incidence in children who sexually abuse [78]. Also found to have significant impact on young people who sexually abuse others is their experience of interfamilial violence [25].

4.9 With regard to the types of sexual offences being committed by juveniles, this varies widely [17]. For example, in two American studies it is reported that rape accounted for 9% [52] and 53% (Ryan et al, 1996; in 17) of offences committed by juveniles in their sample. In one Australian study [Kenny et al, 1999; in 17], 36% of offences were recorded as involving penetration, while a U.K. study (Manocha and Mezey 1998; in 17) reported that more than half of the offences in their sample involved penetration. This variation in behaviour is repeated across most studies; perhaps the only determining factor is age, as younger children with problem sexual behaviours tend to display a wider range of behaviours than do juvenile sex offenders; for example, one study [104] found that 50% of those aged 12 or under in the sample perpetrated both contact and non-contact sexual behaviours in comparison to 20% of those aged 13 or over.

4.10 There is also some evidence to suggest that the characteristics and behaviour of ‘solo’ juvenile sex offenders are different from those who act in a group with, for example, the former showing higher levels of neuroticism, impulsivity and social isolation than the latter [24]. It has also been found that lone assaulters were less likely to use violence and more likely to use penetration in an attack than were group assaulters [94].

4.11 A Canadian study [47] examined the sexual behaviour of 99 sexually abused children, aged 3 to 7 years, in an abuse treatment programme. From an examination of the clinical files of these children, first the sexual behaviour of these children was classified as falling into one of three groups:

- Group 1:** Developmentally expected sexual behaviour (22 children)  
**Group 2:** Problem sexual behaviour that was focussed at the self (15 children)  
**Group 3:** Problem sexual behaviour directed at others (62 children)

4.12 The study went on to find significant differences between the three groups in terms of background and behaviour, some of which are reported in Table 1 below, and these would appear to indicate that the varying experiences of children who are sexually abused could have an impact on their subsequent sexual behaviour, be this problematic or not.

**Table 1: Differences between groups of children with different sexual behaviours**

	% of Group 1	% of Group 2	% of Group 3
<b>Child required to be active participant in own abuse</b>	38%	56%	89%
<b>Lack of empathy in the child</b>	0	7%	47%
<b>Child experiencing feelings of hopelessness and depression</b>	5%	15%	55%
<b>Non-sexual boundary problems in the home</b>	0	29%	63%
<b>Child was physically abused</b>	25%	21%	72%
<b>Child has restricted range of affective expression</b>	18%	33%	73%
<b>Maternal history of childhood neglect</b>	8%	18%	68%
<b>Child sexual arousal during own abuse</b>	0	64%	89%

4.13 This study also conducted regression analysis to see what factors, if any, could be considered predictive of interpersonal problem sexual behaviour in the child; four were found, these being the perpetrators use of sadism in abusing the child, a history of physical and/or emotional abuse, and the sexual arousal of the child during the abuse. Further regression analysis found that a child who had experienced arousal during abuse was 15 times more like to perpetrate interpersonal problem sexual behaviour than one who had experienced no arousal, and that a child with a history of physical abuse was 11 times more likely to perpetrate interpersonal problem sexual behaviour. In using this model across the whole sample, it was reported that it could correctly identify children who would/would not have issues with interpersonal problem sexual behaviour.

4.14 With regard to the identification of young females with problem sexual behaviour, a number of difficulties are evident. For example, there is evidence to suggest that ‘double standards’ are employed when considering the sexual behaviour of males and females [2], even by those tasked with their care in a statutory capacity [39]. It would also seem to be the case that gender perceptions have an impact on considering problem sexual behaviour in females; for example, a survey of professionals working with young people with problem sexual behaviour found that almost half (46%) believed sexual aggression was a characteristic of male perpetrators rather than females [2], while in reality few differences were found. A further finding of this particular study was the belief that “girls are more dangerous than boys, lay more complex plots and traps, and were more likely to re-offend” [2, p.14]. However, no real evidence was provided to support this.

4.15 Some differences that have been noted between male and female juvenile sexual offenders include that females tend to show greater variability in sexual arousal/behaviour patterns, and also rarely offend against adults [80]. In many studies it has been recorded that female juvenile sex offenders and those displaying problem sexual behaviour are more likely to have experienced sexual victimisation than their male counterparts (Araji, 1997; Gray et al 1997; Matthews et al 1997; in 2; 32). While physical and sexual abuse has been noted to have an inconsistent relationship with sexual offending [2], its incidence has been found to be more common for female sexual offenders than males (e.g. 32; 80; 95).

4.16 Females appear to constitute a small but significant proportion of both juvenile sex offenders and children with problem sexual behaviour. For example, Gray et al (1997; in 17) reported that 35% of their

sample was female, while a study by Spaccarelli et al (1997; in 17) reported that 40% of the sex offenders in their sample had been sexually abused by females, compared to 10% having been sexually abused by males. Also, a recent study of 179 juveniles in a residential institution [28] found that, of those who had been sexually abused, 71% reported having been abused by females; it should also be noted that 86% of the victims of the sexual offenders in the sample were female. However, the sample could be considered as an extreme one, as while 46% had been adjudicated for sexual offences, the remainder had been convicted for offences ranging from armed robbery to murder.

4.17 Learning difficulties in juveniles with sexual behaviour problems may also be an issue, as a number of studies report what appear to be relatively high levels of this. For example, Gray et al (1997; in 2) reported that 41% of their sample had ADHD, while a further study [99] reported 49% of their sample had some form of learning difficulty. However, some studies have found that problem sexual behaviour in those with learning disabilities has much in common with the same behaviour in young people in the normal range of ability [21]. Also, it has been suggested that there is a generally poor understanding and acceptance of what constituted 'normal' sexual behaviour in the learning disabled group [43], and so the problem may overestimated.

## CHAPTER FIVE PLACEMENT ISSUES

5.1 Given recent high profile cases in Scotland (e.g. that of Colyn Evans [102]) and subsequent concerns over public safety, whether or not to place in young person with sexual behaviour issues in secure care is a huge consideration. Literature regarding outcomes for young people with sexual behaviour issues in care is limited, but a number of studies do address the issue.

5.2 In a review covering misconceptions around secure placements and evidence to refute these [12], it is stated that there is considerable professional consensus that juvenile sex offenders can be adequately treated in the community, thus avoiding issues such as family separation and possible exposure to a focussed deviant environment; in fact, incarceration of any type may do more harm than good [23]. There is no “convincing evidence” [23, p.405] to suggest that an emphasis on public safety and punishment, i.e. removing sexually offending juveniles from society, is any more effective than rehabilitation and treatment. This premise is also supported for children with problem sexual behaviour. For example, a large American review [83] found that, unless the child’s behaviour is highly intrusive, aggressive or resistant to intervention, the child can be maintained in the family unit providing treatment and supervision are adequate; it is only in the most serious cases that the child will require residential treatment.

5.3 Also, a U.S. study (Livingstone-Smith & Howard, 1994; in 39) found that sexually abused children in care experienced more placements, increased frequency of disrupted adoptive placements, greater behavioural difficulties and more attachment problems than did those children in care who had not been sexually abused. In addition there are some indications that non-sexual recidivism is actually more common for juvenile sex offenders who are treated residentially than those who are treated in the community (Kahn & Chambers, 1991; in 1), particularly first time offenders [76].

5.4 With regard to a mixed environment (i.e. housing juvenile sex offenders with those who have committed non-sexual offences), little useful literature has been found on this subject. However, a recent American study [93] examined outcomes for male juvenile sexual offenders who had either been placed in treatment with only other juvenile sex offenders, or in a treatment situation including all types of juvenile offenders. Although the study was quite poor in the sense that it did not report on factors such as treatment completion or drop out rate, it did find that sexual recidivism rates for both groups were almost identical 5 years after release, at a little below 5%. However, non-sexual recidivism was much higher in the mixed group (71%) than in the sex offender only group (47%).

5.5 A rather worrying U.K. [39] study examined abused and abusing children in local authority care via a case file review of 250 such children and in-depth interviews with 40 of these (22 females and 18 males), 19 of whom were in foster care and 21 in residential care (primarily children’s homes). All of these children were aged 10 and over, with the majority (68%) aged between 13 and 15 years. Of the 40 interviewed, 36 had been sexually abused and half of these showed sexually abusive behaviour towards others. The remaining 4 young people had been sexually abused, but had not sexually abused others.

5.6 The first of the concerning findings from this study was that 4 of the females became pregnant during the course of the study, with 3 of these aged under 16 at the time. Interestingly, while it was noted that promiscuous<sup>4</sup> sexual behaviour in the girls was censured, similar behaviour in boys was not; that male and female sexual behaviour is treated differently in this setting was found in another U.K. study also [46]. In fact five of the young people, including 4 boys, were noted as appearing “..to be involved in prostitution.. and a few were even, on occasions, collected by their clients/perpetrators from the doors of their care residences.” [39, p.103/4]

5.7 It was further noted that in 42% of the cases where the child had been sexually abused and in 53% of cases where the child has sexually abused others, this information had not been passed on to the carers.

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<sup>4</sup> That is, apparently indiscriminate sexual contact with multiple partners.

However, in general it was found that those workers in residential care settings had an overall lack of knowledge in how to deal with sexually problematic or promiscuous behaviour, particularly in girls, and appeared to view sexual abuse and subsequent sexual behaviours as unrelated. There was also an indication that some carers minimised previous abusing behaviour, and while there was evidence to suggest that work was done to curtail problem sexual behaviours, little effort was made to address any root causes.

5.8 A general lack of sexual knowledge and education was identified as a factor effecting these children [see also 58]. Carers, particularly those in residential settings, appeared to take a rather passive stance towards this, though the following quote indicates that this may a failure of policy more than anything else:

*“We’ve got leaflets. We’ve got a pile of stuff that they can look at. But we’re not actually allowed to say ‘I’m going to talk to you about this now’”* [58; p. 106]

5.9 Another U.K. study [46] reported that there appeared to be inadequate staff training with regard to dealing with the sexually abused/abusing in residential settings [see also 58], with a lack of discussion of sexual issues with these young people identified as being particularly problematic. An American study [58] involving workers in child residential care stated:

*“Developmentally appropriate behaviour of sexually abused children, as well as behavioural manifestations of child sexual abuse, [are] often misinterpreted and mismanaged.”* [58, p.211]

5.10 While the following quote is a lengthy one, it bears repeating as it clearly sums up the findings of this study and highlights some of the issues that should be taken into consideration regarding children who have been sexually abused and/or are abusing others:

*“..findings ..suggest that the key areas for managing looked after sexually abused and/or abusing young people fall into four areas: close supervision, effective sex education, modification of inappropriate behaviours, and therapeutic attention to the children’s deeper unmet needs, underpinned by a thorough understanding of the young people’s history, so that their behaviours are seen in the context of their past experiences.”* (39, p.111)

## CHAPTER SIX AIMS & OBJECTIVES OF TREATMENT

6.1 It has been proposed that an increasing trend in the U.K. of a punitive approach to young offenders is neglecting to take into account the needs of many of these young people; however, the welfare of these individuals should not be ignored [44; 66; 96]. It has also been proposed that the term ‘risk management’ often takes the focus away from the needs of the child and how they can be addressed to reduce the potential for further harm [97]. In an extensive American review of the literature [78], it is stated that:

*“Risk management strategies likely to be most effective are those that address the needs underlying a juvenile’s behaviour” (p.57)*

6.2 Even when not stated explicitly, the literature tends to fall into either the ‘needs’ or ‘deeds’ camp, and it is rare that the two are considered together. No matter how efficacious the findings in either field however, there is no evidence to suggest that one can be ignored at the expense of the other [97]. For example, there would seem to be no point in trying to address deeds if a child’s needs negate a useful intervention, such as in the case of certain learning disabled children who may require some cognitive behavioural work before an intervention can begin [21; 43]. It has also been found that sexually abusive young people more commonly react to stressful situations by withdrawing and having internalising coping strategies than do young people with non-sexual behaviour problems [64], so again this may be a need that requires to be addressed before a deed-based intervention will be effective.

6.3 Equally, it would seem contradictory to address needs without taking deeds into consideration e.g. while a particularly vulnerable child may be better off living in a supportive family environment [26; 74], if he/she has been abusive towards other children or their behaviour has persisted despite adult intervention [83; 97], then this must be taken into account. Also, those young people approaching adulthood need to learn that there are consequences to behaviour, be this harm to themselves or others (deeds), no matter how troubled their background has been (needs).

6.4 Although not a straightforward answer, in general the literature supports a treatment approach which takes into account both the characteristics of and the circumstances around a particular individual, and which will address both needs and deeds in an appropriate fashion.

## CHAPTER SEVEN TREATMENT ISSUES

7.1 To date, there is no real evidence to support any one form of treatment as being more effective than another when it comes to interventions with juvenile sex offenders [1], and the heterogeneous nature of the group makes treatment decisions difficult [52]. Given this heterogeneity and the differing psychological needs of these young people [23], it is recommended that “all assessment, treatment and policy procedures should be tailored to the needs of the individual” [19, p.166; 78]. Also, the approach taken should be holistic in nature, taking into account the developmental stage of the child [96].

7.2 Cognitive behavioural treatments and systematic interventions have been associated with a reduction in both sexual and non-sexual recidivism (Hansen et al, 2002; in 1). Multi-systemic therapies have also found some support (Borduin and Schaeffer, 2001; in 1). Multi-systemic therapy (‘MST’) is an intensive family- and community-based treatment designed to address serious antisocial behaviour in juvenile offenders. The MST approach views the individual as being sited in complex, interconnected systems that encompass the young person, their family and extra-familial factors such as school and neighbourhood, with intervention perhaps being necessary in all of these areas [116]. Thus, MST “addresses the multiple known determinants of serious antisocial behaviour... in the natural ecology of the youth and his or her family” with services being provided “in the home, school and other community locations” [117, p.821-822]. However, despite use of the word ‘therapy’, MST is regarded as more of an amalgam of best practice than a set method of treatment/intervention [118].

7.3 The majority of work examining the efficacy of MST has so far been conducted in the U.S.A. [119]. For example, a long-term study from the Missouri Delinquency Project [120] collected follow-up data on 176 juvenile offenders on average 13.7 years after they and their families had been randomly assigned to either MST or individualised therapy (‘IT’). Outcomes with regard to further offending were reported as more positive for those assigned to MST; for example, 81% of those assigned to IT had reoffended in the follow-up period in comparison to 50% of the MST group. Specifically, those assigned to the IT group were over twice as likely to have been re-arrested for a violent offence (30%) or a drug-related offence (33%) than those in the MST group (14% and 13% respectively). Also, those assigned to the MST group had half as many arrests and were sentenced to less than half as many days of incarceration during the follow-up period than had those assigned to the IT group.

7.4 The first study examining the efficacy of MST in Europe was conducted in Norway [119] and involved 100 adolescents with serious antisocial behaviour and their families, these being randomly assigned to either MST or the usual interventions supplied by Child Welfare Services. The adolescents who had been assigned to the MST group showed a greater decrease in both their internalising and externalising behaviours, as well as a significantly greater increase in their social competence than did those assigned to Child Welfare Services. In addition, the MST families showed a greater increase in family cohesion, with a higher proportion of adolescents in this group being maintained at home.

7.5 There is no empirical evidence, however, to support the idea that psycho-education techniques, e.g. sex education, anger management etc. are effective with juvenile sex offenders, although such work may be of more use for younger children with problem sexual behaviour. One American study [32] found no difference in outcomes between two groups of 6 to 12 year olds who had undertaken treatment for problem sexual behaviour via either cognitive behavioural therapy or dynamic play therapy. For example, at a two-year follow up, 15% of those who had received cognitive behavioural therapy and 17% of those who had received dynamic play therapy reported further problem sexual behaviour having occurred during that time. However recent work has found dynamic play therapy to be less effective than previously believed [100].

7.6 It is still a concern that knowledge of adult sex offenders and treatments for the same are applied to juvenile sex offenders [17; 23; 65; 72]. For example, a common statement made in many studies is that a high proportion of adult sex offenders report that their sexual offending began when they were an adolescent [55], and this is hypothesised ‘backwards’ to make assumptions that many juvenile sex offenders

will continue sexual offending into adulthood. However, without establishing the levels of juvenile sex offending in offenders who commit non-sexual offences, and also in those who have not offended as adults, this statement means little. Also, sexual development continues throughout adolescence and as such is not the static construct found in adults [19; 21; 93]; this is also the case for psychosocial development in general [63; 65; 97]. It is believed important to remember that that juvenile sex offenders are “children and adolescents firsts”, and as such cannot be treated the same as adult offenders [78, p.57; 93]. In fact, no empirical support has been found for the notion that juvenile sex offenders have more in common with adult sex offenders than they do with other juvenile delinquents [63; 65]. This is not to say that nothing can be learned from the literature on adult sex offenders, only that such findings should be treated with caution when considering an entity whose personality, character, etc. is not yet fixed, as even expressions of personality pathology can change over time [97].

7.7 There is some evidence to suggest that problem sexual behaviours in those with learning difficulties show little difference when compared to those in the normal range of abilities [21]. As such, it may be the case that the approach to problem sexual behaviour in those with a learning disability should not be all that different than for a normal population, providing the interventions take account of specific needs and difficulties. For example, it has been hypothesised that Fetal Alcohol Syndrome (which is associated with a high incidence of mental retardation) may be a factor in problem sexual behaviour, with a study by Striessguth et al (1997; in 22) having found that almost half of adolescents/adults with FAS displayed problem sexual behaviour. In such circumstances, it may therefore be the case that cognitive behavioural work is required before the problem sexual behaviour is addressed, even though this work may take longer with a learning disabled young person than it would do in a child of normal ability (Lindsay et al 1999; in 43).

7.8 There is also some indication that a resistance to ‘labelling’ problem sexual behaviour in the learning disabled group is impeding the identification of those who may be in need of a specialist service [43], although the labelling issue could also be considered as relevant to all young people with problem sexual behaviour. Other particular difficulties in the treatment of this group are that they often have few opportunities to develop age-appropriate relationships with peers, particularly as carers may feel ill-equipped to deal with nascent sexuality in this group and may not provide adequate sex education [43]. In the study from which these findings are reported, it was also found that while there was some indication that abuse perpetrated by learning disabled adolescents was investigated in criminal justice terms, no action was being taken against the individuals who had abused that particular young person; also, there was evidence to suggest that an investigation of the learning disabled adolescents abusive behaviour was more likely if the victim was in the normal range of ability.

7.9 In addition, the importance of the family context should not be underestimated when considering assessment and treatment as the family system is significant for the developing young person [27; 86], particularly in terms of familiar adaptability and cohesion [26; 86]. Involving the family in any intervention/treatment is also considered important [29; 74; 81; 96].

7.10 With regard to a young persons’ readiness to change an American study [52], though limited in nature, reported that treatment compliance for juvenile sex offenders in a community treatment programme was best predicted by the openness and accountability of the juvenile. However, these and other similar studies are limited in their scope, particularly in terms of numbers, and so findings such as these must be treated with caution. Nevertheless, the importance of early and appropriate intervention, particularly with younger children, is emphasised in a number of studies [e.g. 55].

7.11 Also, there is some evidence to suggest that sexually abusive young people are significantly more likely to withdraw into themselves when upset, internalise problems and have an internalising coping strategy than do young people with non-sexual behaviour problems [64]. It is easy to imagine a scenario where such a young person could be perceived as resistant to change, but it may just be the case that this ‘obstacle’ will have to be overcome before work can begin.

7.12 The health and education of children in residential care were also noted as emerging issues in the SWIA review. However, it is acknowledged that research in both of these areas is limited [111; 113], and no literature at all that was directly relevant to children with problem sexual behaviour in this context could be found. There are nevertheless some points from the general literature that are worth noting.

7.13 With regard to health, it is proposed that multiple placements can have a detrimental effect on the quality and continuity of healthcare [111]. In relation to this it is also proposed that, as positive attachment is important for good mental and physical health, frequent moves could also have a negative impact on this process [111]. In terms of mental health, it is further suggested that a move towards ‘normalisation’ of experiences for young people (e.g. the increasing emphasis on inclusion) may contribute to an underestimation of some of the mental health needs/issues that young people have [112]. In fact, an apparent reluctance to categorise or ‘label’ children in relation to their mental health needs can hinder any treatments or interventions that may be beneficial to them [112]. It is mooted that a lack of coherence in terms of the philosophy and practice aims in residential units, along with a lack of training for staff in mental health issues, can contribute to this [112].

7.14 As for education in residential settings, it has been suggested that education is sometimes viewed as a low priority in comparison to the other needs a child may have [110] with a failure to take educational issues into account when considering care placements and moves seen as an example of this [110]. Pessimism over what a child can achieve academically [113; 114] and a lack of support/encouragement from significant adults [110; 113] is also believed to contribute to negative educational outcomes for children in care. In addition, it is proposed that a lack of communication between social work and education staff [110], along with teachers potentially having a poor understanding of the care system [113; 114], may have some impact. In contrast, some children report that the support and structure offered by the residential environment had improved their educational progress, while school was viewed as their only source of stability by others [110].

7.15 Some improvements to the way education is approached in care have been suggested by children and young people who have passed through the care system themselves [110; 113]. These include:

- Providing continuity of education
- Having a quiet place within the residential unit for study
- Having regular access to books (including local libraries) and written media
- Having significant adults take an interest in and display encouragement towards educational issues, inculcating a sense of the value of education
- Making more efforts towards facilitating children in care to participate in out-of-school activities, hobbies etc.

7.16 Finally here, it would appear that there are no clear definitions of what a positive outcome is for a juvenile sex offender [38]. With regards to children with problem sexual behaviour, the most logical positive outcome would seem to be a cessation of the behaviour. Overall, outcomes will be dependent on the individual circumstances of the young person and the aims of the treatment, with the horizontal approach exemplified by such as multisystemic interventions appearing to be the most efficacious.

## CHAPTER EIGHT ASSESSING AND MANAGING RISK

8.1 There are no currently validated actuarial tools for assessing risk in juvenile sex offenders [65; 96; 97] and it is suggested that:

*“At present.. the superiority of actuarial decision-making is an article of faith rather than a fact”* (Hart et al, 2004; p.11: in 97)

8.2 It is also the case that many assessment tools take into account only static risk factors (e.g. early life experiences, permanent disabilities, etc.) while stable (e.g. temperament, intellect, etc.) and dynamic risk factors are also very important [65]. It is further proposed that a focus on risk often precludes an assessment of protective factors and rarely takes into account a child’s readiness for treatment [97]. However, work on J-SOAP<sup>5</sup> [75; 79] and ERASOR (101) appears to be progressing positively. From the feedback of Scottish practitioners working with children with problem sexual behaviour and juvenile sex offenders, the consensus is that the most useful tool used at present with this particular client group is the AIM assessment (Print et al, 2001; in 96). Also, some of the specialist problem sexual behaviour services in Scotland are developing their own assessment tools [104], although validation of these remains an issue. Although related to risk of offending in general, the use of ASSET [105] and YLS/CMI [106; 107] are also being used with this client group across the U.K. [96].

8.3 With regard to AIM (Assessment, Intervention and Moving on), this has been described as a “clinically adjusted actuarial model of assessment which takes empirically supported factors and adds in those factors which are clinically supported by practitioners” [96, p.56]. In a recent Youth Justice Board evaluation and adapted from same [115], AIM has been described as providing a framework for the initial assessment of young people with sexually harmful behaviour to open dialogue and create consistency of assessments across agencies, using an assessment model to look at offence-specific factors, developmental factors, family/carer and environment/community dynamics. The framework has 10 steps to assist and encourage practitioners to gather and analyse information that is relevant to the concerns posed by the young person, along with their individual strengths or needs.

8.4 As a model intended to help practitioners form opinions and recommendations based on information they have collected, along with what is clinically/empirically known, it is believed that the more information collected from varying sources during the AIM assessment the more accurate the model is. The practitioner uses this tool to analyse separately the level of concern and then also the degree of strengths unique to the young person. As a result of incorporating a strengths-based review within the AIM assessment model, practitioners can identify a programme of work to build on assets and protective factors while reducing risk through offence specific interventions. However, although development is ongoing [115] it should be noted that further work is still required with AIM in order to assess its empirical validity [96].

8.5 It is clear from the literature that there is a limited set of empirically supported risk factors in terms of considering sexual offence recidivism in juveniles. In addition, different sets of risk factors appear to be related to different types of recidivism; for example, antisocial attitudes and behaviours have been related to risk of violent non-sexual reoffending [86], while sexual deviance or compulsivity have been related to sexual reoffending [5]. However, these and other promising risk factors still require further corroboration, while several ‘popular’ and often cited risk factors do not actually have empirical support. It is further suggested that with regard to the management of risk in juvenile sex offenders, strategies which “make the most of the juvenile’s existing strengths and positive supports” are the most effective (78; p.57).

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<sup>5</sup> In the development work around J-SOAP it is noted that at least part of the tool’s basis is that delinquency and antisocial behaviour among juvenile sex offenders has “stability and continuity.. from childhood into adolescence and adulthood” [79; p.77]. However, there is no sound basis in the literature to support this premise so it is unclear how the developers of J-SOAP have formed this impression.

8.6 In a useful Canadian review [5], risk factors related to juvenile sexual reoffending and their support (or not) in the literature are detailed, and these are reported in Table 2 below. Perhaps most surprising are some of those factors recorded as being unlikely to be related to sexual reoffending. For example, there are a wide range of interventions/treatments with both juvenile and adult sex offenders that deal at least in part with the issue of victim empathy [5; 70] and offence denial [23; 97]; however, it may be the case that these factors are of less significance than has been proposed.

8.7 Another review of the literature [33], along with other studies [55], reported some similar factors as being important when evaluating risk in juvenile sex offenders:

- A history of multiple sexual offences, particularly after treatment/intervention
- A history of repeated non-sexual juvenile offences
- A clear and persistent sexual interest in children
- Failure to comply with treatment
- Family resistance to supervision and compliance

8.8 A relatively large number of studies include self-report data from adult sex offenders, with estimates of between 50% and 80% of offenders in these studies reporting that their deviant sexual behaviour began before the age of 18<sup>6</sup> (Abel & Rouleau, 1990; in 9). These findings are often used to hypothesise that juvenile sexual offenders will continue to sexually offend into adulthood, and are therefore a high-risk population. However, there is little evidence to support that premise and this highlights the danger of relating findings on adults to a juvenile population.

8.9 In one study [25] which tested retrospective findings on a prospective sample, found that for young males who had been sexually abused, the most significant factors in determining whether or not they would go on to abuse others were experiencing and/or witnessing interfamilial violence [see also 83] and experiencing care rejection [see also 55]; these factors were less significant in young males who had been sexually abused but had not sexually abused others, and also boys who had sexually abused others but had not been abused themselves. For the later group, having a mother who had been physically and/or sexually abused both in childhood and in adulthood, was also found to be significantly related to abusive behaviour against others.

8.10 A further study [28] found that, of the juveniles in their sample who had been sexually abused, those whose abusers had been both male and female, had been abused by relatives, where force was used in the abuse, where acts of penetration occurred and where the abuse took place over several years were 23 times more likely to abuse others than those who had not experienced these factors. Although these findings are yet to be replicated, given the high odds reported the factors in this study that appear to be related to the 'abused becoming abusers' are nevertheless worth taking into consideration, and would certainly bear further investigation.

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<sup>6</sup> This reporting does not extend to deviant sexual behaviour in childhood (under 12 years of age) as this is rarely reported by adult sex offenders [83].

**Table 2: Risk Factors for Juvenile Sexual Reoffending**

Supported in the literature	Showing promise in the literature	Possibly related to sexual reoffending	Unlikely to be related to sexual reoffending
Deviant sexual interests <sup>7&amp;8</sup> [also 71]	Problematic parent-child relationship <sup>9</sup>	High-stress family environment	Denial of sexual offence [also 23; 97]
Prior criminal sanctions for sexual assault	Parental rejection [also 25]	Obsessive sexual interests	Lack of victim empathy [also 70; 97]
Past offences against 2 or more victims [also 33]	Attitudes supporting of sexual reoffending	Sexual preoccupation	History of non-sexual crimes
Stranger victim		Impulsivity	Penetrative sexual assaults
Social isolation		Selection of male victim	Own history of child sexual abuse <sup>10</sup>
Incomplete offence-specific intervention		Negative peer associations & influence	
		Environment supporting opportunity to reoffend	
		Sexual assault against a child	
		Use of threats, excessive violence or weapons	
		Indiscriminate choice of victims	
		Interpersonal aggression	
		Antisocial interpersonal orientation	
		Recent escalation in anger or negative affect	

8.11 It has been suggested that social learning theory (Bandura, 1986; in 28) can explain why those who have been sexually abused themselves will display sexual aggression at a much earlier age than those who have not [28, 29; 30]. There is also some evidence to suggest that young people who have been abused

<sup>7</sup> In contrast, it has been hypothesised that deviant sexual fantasies are possibly most productively considered in the more serious sexual offenders [20] and those who target younger victims [86]; it has been proposed that these are directly related to recidivism in this group [56]. It has also been reported that deviant sexual arousal/deviant fantasies are more relevant in the consideration of risk in adult sex offenders than juveniles [33].

<sup>8</sup> At least one study reports [67] that a paraphilic diagnosis is actually related to a decreased risk of recidivism in juvenile sex offenders. Many studies on adult sex offenders report paraphilias as a significant factor in sexual recidivism and, as with other factors related to adult sex offenders, the significance of paraphilias in juvenile sex offender recidivism could be questioned.

<sup>9</sup> This could also be related to attachment issues. For example, in a study by [64] it was found that a sample of sexually abusive young people (aged 7 to 16) had experienced multiple disruptions to attachment in comparison to a similar group of young people who had only non-sexual behaviour problems. There is also some support for the notion that verbal abuse/violence in the family setting is more commonly found in juvenile offenders than non-offenders, particularly verbal aggression from mother to child [87].

<sup>10</sup> A large self-report study (a non-clinical population of American students in Grades 9 and 12; 2164 from 71,594 responding positively to a question regarding forcing someone into a sexual act) found that, after other factors had been controlled for, those who reported perpetrating sexual violence were more likely to have been sexually abused, with this more significant for males than females [27]. Elsewhere it is reported that prior sexual abuse is more commonly found in juvenile sexual offenders than juvenile non-sexual offenders [89].

may repeat the acts they have been abused with on other children [28; 91]. That is, sexually abusing others becomes a 'learned' behaviour like any other (e.g. saying 'please' and 'thank you') when expressed in a normalised fashion within an abusive situation. This implies that the behaviour can be 'unlearned' through various forms of intervention; therefore, the risk will only persist for as long as the behaviour remains unchallenged.

8.12 Across a number of studies, reoffence rates have been found to be higher (8% to 58%) for those who have committed non-sexual offences than those who have committed sexual offences (5% to 14%) [12]. An Australian study [73] followed 292 juvenile sex offenders for a minimum 4-year period (some were followed for over 12 years) in order to examine sexual recidivism in this population. All in the sample had been found guilty of a sexual offence between the ages of 10 and 18, and were first time sexual offenders; however, 55% had previously been found guilty of non-sexual offences. The study found that 25% of the group received further sexual offence convictions as juveniles while only 14 received further sexual offence convictions as adults; of these 14, 5 were juvenile sexual recidivists. Therefore, only 2% of the juvenile sex offenders continued to sexually offend into adulthood. In contrast, 61% had non-sexual convictions in adulthood. It was also recorded that those originally convicted of assaulting peers or adults were significantly more likely than those who had been convicted of child molestation to be convicted of both sexual and non-sexual offences in adulthood [supported by 76]. Overall, the study found that that older the juvenile was at first conviction, having a history of non-sexual offences [supported by 76] and a higher number of charges for the index sexual offence were all related to recidivism.

## CHAPTER NINE CONCLUDING REMARKS

9.1 This review has highlighted that research into the effectiveness of interventions with children and young people who have displayed harmful or offending sexual behaviours is limited. The evidence that does exist suggests that the approach to assessment and intervention should be holistic and multi-systemic in nature, addressing the specific difficulties in the context of meeting the broad range of social and developmental needs presented by most of these children and young people.

9.2 With regard to the prediction of future behaviour, it has been argued that there may never be possible to develop a precise predictive tool [108]. Therefore it is important that sound professional judgment and effective case management systems be an integral part of the response to the monitoring, supervision and care of young people with harmful or offending sexual behaviour. As suggested in the review and elsewhere, assessment should incorporate factors such as an examination of motivating factors and responses to intervention, as well as taking into account issues such as a full history of the child, the wider social context surrounding the child (e.g. relationships and interactions) and the family environment [104].

9.3 As to current policy developments the recently published report from the Youth Justice Improvement Group [109], in relation to the workstream tasked with “Ensuring that high risk offenders’ needs are properly assessed” (p.45), does not make set recommendations as to the approach that should be taken towards young people whose sexual behaviour is of risk to others. However, it does set out a number of key action areas and goals to be achieved within these areas “in order to bring about further real improvements in services” [109, p. 47]. Although not all are strictly relevant to this review, these action areas and goals have been adapted from the report and summarised in Annex I.

9.4 While the YJIG report [109] has been published too recently to be taken into full account for this review, a number of factors are immediately apparent. At ‘Goal 1’, the improvement of identification of high-risk young offenders is mentioned. However, from the work considered for this review it would seem that this task is not yet a simple or straightforward one in terms of those who may be of risk to others in terms of their sexual behaviour, as factors related to risk in this context vary considerably depending on individual characteristics and circumstances.

9.5 ‘Goal 2’ suggests that risk assessments should be approved and appropriate for the client group. However as reported in this review there is, as yet, no fully validated risk assessment tool for those displaying problem or offending sexual behaviour. As mentioned at ‘Goal 6’, the issue of appropriate training for those dealing with this client group has been raised by the review, with this factor being important to successful interactions with these young people.

9.6 Key Action Areas 4 and 5 mention effective transfer of information between the child and adult systems; however, although ‘Goal 3’ and ‘Goal 12’ both mention inter-agency working, no direct mention is made of information transfer between agencies responsible for the young person while still in the youth system. This issue has been highlighted as a difficulty during this review and it would be suggested that both horizontal and vertical information sharing is important.

9.7 As has been found in many studies considered for this review, the YJIG report does not appear to fully take into account the developmental changes that occur as a young person grows older. For example, Key Action Area 6 mentions the early identification of young people who are at most risk of developing behaviours that could cause serious harm to others. Not only is there little evidence to suggest such early identification is possible, it also neglects to take into consideration the many changes young people go through.

9.8 These points are raised not to suggest that the YJIG report has no value, only that it appears to have some limitations which may impact on the success (or not) of achieving the goals set out in relation to young

people who pose a risk to others as a result of their sexual behaviour. Overall, although it is felt this review has gone some way towards consolidating the existing data on young people with harmful or offending sexual behaviour, the field nevertheless requires much further work.

**ANNEX 1 SUMMARY OF THE KEY ACTION AREAS AND ATTENDANT GOALS<sup>11</sup> FROM THE REPORT OF THE YOUTH JUSTICE IMPROVEMENT GROUP, WHICH ARE RELEVANT TO YOUNG PEOPLE WHOSE SEXUAL BEHAVIOUR IS OF RISK TO OTHERS**

<b>Key Action Area 1</b>	<b>Measures to improve the identification, risk assessment, planning for and management of young people who pose a serious risk to others through violent or sexual offences</b>
<i>Goal 1</i>	Better identification of high risk young offenders so that those who need to be involved with these young people are better informed of risks, the evidence of them and how they have been handled in the past
<i>Goal 2</i>	Risk assessments should be approved and appropriate for the client group, building on the shared single assessment and planning processes developing through 'GIRFEC'
<i>Goal 3</i>	Agreement of an inter-agency risk management plan for all young people assessed as high risk, with the efficacy of the plan to be regularly reviewed
<b>Key Action Area 2</b>	<b>Provision of specialist programmes, in both community and residential settings</b>
<i>Goal 4</i>	All specialist services responding to young people whose sexual behaviour is of risk to others should be subject to an approval process by December 2007
<b>Key Action Area 3</b>	<b>Ensure that those working with young sex offenders have sufficient expertise for the task</b>
<i>Goal 6</i>	Each young person of a risk to others as a result of their sexual behaviour to be allocated a designated professional with specialist training
<b>Key Action Area 4</b>	<b>Arrangements are in place to ensure the continued support and oversight of young people as they move into adulthood</b>
<i>Goal 7</i>	No Children's Hearings supervision requirement of a young person assessed as high risk should be terminated except on the grounds that the risks were evidenced to have been reduced to the extent that special supervision was no longer required
<i>Goal 8</i>	The Children's Reporter and the Procurator Fiscal should review the arrangements for 'joint discussion' of high risk young offenders and put in place protocols for information to be shared about their needs and the risks they pose
<i>Goal 9</i>	The assessment and planning processes required for high risk young people under GIRFEC should be consistent with the requirements of Multi-Agency Assessment and Planning (MAPPA) and vice versa. Also, appropriate transition plans should be made for those young people moving into the adult system, including consideration of inclusion as a Non-registered Sex Offender after the age of 18.
<b>Key Action Area 5</b>	<b>Arrangements need to ensure that appropriate information is transferred from the children's to the adult system</b>
<i>Goal 11</i>	Procedures are put in place to ensure that Criminal Justice staff obtain children's service case records of any person being assessed or under supervision/treatment as an adult
<b>Key Action Area 6</b>	<b>Earlier identification of those young people who are at most risk of developing behaviours that could be of serious harm to others</b>
<i>Goal 12</i>	Inter-agency working to collectively and regularly review the circumstances around and plans for high risk young people, to ensure that the children are supported and risks to their own or others safety is managed and reduced where possible
<b>Key Action Area 7</b>	<b>Supporting services through robust quality assurance systems</b>
<i>Goal 13</i>	The action taken by each Police Force and LA in response to the Colyn Evans report should be included in the inspection programmes of SWIA, HMIC and HMIE from June 2006 to June 2009
<i>Goal 14</i>	Agencies should "take into account any guidance from an approval mechanism to be established by the Scottish Executive in their procedures for registration and inspection"

<sup>11</sup> For ease of reference, 'Goal' numbering follows the YJIG report; therefore, the apparent 'omission' of Goals 5 and 10 is as a result of an error in the YJIG report and not a miscalculation of this paper.

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