TRENDS & ISSUES
in crime and criminal justice

Australian Government
Australian Institute of Criminology

No. 315 May 2006

Residential placement of intra-familial adolescent sex offenders

Jan Grant, Jenny Thornton and Christabel Chamarette

In 2003, 1,821 males and 5,669 females aged under 15 years were recorded by police as victims of sexual assault but we know from crime victim surveys that sexual assault is the crime least likely to be reported to the police. We also know from research that adult sex offenders and victims are significantly more likely to have suffered abuse as children. A significant proportion of this abuse occurs within the family by intra-familial offenders. Interventions that will protect the victim but also break the cycle of reoffending will have a significant positive impact on families. However, there is some research that suggests particular interventions may make matters worse. This paper focuses on the issue of removing the intra-familial adolescent sex offender from the family home and describes an alternative model to relocation being used in Western Australia. As the paper reports there has been little rigorous evaluation of all types of interventions to determine what works best and under what circumstances. To reaffirm the authors' conclusion, 'urgent evaluation of the efficacy and effectiveness of both community-based and residential treatment programmes for young offenders should be a priority'.

Toni Makkai
Director

Introduction

Adolescent sexual offending is increasingly recognised as a serious social issue. While research into adolescent sexual offending has expanded rapidly in recent years, there is comparatively little focus on adolescent sibling incest. It is estimated that adolescent boys perpetrate 30–50 percent of child sexual offences, with 40 percent of these offences involving a biological relative. These adolescent offenders are relatively young, with a modal age of 14–15 years (Ryan & Lane 1997), and the developmental vulnerability of this age group makes decisions about their welfare problematic. A particular concern is decision-making about the best place for these young people to live while they are undergoing treatment. This paper reviews research and practice in this troubled area and highlights one alternative to removal from the family home. This review demonstrates the value of interdisciplinary studies in social issues and the need for further study.

Residential relocation: current practices in Australia

The decision to remove a young intra-familial sex offender from the family home is difficult and controversial. The risk to the community and the interests of the victim are of paramount concern and take priority over those of the offender. Treatment for adolescent intra-familial sex offenders is

ISSN 0817-8542

ISBN 1 921185 08 2

GPO Box 2944
Canberra ACT 2601
Australia
Tel: 02 6260 9272
Fax: 02 6260 9293

For a complete list and the full text of the papers in the *Trends & issues in crime and criminal justice* series, visit the AIC website at: http://www.aic.gov.au

frequently made on the proviso that the young person is removed from the home.

For this review, an internet search of all Australian state child welfare departmental policies on child abuse was conducted. In addition, in a national phone survey, key stakeholders of a number of child welfare departments and treatment providers were surveyed. These surveys found that few formal guidelines or policies exist for the placement of intra-familial adolescent sex offenders. Generally, each situation is assessed on a case-by-case basis, with protection of the victim being the main consideration. Most child welfare agencies appear to hold the view that removal of the adolescent from the family home is the preferable alternative. However, placement of adolescent offenders is largely governed by the availability of suitable options and a lack of suitable placement options was a difficulty mentioned by a number of providers.

Risk assessment in adolescent sexual offending

If adolescents are left in the family home or reunited with the family after treatment, conducting a comprehensive psychosocial and risk assessment is an essential element of the therapeutic work (Prentky et al. 2000). Two approaches have characterised risk assessment in adolescent sexual offenders: unstructured clinical predictions and actuarial predictions (Witt, Bosley & Hiscox 2002).

Unstructured clinical predictions rely on the integration of clinical information by professionals. This approach has the advantage of harnessing specific and idiosyncratic information to assess an individual's vulnerability to reoffend (West 2001; Witt, Bosley & Hiscox 2002). However, unstructured clinical predictions of adolescent sexual recidivism have been criticised for their subjectivity, lack of accuracy (Hanson & Bussiere 1998), and the potential for discrepancies between clinicians (Grubin 1999).

Actuarial assessment tools evaluate a series of risk factors according to a structured and objective rating system. They demonstrate a relatively high degree of inter-rater reliability (Tomison 2002) and out-perform the accuracy of clinical predictions of reoffending risk (West 2001). However, actuarial measures based on generalisations about cohort behaviour are of limited value when assessing the risk to a particular child and family (Tomison 2002). There needs to be a multi-method approach, drawing from the use of actuarial tools, clinical information, and assessment of the family situation (Righthand & Welch 2001).

Advantages and disadvantages of residential relocation

Although residential relocation of the adolescent offender appears to be the preferred option in most Australian treatment facilities, there is a paucity of research investigating the impact of residential relocation on adolescent intra-familial sex offenders, their victims and families, relapse rates, and treatment outcomes.

The best interests of the child is the guiding principle normally used when considering the removal of a child from the family (Bankes, Daniels & Quartly 1999). When an adolescent offence occurs, however, there are two children involved: the victim and the adolescent. Once they have offended, the offender loses the status of being a child who needs the protection, guidance, and security of their family. Treatment programs typically last one to two years and this is an extended period of family separation during this formative stage of development. Within Australia, 23 percent of juvenile offenders are only 10–12 years old and 70 percent are 15 years or younger (Griffith University Adolescent Forensic Assessment and Treatment Centre 2005).

The majority of adolescent sex offenders differ from adult offenders in terms of the aetiology of their offending behaviour. They rarely experience deviant urges, fantasies or specific targeting of victims, they have fewer fixed patterns of thought and behaviour, and recidivism rates are lower (Prentky et al. 2000). However, most of the treatment models for adolescent sex offenders are based on established adult programs. Punitive systems are implemented and these are similar to those used with adults (Chaffin & Bonner 1998). As Goldson (2000: 256) comments, 'children in trouble have been increasingly regarded and thus treated as offenders first and children second'.

One of the obvious advantages of removing the adolescent is the minimisation of the risk of future reoffending. Not only does this action protect the victim(s) from further abuse, it also serves to provide some degree of protection to the adolescent offender. Expressions of blame, anger, shame, and disgust directed at the offender can have profound negative psychological effects. Removing the offender from this environment provides not only the offender, but also the rest of the family with breathing space to deal with the offence. Given the contribution of dysfunctional family systems to offending behaviour (Letourneau, Schoenwald & Sheldow 2004), relocation may also provide a break from the environment where the sexually inappropriate behaviour originated.

There is currently no available research examining the effect on the victim of removing the perpetrator from the family home. Removing the offender may validate the victim's experience and recovery may be more likely if the victim

feels fully supported. Conversely, placing the offending adolescent in alternative accommodation may have a negative impact on the child victim. Full disclosure of the extent of the abuse may be inhibited by the victim's knowledge that their claims will result in the removal of their sibling and breakdown of the family unit.

When the adolescent offender is removed from the home, there may be a number of negative consequences. Primarily, the removal may result in significant disruptions to familial and peer attachments at a time when family support is most needed (Bullock 2000; Cashmore 2000).

Adolescence is a particularly critical stage of development (Witt , Bosley and Hiscox 2002). In particular, the influence of parents, family, and peers is crucial in the decisions that adolescents make. Parents can still be highly influential in assisting a child back to a more normative developmental pathway (Duane & Morrison 2004). Extended periods in care can erode the adolescent's place in the family home, making it difficult to return and undermining the positive influence that parents can have. Thorpe (1988: 140) found that 'children who remain in care beyond 6 weeks are three times more likely to stay in care than to leave care within 52 weeks'. Attachment bonds, which are already insecure, are likely to become more fractured.

Ryan (1999) indicates that 40 to 90 percent of offenders' parents have themselves experienced physical, sexual, or severe emotional abuse or neglect. There is also considerable evidence that sexually offending adolescents come from families where instability, disorganisation, and violence are prevalent (Bagley & Shewchuk-Dann 1991; Morenz & Becker 1995). While removing the offender has the advantage of taking them from that environment, it fails to address the underlying family dynamics that have led to an environment where the abuse occurred. Families are less likely to be involved in treatment when their adolescent is in residential care (Bullock 2000).

A further problem with relocation is the apparent lack of suitable and stable placement facilities specifically for adolescent sexual offenders. Research suggests that unless appropriately placed, adolescent offenders present a high risk of abusing other children in care (Green & Masson 2002).

The option of placement of the adolescent offender with relatives is more likely to be used in Australia than other places; this has the possibility of providing stability and some connection to family members (Cashmore 2000). Such placements are also problematic because the alternative carers are less likely to receive adequate support from government agencies. Parents are often conflicted about the situation and their desire to protect both the victim and the offender. Placing the offender with another family member and splitting the nuclear family also creates additional financial and emotional pressures. In general, there is little published research into the efficacy of kinship placements.

There is concern that the basic physical, psychological, developmental, and emotional needs of the placed adolescent are not met while in alternative care at a critical period in their life (Bullock 2000; Mears & Travis 2004). The situation is often exacerbated by poorly funded facilities and inadequate levels of support for carers of adolescent sex offenders (Farmer & Pollock 2003). Further, separating the adolescent from their family may reinforce the adolescent's perception that they are being ostracised for their inappropriate sexual behaviour, fuel a sense of rejection, and increase denial.

Implications for treatment

The removal of the adolescent from the home also has implications for the treatment provided. Parents may be less likely to seek assistance if they are aware that disclosing the abuse will result in residential relocation and possible involvement in the justice system. Moreover, the family may receive fewer support services if either child (victim or perpetrator) is removed from the home.

The US National Task Force on Juvenile Sexual Offending (1993) recommended that treatment be provided in the least restrictive environment possible, while accounting for community safety. Furthermore, an American review highlighted several problems associated with the detention of young offenders, specifically that there is often inadequate access to appropriate treatment programs and preparation for re-entry to society (Mears & Travis 2004). Several writers have argued that institutionalised residential accommodation is unsuitable for adolescent sexual offenders and is associated with a high incidence of further sexual offending and victimisation (Farmer & Pollock 1999; Green & Masson 2002). Other problems associated with institutionalised accommodation include a lack of careful placement planning, inadequate training and supervision for carers, a general failure to meet the therapeutic needs of these children, and no continuity of contact between the adolescent and family (Green & Masson 2002; Poertner, Bussey & Fluke 1999). Placement of adolescents in residential care is costly, often resulting in a decrease in available funds for treatment programs.

The cycle of offending is often triggered by distress or other negative psychological arousal and is likely to be exacerbated by such a significant change

in the circumstances of the young offender (Hunter & Figueredo 1999; Mears & Travis 2004). For some, detention enhances their reputation as 'bad boys' and reinforces patterns of offending behaviours, particularly where it places treatable adolescents in an environment where they may be influenced by more delinquent individuals (Hunter et al. 2003). This is particularly pertinent for adolescent sex offenders, as research suggests that once an adolescent's offending has been officially identified, the rate of detected sex offending recidivism is relatively low, ranging from seven to 12 percent (Rasmussen 1999). They are at greater risk of becoming general offenders (Caldwell 2002; Hunter et al. 2003).

An alternative model to relocation

In Western Australia, the main treatment facility for intra-familial adolescent sex offenders is a community agency, SafeCare. It is a nongovernment agency, partially funded by a grant from the WA Department for Community Development. SafeCare offers an alternative to automatic residential relocation of the adolescent offender. The SafeCare Young People's Program (SYPP) integrates theory, research, and treatment based on the models of Giarretto (1982), Worling (1995) and Worling and Curwen (2000). It is a comprehensive service, offering treatment to the adolescent offender, child victim, parents, and other affected family members. SafeCare separates case management of the offender and victim(s). Treatment may include a group program and individual therapy for the offender, couples counselling, parent-child sessions, and individual therapy for child victims.

Although the focus of SYPP is child protection, an adolescent responsible for abuse is not automatically removed from the family home. The whole family meets with a clinician during a six-week assessment phase. A risk analysis of the home situation and the adolescent is undertaken. The SafeCare approach is most closely aligned with family risk assessment models that emphasise the dynamic interaction between danger, strengths, and safety (Brearley 1982; Turnell & Edwards 1999, 1997). This means that the adolescent's risk of reoffending is judged in the context of the strengths of the family in relation to future provision of safety for the victim. The following factors are used to determine the risk of reoffending:

- age of the victim
- level of intimidation and fear felt by the victim
- age of other potential victims in the family
- whether the abuse occurred in the past or the present
- age of the offender, including the mental age and developmental age (e.g. whether the offender is developmentally delayed or has a co-existing disorder such as Aspergers)
- treatability of the offender including motivation to change
- severity and frequency of sexual contact (e.g. whether offence is contact, non-contact, or penetrative contact; whether manipulation or force were used; whether contact is an ongoing pattern or a single incident)
- capacity for parental supervision of children
- situational factors such as where, when, and how the abuse occurred
- parental capacity for learning new parenting behaviours and changing family patterns to provide safety.

In addition, the adolescent is individually assessed, using a clinical interview and a series of psychometric measures to assess cognitive distortions, sexual knowledge, personality, psychopathology, and family relationships.

If the clinical team and the parents decide that the adolescent can remain at home during treatment, protective measures to ensure the safety of any children from risk of abuse are instituted. These include:

- negotiation of contracts for the parent/s and for the young person responsible for the abuse
- restrictions on unsupervised access to young children
- changes to family routines to promote physical safety
- training of parents in boundary setting, vigilance, and supervision of children.

Part of the task is to assist parents to be fully responsive to the needs of the victim. The child victim is taught that reporting such behaviour is a positive action and that parents and therapists want to know if any future inappropriate sexual behaviour occurs. Parents are taught to minimise opportunities for inappropriate sexual behaviour by providing other more rewarding activities (e.g. sporting and club activities). Knowing exactly where, when, and how the abuse occurred allows new family rules to be set, for example not allowing the adolescent to:

- be in the bathroom at the same time as younger children
- babysit younger siblings
- be in a bedroom alone with younger siblings.

One of the primary advantages of a comprehensive treatment program for the whole family is that the agency is in contact with both parents and the child victim and this makes it highly likely that any subsequent offending would be reported to therapists.

Although uncommon, it may be necessary to remove the young person responsible for the abuse from the family home. Any known breach of the contract by either the adolescent or parents, which places a child at risk, may be reported to the Department of Community Development. Any acts of child sexual abuse during treatment are immediately reported. An analysis of available records for adolescents treated at SafeCare from 2000 to 2005 (n=72) indicates that 65 percent remained at home, 21 percent were placed with a family member, eight percent with a non-family acquaintance, and six percent in foster or residential care. Of those who were removed from the family home, 15 percent were relocated by state agencies, generally prior to treatment. Some families had already voluntarily relocated their adolescent to another family member before seeking treatment.

This model addresses many of the problems in adolescent sex offender treatment. It is congruent with risk assessment models that assess the strengths of the family as well as the dangers or risks, used in the Victorian Department for Human Services and the Western Australian Family and Children's Services (Turnell & Edwards 1997). It utilises a comprehensive six-week assessment period aimed at minimising recidivism by targeting general and idiosyncratic risk, strength, and safety factors for the individual and their family. This allows the most appropriate choice to be made for each offender, incorporating the context of both offending behaviour and family.

Conclusions and recommendations

This review has tackled the hard question of residential relocation for adolescent intra-familial sex offenders, overviewed current practice, and described an alternative model. It posits that there are at least two children involved in intra-familial sex abuse and that while protection of the victim must be the first priority, the offender's developmental needs must also be taken into account. Given that the majority of offenders are younger than 15, that attachment bonds in many of these families are already strained, and that treatment takes 12–24 months, it challenges the assumption that relocation of the adolescent is automatically the best alternative. It is hoped that this will open the way for further debate and much needed policy formulation in this difficult area.

It is suggested that the assessment of adolescent offenders remains ill-informed and unsupported by clinical data. With specifically targeted risk assessment tools having only recently been introduced, there is an urgent need for an empirically based, unified approach to risk assessment and decision making processes. This includes the development of an assessment protocol that examines the needs of the entire family unit, including victim and offender, and matches treatment consistently with this.

Current relocation practices in Australia have little research to guide good practice. As there are potentially devastating effects on all affected parties from inappropriate relocation, the lack of placement protocols is a major concern. Although placement in residential facilities is seen as being advantageous, very few such placements are available in Australia.

Urgent evaluation of the efficacy and effectiveness of both community-based and residential treatment programs for young offenders should be a priority, with the goal being provision of placement options that suit the therapeutic and developmental needs of the offender and the victim. Regardless of the option chosen, it is vital that continued support of the family unit be provided, to ensure that familial bonds are not further eroded.

Acknowledgments

We want to acknowledge the contributions of Gillian Stevens, Christian Gill, Andrea Halse, Amanda Thompson, and the SafeCare Young People's Program staff. We also acknowledge the Criminology Research Council for its funding of the project *Risk assessment and treatment outcomes in adolescent intra-familial sex offenders*. Further reports from the research are in preparation.

References

Bagley C & Shewchuk-Dann D 1991. Characteristics of 60 children and adolescents who have a history of sexual assault against others: evidence from a controlled study. *Journal of child and youth care* 6: 43–52

Bankes N, Daniels K & Quartly C 1999. Placement provision and placement decisions: resources and processes. In Erooga M & Massia H (eds) *Children and young people who sexually abuse others*. London: Routledge

Brearley P 1982. *Risk and social work*. London: Routledge

Bullock R 2000. Juvenile offending: treatment in residential settings. In Hollin CR (ed) *Handbook of offender assessment and treatment*. Chichester: John Wiley & Sons

Caldwell MF 2002. What we do not know about juvenile sexual reoffence risk. *Child maltreatment* 7: 291–302

Cashmore J 2000. What the research tells us: permanency, planning, adoption and foster care. *Children Australia* 25: 17–22

Chaffin M & Bonner B 1998. 'Don't shoot, we're your children': have we gone too far in our response to adolescent sexual abusers and children with sexual behaviour problems? *Child maltreatment* 3: 314–316

Duane Y & Morrison T 2004. Families of young people who sexually abuse. In O'Reilly G et al. (eds) *The handbook of clinical intervention with young people who sexually abuse*. New York: Brunner-Routledge: 103–128

Farmer E & Pollock S 2003. Managing sexually abused and/or abusing children in substitute care. *Child and family social work* 8: 101–112

Farmer E & Pollock S 1999. Mix and match: planning to keep looked after children safe. *Child abuse review* 8: 377–391

Giarretto H 1982. A comprehensive child sexual abuse treatment program. *Child abuse and neglect* 6: 263–278

Goldson B 2000. 'Children in need' or young offenders: hardening ideology, organisational change, and new challenges for social workers with children in trouble. *Child and family social work* 5: 255–266.

Green L & Masson H 2002. Adolescents who sexually abuse and residential accommodation: issues of risk and vulnerability. *British journal of social work* 32: 149–168

Griffith University Adolescent Forensic Assessment and Treatment Centre 2005. *Adolescent roundtable summary statistics*. Brisbane: Griffith University Adolescent Forensic Assessment and Treatment Centre

Grubin D 1999. Actuarial and clinical assessment of risk in sex offenders. *Journal of interpersonal violence* 14: 331–343

Hanson RK & Bussiere MT 1998. Predicting relapse: a meta-analysis of sexual offender recidivism studies. *Journal of consulting and clinical psychology* 66: 348–362

Hunter JA et al. 2003. Juvenile sex offenders: toward the development of a typology. *Sexual abuse: a journal of research and treatment* 15: 27–48

Hunter JA & Figueredo AJ 1999. Factors associated with treatment compliance in a population of juvenile sexual offenders. *Sexual abuse: a journal of research and treatment* 11: 49–67

Letourneau EJ, Schoenwald SK & Sheldow AJ 2004. Children and adolescents with sexual behaviour problems. *Child maltreatment* 9: 49–61

Mears P & Travis J 2004. Youth development and reentry. *Youth violence and juvenile justice* 2: 3–20

Morenz B & Becker JV 1995. The treatment of youthful sexual offenders. *Applied and preventive psychology* 4: 247–256

Poertner J, Bussey M & Fluke J 1999. How safe are out-of-home placements? *Children and youth services review* 21: 549–563

Prentky R et al. 2000. An actuarial procedure for assessing risk with juvenile offenders. *Sexual abuse: a journal of research and treatment* 12: 71–93

Rasmussen LA 1999. Factors related to recidivism among juvenile sexual offenders. *Sexual abuse: a journal of research and treatment* 11: 69–85

Righthand S & Welch C 2001. *Juveniles who have sexually offended: a review of the professional literature*. Washington DC: Office of Juvenile Justice and Delinquency Prevention

Ryan G 1999. Treatment of abusive youth: the evolving consensus. *Journal of interpersonal violence* 14: 422–436

Ryan G & Lane S 1997. *Juvenile sexual offending: causes, consequences, and correction*, 2nd ed. San Francisco: Jossey-Bass

Thorpe D 1988. Career patterns in childcare: implications for service. *British journal of social work* 18: 137–153

Tomison AM 2002. Child protection and child abuse prevention 'down under': key trends in policy and practice. Paper presented at the International perspectives on child protection, Glasgow Scotland

Turnell A & Edwards S 1999. *Signs of safety: a safety and solution oriented approach to child protection casework*. New York: Norton

Turnell A & Edwards S 1997. Aspiring to partnership: the signs of safety approach to child protection. *Child abuse review* 6: 179–190

US National Task Force on Juvenile Sexual Offending 1993. Revised report. *Juvenile and family court journal* 44(4): whole issue

West AG 2001. Current approaches to sex-offender risk assessment: a critical review. *British journal of forensic practice* 3: 31–41

Witt PH, Bosley JT & Hiscox SP 2002. Evaluation of juvenile sex offenders. *Journal of psychiatry and law* 30: 569–592

Worling JR 1995. Adolescent sibling-incest offenders: differences in family and individual functioning when compared to adolescent nonsibling sex offenders. *Child abuse and neglect* 19: 633–643

Worling JR & Curwen T 2000. Adolescent sexual offender recidivism: success of specialized treatment and implications for risk predictors. *Child abuse and neglect* 24: 965–982

Dr Jan Grant is Associate Professor in Counselling Psychology and Dr Jenny Thornton is Senior Lecturer in Counselling Psychology at Curtin University of Technology. Christabel Chamarette is Director of SafeCare.

General editor, *Trends & issues in crime and criminal justice* series: Dr Toni Makkai, Director, Australian Institute of Criminology, GPO Box 2944 Canberra ACT 2601
Note: *Trends & issues in crime and criminal justice* papers are peer reviewed

The AIC is a statutory body with a Board of Management comprising Australian, state and territory government representatives, administered under the *Criminology Research Act 1971*