Developing Work with Sexual Offenders,
Preventing Sexual Abuse

A Series of Position Papers Submitted by:

NOTA Ireland

A National Intervention Proposal for the Treatment of Individuals of who have Sexually Abused

Submitted to:
Minister Brian Lenihan, TD
Minister of State at Department of Health and Children

October 2005

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Rhonda K. Turner
Chairperson, NOTA Ireland

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The Necessity to Treat Sexual Offenders: An Overview

Child sexual abuse is one of the most pervasive social problems faced by this society. Its impact is profound because of the sheer frequency with which it occurs and because of the immeasurable trauma brought to the lives of children and adults who have experienced this crime. Societal attitudes have shifted over time from "this problem doesn't exist" to "it's a family problem"; when in truth sexual abuse/assault affects us all. Research shows that one in four adults were victim of a sexual offence at some time in their life; therefore, it is highly likely that every person knows someone who has been a victim of sexual assault. Research indicates that early victimization places individuals at risk of subsequent psychological problems; resulting in significant costs not only to the individual and their family, but also to the National Exchequer.

Recent years have seen the development of abuse prevention programmes, such as the Stay Safe model; which encourage children to tell if someone has done something to them or if they have felt uncomfortable. Whilst such developments are useful, and have been proven to facilitate children's disclosures; they do not necessarily prevent initial abuse from happening. Current prevention models place the responsibility on the child to tell about something that has already happened to them; as opposed to creating systems that place responsibility on the offender to come forward, tell the truth, and change their behaviour.

In order to stop cycles of sexual abuse, we must place this issue on a Public Health footing; similar to how Mother's Against Drunk Drivers changed societal attitudes about drink driving. Public Health Programmes have been developed in the UK & the US which encourage individuals who have "thought of harming a child" to reach out for help. These programmes have yielded positive results in their localities, and are worthy of pursuing in the Irish Context. NOTA supports one such programme, STOP it Now UK & Ireland (Northern), which is in the very early stages of development here. The development of STOP it Now Republic of Ireland would be a positive step towards increasing public awareness and empowering people to act responsibly to protect children.

The most important way though for offenders to take responsibility for their actions is to participate in effective Treatment Programmes; whether in the Community, Prisons, or post-release. As such, treatment options/mandates should exist at these 3 levels, with systems in place to facilitate access to proposed local treatment services. The attached papers will address both the enormous cost benefit to the National Exchequer by providing Specialist Treatment and the efficacy of current therapies.

Lastly, NOTA is mindful of our need to enhance the current Sex Offender Registration System, under the Sex Offender Act 2001. Implementation of the Act has proved helpful to statutory organizations; however in our opinion it does not go far enough compared to related structures in Northern Ireland. Their legislation requires Registered Sex Offenders to register in person, as opposed to in writing. Additionally, all such individuals participate in a Risk Assessment post-release from Prison through MASRAM (Multi-Agency Risk Assessment Meetings), with the expectation that the individual will cooperate with its treatment recommendations. Such structures enhance the safety of our children and communities by increasing the number of sex offenders who participate in treatment; and it clearly places the responsibility to participate in treatment on the offender. To move forward with such a model however, we must have established treatment services.

The following papers will speak to the vast amounts of harm which can be inflicted by those who have sexually abused and the need for treatment services to be provided to young people and adults, the cost benefits of providing such services, treatment efficacy, and propose various models appropriate to the age groupings of the offender: Children, Adolescents, and Adults. In order to protect others from further sexual abuse, it is imperative that treatment services be developed nationally, on a Regional basis, within communities; and within prison services for individuals who have sexually abused.

Developing Work with Sexual Offenders,
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Position Paper

Children and Adolescents with Sexually Harmful Behaviours

Submitted to:
Minister Brian Lenihan, TD
Minister of State at Department of Health and Children

October 2005

Submitted by:

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Developing Work with Sexual Offenders,
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Children and Adolescents with Sexually Harmful Behaviours

Executive Summary

- Adolescent sexual violence is a serious problem for society. In Canada in 2002 the rate of adolescent males charged with sexual assault was double that of adult males (Statistics Canada, 2003). In the United States juveniles represented 16% of arrestees for forcible rape and 17% of arrestees for other sex offences in 1995 (US Department of Justice, 1997). In England and Wales, adolescents also commit a disproportionately higher number of sexual offences than do adults (UK Home Office, 1999).

- In the United States, they have researched the tangible costs attached to sexual abuse and other crimes (Miller, Cohen, Wiersema, 1996). Their research, conducted by the US Department of Justice found that crimes connected to Sexual Abuse/Rape costs the Government $125,000 per victim, at an annual loss of $165 Million US Dollars (in 1993 monies). Australia has researched the costs of reoffences, and found it to be $157,290 per reoffence for tangible costs incurred (Donato & Shanahan, 1999). Canada has shown that they would save $2.3 Million per 100 treated sexual offenders; only costing their government $700,000 per 100 treated. Clearly, the benefits of treatment and its link to prevention and savings are clear. Sex offender treatment is cost effective. Research in other countries has shown that a 1% reduction in recidivism pays for the treatment of all treated sex offenders by reducing costs related to investigation, trials, incarceration, victims, and supervision. Any further reduction in recidivism results in cost savings to the state

- Another valuable source of information are our victim services, as through them we can track the age of their alleged perpetrators. St. Louise's Unit, which is a Child Sexual Abuse Assessment and Treatment Service for South Dublin, County Kildare, and County Wicklow, reported that 1/3 of their referrals over the last number of years named a young person under the age of 18 as the perpetrators of their sexual abuse. On average, eighty-five percent of those accusations were confirmed. In 2004, sixty two children named someone under the age of 18, forty-one of which were against an adolescent; however only 12 of those adolescents were referred to that area's group therapy service for adolescents who have admitted to having sexually abused. That group therapy service is the Southside Inter-Agency Treatment Team (SIATT).

- SIATT has analysed the offences of those young people referred to their service. Their results indicated that of 92 young people referred from 1997 to 2004, committed nearly 6,000 sexual offences

- Attempts have been made to gauge how many children there are with sexualised behaviour problems which warrant intervention. This has not been achieved; however, O'Reillly & McMahon (in press) found an equal distribution of children known to services across the following age bands; under 10's, 10 – 13, and 14 – 17. This implies that services are just as needed for children as they are for adolescents.

- Worling & Curwen's research in 2000 provides a firm foundation regarding the efficacy of treatment for young people who have sexually abused and the reduction of recidivism. They compared the recidivism rates of treated sexual, violent non-sexual, and non-violent offenders to those who had refused or dropped out of treatment. They found the following:

Category	***Treated Recidivism Rates***	***Control Group***
Sexual	*5.17%*	*17.8%*
Violent Non Sexual	*18.9%*	*32.2%*
Non Violent	*20.7%*	*50%*

- In light of the above facts, we recommend that a range of Specialist Treatment Services be developed nationally, on a regional basis, to provide services for children and adolescents, males and females, including those with learning difficulties who have exhibited sexually harmful/abusive behaviours. The services should encompass triage response, assessment of deniers and admitters, individual therapy, group therapy, parental therapy, family therapy, and aftercare. The services should be led by a Regional Services Clinical Director who would oversee the service and a full clinical team of appropriately qualified professionals. The services would require dedicated funding and resources and should be linked to recommended Specialist Residential Treatment Programmes

Developing Work with Sexual Offenders,
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Children and Adolescents with Sexually Harmful Behaviours

PURPOSE:

The purpose of this paper is to provide a briefing of services currently available in Ireland, to enhance the reader's awareness of this population and their needs, to propose a service model for treatment, to demonstrate the cost effectiveness of providing such therapy, and to highlight the special needs of those young people who have sexually abused.

INTRODUCTION:

Adolescent sexual violence is a serious problem for society. In Canada in 2002 the rate of adolescent males charged with sexual assault was double that of adult males (Statistics Canada, 2003). In the United States juveniles represented 16% of arrestees for forcible rape and 17% of arrestees for other sex offences in 1995 (US Department of Justice, 1997). In England and Wales, adolescents also commit a disproportionately higher number of sexual offences than do adults (UK Home Office, 1999). Victimization surveys indicate that approximately 90% of sex offences are not reported to police (Juristat, 1999; SAVI Report) suggesting that official rates provide only a small indication of the extent that sexual victimisation impacts individuals, families, and society at large. (text from Gretton, Catchpole, McBride, Hare, O'Shaughnessy, & Regan, *Children and young people who sexually abuse: New Theory, research, and practice developments, 2005*).

Statistics show that approximately one third of all sexual abuse is perpetrated by someone under the age of eighteen (O'Reilly & Carr, 1999); as such providing a more comprehensive service to young people with sexually problematic behaviours would play a significant role in the reduction of further victims, thus protecting children and vulnerable individuals. It is well documented that 50% of adults who

have sexually abused, began abusing during their adolescence (Hunter, 1997; Abel, Mittleman, & Becker, 1985; Briggs & Hawkins, 1996; Elliott, Browne, & Kilcoyne, 1995; Groth, Longo, & McFadin, 1982; Knight & Prentky, 1993). Research now indicates that 25% of adolescents who have sexually abused began exhibiting sexual inappropriate/abusive behaviours during childhood (Beckett & Brown, in press). This highlights the need for service development to also include the needs of children with sexual behaviour problems.

Professionals working with such young people are aware of the differences between young people who have exhibited sexually harmful/abusive behaviour and adults who have sexually abused. We are mindful that the former are still children whose development is ongoing and unfinished, creating a window of opportunity for effective intervention. Sexual development is a process that begins in infancy and continues on into adulthood. Many young people will go through various phases wherein they are curious about other children's bodies; for some children this curiosity extends and becomes problematic. Young children may persistently make advances of a sexual nature to other children. Occasionally their sexual behaviours may be considered abusive.

When a child discloses that they have been sexually abused, their world is changed forever. Their parents may find it hard to parent or be emotionally available to their child due to their own levels of distress. Some couples have separated as they became less able to communicate and drift apart, and some parents have needed the support of adult mental health services, including psychiatric hospitalisations. The victims may find that they can no longer see favourite relatives, due to family fall out. They may no longer be able to play outside in freedom, due to fears of the accused. The child may not progress as well in school, lose out on friends, be treated differently by their peers; and of course may have nightmares, or an array of other post traumatic symptoms.

Many times the victim lives in close proximity to the accused young person, and this further compounds their recovery. Sometimes the accused young person continues to behave inappropriately in their community by staring at their victim, passing their house unnecessarily, intimidating them and/or bullying others. Thankfully, treatment services for victims, both children and adults, are more readily available throughout the country. This Paper acknowledges the extensive needs of victims of sexual abuse; however the purpose of this paper is to address the necessity of providing effective treatment for young people who have sexually abused on a national level and the extent of this problem. Only by assessing and treating young people with abusive or problematic sexual behaviour can we protect others from future sexual victimization.

The world of a young person who has sexually abused and their family is also turned upside down when an accusation is made. Often times a young person who has been accused of sexually abusing develops depressive symptomatology and may present with suicidal ideation. Their families are thrown into turmoil and chaos as they cope with the reality of their sons/daughters actions. Without intervention, family systems and the young person's position within the family may deteriorate to such an extent that their risk in engaging in other sexual behaviours or other antisocial criminal behaviour increases.

With intervention, there is hope that the young person can be returned to a more normal developmental path, rebuild the supports that they need from their parents with regards to treatment and future supervision, with the hope that they can be reintegrated as a productive member of our society. The sooner such interventions can be made available, the more likelihood that an appropriate and effective intervention can be matched to the young person and family needs. For example, research has indicated (Beckett and Brown, In press) that the cognitive distortions of a sexual offender appear more stable and less likely to change from the age of sixteen. We know from research on adults who have sexually abused that cognitive distortions that are pro abuse are more resistant to change. We also know that at around age sixteen, adolescents who sexually abuse and who fall into a high concern category for future sexual offences have very similar cognitive distortions pattern to their adult counterparts. This does not mean that change is impossible, but supports the needs for early intervention whilst young people are still developing.

When an adolescent is confronted with an allegation, often their initial reaction is to deny any involvement. They fear removal from their home, incarceration, social stigmatisation, loss of friends and family, loss of a "normal" life, fear of harassment and media involvement. Similarly parents who are advised that there is an allegation against their son/daughter wish to protect the family unit. Typically they wish to protect their child's future as well as their own reputation. They fear at some level that they have failed their child as a parent, are concerned with family fallout, how their child will be labelled, social stigmatisation, involvement with the criminal system, and their own personal histories of previous sexual abuse may be triggered (if present). All of these variables interact with each other and affect the young person's ability to acknowledge having sexually abused. Clinical opinion indicates that the longer an adolescent maintains his denial the more difficult it is for him to come forward. It is with this in mind that a triage (crisis response) aspect to service development should be considered. This will be further elaborated on within this paper.

Lastly, in order to enhance the reader of this papers' understanding of what it is like for a young person who has sexually abused and their family, an appendix has been attached which provides a case example, with consent of the young person and family involved (Please refer to Appendix D).

COST EFFECTIVENESS:

Research over the last 10 to 15 years has clearly established that Programmes that reduce recidivism can generate substantial cost-savings in the long run. Cost savings have typically included reduced criminal justice costs, reduced monetary victim expenses such as loss of wages (parents & older victims), medical expenses, mental health expenses, property loss (moving); and more recently inclusion of intangible victim losses such as reduced pain and suffering and reduced loss of life (suicide) (Brown, 2000). It has also been estimated in other countries that one chronic juvenile offender (general criminal) could incur between 1.3 and 1.5 million dollars in criminal justice expenses (20%), intangible victim costs (50%), tangible victim costs (25%), and foregone offender productivity (5%). This implies that relatively small treatment effects can generate substantial cost savings. For example, a program that costs $500,000 to treat 100 chronic juvenile offenders

would still be deemed cost effective with a success rate as low as 1%; however, in reality, success rates are substantially higher, particularly for juvenile treatment programs.

In the United States, they have researched the tangible costs attached to sexual abuse and other crimes (Miller, Cohen, Wiersema, 1996). Their research, conducted by the US Department of Justice found that crimes connected to Sexual Abuse/Rape costs the Government $125,000 per victim, at an annual loss of $165 Million US Dollars (in 1993 monies). Australia has researched the costs of reoffences, and found it to be $157,290 per reoffence for tangible costs incurred (Donato & Shanahan, 1999). Canada has shown that they would save $2.3 Million per 100 treated sexual offenders; only costing their government $700,000 per 100 treated. Clearly, the benefits of treatment and its link to prevention and savings are clear. Sex offender treatment is cost effective. Research in other countries has shown that a 1% reduction in recidivism pays for the treatment of all treated sex offenders by reducing costs related to investigation, trials, incarceration, victims, and supervision. Any further reduction in recidivism results in cost savings to the state.

The development of a child who has been sexually abused can be significantly disrupted resulting in a range of needs including but not limited to: special education, mental health (child and adult), health services (psychosomatic complaints, physical injury, sexually transmitted diseases, psychiatric hospitalisation, etc), substance abuse, teen pregnancy, Social Welfare dependency, long term unemployment, domestic violence, homelessness, juvenile delinquency, adult criminality, and early death. These needs can exist for brief periods of time or over the course of their life, dependent on a variety of factors (e.g. disclosure, protection, services, family support, etc.).

To consider how a life might have been different had they not suffered sexual abuse is inestimable, and thus intangible. However the tangible costs attached to the provision of services for those needs is something that can be costed for. The position of this paper, and supported by the research, is that by treating sexual offenders we are reducing the costs over time that are required for the long term treatment of victims of sexual abuse, and protecting others. (Please refer to appendices A and B pertaining to measurable and intangible costs of child sexual abuse).

Another cost consideration is the current expenditure for accessing Specialist Residential Treatment Care for young people who must be sent to the UK for treatment, as appropriate facilities are not available within Ireland (See Appendix C). The annual costs can be as high as €330,000 per young person. It is thought that there are currently 5 young people receiving specialist treatment for having sexually abused in the UK; this however is only an estimate. Not all young people who have sexually abused require that level of intervention; however when it is required, it is only right and just that the young people have the opportunity to be treated in their own country, where they can have easier access to their families. Familial involvement in treatment is positively correlated with treatment outcome. If Specialist Residential Treatment Programmes were available in Ireland, it would benefit the HSE financially and those funds could then be redeployed more effectively. The need to develop Specialised Residential Treatment Services in Ireland will be further highlighted in a separate paper.

CURRENT IRISH SERVICES:

Currently, HSE Community Care Social Work teams do not have consistent systems in place to track the number of young people accused of having sexually abused. The Garda National Juvenile Office has reported that in 2002, 140 young people were charged with sexually related offences; and 103 were reported in 2003. One must consider though that not all young people who have committed a sexual offence will become involved with the Criminal Justice System. Many times the young person's victim is a relative, and as such the families do not want to make statements to the Gardai about the concerns.

As national numbers are not available from the HSE, this author has attempted to gather other statistics that might indicate the numbers of young people where there have been concerns about their sexual behaviour. The former Eastern Regional Health Authority had attempted to track the extent of the problem in its area as part of the actions of a Working Party on Young People with Sexual Behaviour Problems. In 2004 Gary O'Reilly & Eimer McMahon, UCD conducted research for the Working Party (in press) and found that 72.4% of professionals surveyed felt that work with this population was expanding. The participating agencies estimated that they had contact with 96 such young people during the preceding year. It is also worthy to note that during that same preceding year, 103 juveniles were made known to the Garda Juvenile Office Nationally, and at minimum 96 were known within the ERHA. Overall, O'Reilly's research strongly supported the need for further service development in this area. It should also be noted that the aforementioned Working Party has not been reconvened since November 2004 and its work remains unfinished.

Another valuable source of information are our victim services, as through them we can track the age of their alleged perpetrators. St. Louise's Unit, which is a Child Sexual Abuse Assessment and Treatment Service for South Dublin, County Kildare, and County Wicklow, reported that 1/3 of their referrals over the last number of years named a young person under the age of 18 as the perpetrators of their sexual abuse. On average, eighty-five percent of those accusations were confirmed. In 2004, sixty two children named someone under the age of 18, forty-one of which were against an adolescent; however only 12 of those adolescents were referred to that area's group therapy service for adolescents who have admitted to having sexually abused. That group therapy service is the Southside Inter-Agency Treatment Team (SIATT).

SIATT has analysed the offences of those young people referred to their service. Their results indicated that of 92 young people referred from 1997 to 2004,

- they had sexually abused approximately 192 children or adults,
- Committed nearly 6,000 sexual offences
- which included all forms of sexually abusive behaviours (voyeurism, exhibitionism, obscene telephone calls, stalking, harassment, fondling, masturbation, penetrative sex, oral sex, and rape),
- that their offences included a range of force from grooming/bribery to use of violence and weapons,
- and their known victims ranged in age from 1 to 86.

Similarly the Northside Inter-Agency Project (NIAP) worked with 165 young people and their families between 1997 and 2004. These young people, between the ages of 13 to 18years, had sexually abused 270 victims who ranged in age between three and fifty five years. Their offences included all forms of sexually abusive behaviours.

St. Louise's Unit also sees some young people who have committed sexual offences; however those clearly deemed too concerning or unsuitable for group therapy in a community facility are not referred on to SIATT; as such they are not represented in SIATT's statistics. An offence analysis has not yet been done by St. Louise's Unit on the adolescents accused of having sexually abused and seen by their service; however one such young person, whose case is highlighted in Appendix E, has at least 5 victims and committed over 4,000 sexual offences over a 2-3 year period.

Attempts have been made to gauge how many children there are with sexualised behaviour problems which warrant intervention. This has not been achieved; however, O'Reillly & McMahon (in press) found an equal distribution of children known to services across the following age bands; under 10's, 10 – 13, and 14 – 17. This implies that services are just as needed for children as they are for adolescents. Many Community Care Social Workers have referred to how extensive the problem is on their caseload. Also, they frequently indicate that they find it nearly impossible to acquire therapy specific for Children with Sexualised behaviour problems. For example, a child with sexualised behaviour problems might attend a Child Guidance Service; however their treatment plan might be for ADHD or Attachment Disorder, and not directly addressing management of the sexualised behaviour. The treatment plans are thought to be addressing the underlying features of the sexualised behaviour problem. Research has not been conducted to clarify which is more effective (direct or indirect approaches). It is hypothesized though that both aspects are necessary for treatment efficacy.

Irish Services for Children with Sexual Behaviour Problem:

Currently in Ireland there are very few services specializing in the needs of children and adolescents with sexually harmful behaviour. Children with sexualised behaviour problems are typically referred to their local Child Guidance Teams, and in some areas are able to access services that are for victims of sexual abuse. Many children with such problems do not have a history of being sexually abused, but do have very complicated early life histories which may encompass other forms of abuse, attachment difficulties, or exposure to violence. As such locating a service which will address their needs can often times be difficult and depends on the agencies comfort level in working with issues connected to childhood sexuality and or abuse histories.

Current Status of Irish Services Available for Adolescents:

With regard to services for adolescents who have been accused of or who have admitted to having sexually abused, there are specialist services available; however the range of service availability is often limited. The status of services linked to the

Health Service Executive for adolescents who have been accused of and/or admitted to sexually abusive behaviours are as follows:

HSE Dublin Northeast / Mid Leister Region:

- Southside Inter Agency Treatment Team (SIATT) – provides only an inter-agency group treatment program for adolescent males who have admitted to having sexually abused, along with a parallel group for their parents/carers within South Dublin, Co. Kildare and Co. Wicklow. The service conducts comprehensive assessments prior to devising holistic individualized treatment plans for group participants. Despite the programmes efficacy, this service is currently considering its viability in the absence of dedicated funding and personnel; and may be closing to new referrals.

- St. Louise's Unit, Our Lady's Hospital for Sick Children, Crumlin - Conducts Assessments of adolescent's accused of having sexually abused a first degree relative, when the alleged victim was also seen by the Unit. The Unit also sees children with sexual behaviour problems for Assessment, when there is a grounded reason to believe that the aetiology of the sexual behaviour is due to the child having been sexually abused.

- Portlaoise Child and Family Centre – provides limited individual therapeutic work with adolescents who have sexually abused.

HSE Dublin North East Region:

- Northside Inter Agency Project (NIAP) – provides a holistic treatment service for young people, who have admitted to having sexually abused, and their families. They have extended their service to work with young people who are in denial of their offences and young people who are learning disabled and their families. Treatment includes individual, group and family work. Their catchment area covers the HSE Northern Area.

- St. Clare's Unit, The Children's University Hospital, Temple Street - Conducts Assessment of adolescents accused of having sexually abused and assesses children with sexual behaviour problems when there is a concern that their behaviour may stem from having been sexually abused.

- Co. Meath Child Guidance – A psychologist has ran a Group Therapy Programme for the last four years; however their referral rate has dropped resulting in a suspension of the Group Therapy Programme. They theorise that the reason for the drop in referrals is due to their local Community Care teams having had an extensive waiting list for duty social work support, resulting in this populations referrals not being prioritised. An assessment service is still available.

HSE Southern Region:

- Kilkenny High Support Unit - providing residential care for adolescents who have sexually abused along with provision of therapy to their residents.

HSE South Western Region:

- The Carraig Project - Cork had received funding and resources to provide treatment to adolescents who had sexually abused; however funding was ceased resulting in a phased closure of the service.

HSE Western Region:

- Galway – has recently begun providing a multi site programme for adolescents who have sexually abused. The multi site approach allows for individual work to be done locally with the family, and group work offered monthly on a regional level. Team members have other responsibilities outside of work with this population.

HSE North Western Region:

- Donegal / Sligo – a special community care team has been developed to assess and treat adolescents accused of having sexually abused. This project is in its very early stages of development. Team members have other responsibilities outside of work with this population.

Resource Considerations:

Of the above mentioned services, NIAP and Galway are the only services which have designated funding from the Health Service Executive for work with adolescents who have sexually abused.

- NIAP has funding for a full-time Director and half-time administrative support. In keeping with an inter-agency model, five staff are seconded to the project from other agencies for six hours every week (unfunded). The present resources are inadequate to meet the demands of the therapeutic work and to maintain a high standard of good practice. Without adequate funding other areas of work cannot be developed to their full potential.
- Galway is thought to have made funding available for a half-time coordinator.
- The High Support Unit in Kilkenny obviously has its own dedicated funding as a residential unit.

The other treatment services, which have been referenced above, exist solely on the ability of the region to release professionals to conduct work with adolescents who have sexually abused (approximately one day per week) to varying degrees. For example SIATT has no dedicated funding for personnel, resources, or training. Its team is comprised of professionals from a variety of local agencies whom have been released by their employer to work with the SIATT program three quarter days per week. Absence of dedicated funding and personnel continues to threaten the services viability, as it has become increasingly difficult to acquire new staff to be released from other agencies that are experiencing their own staff shortages. SIATT has advised that it is considering its ability to provide effective treatment due to staffing and resource difficulties, and the viability of the service under its current structure. If circumstances do not change in the near future for this service, it may no longer be accepting referrals.

NIAP and SIATT, as the longest standing specialist treatment organizations for adolescents who have sexually abused, have long identified the need for a

continuum of services to be developed which would encompass triage (crisis response), assessment of adolescents accused of having sexually abused (deniers/admitters), parental support, individual therapy, group therapy, family therapy, and aftercare. It has also been identified that a similar range of age appropriate services is required for children whose sexual behaviour has been labelled problematic/abusive, versus normal childhood sexual curiosity.

TREATMENT EFFICACY:

Worling & Curwen's research in 2000 provides a firm foundation regarding the efficacy of treatment for young people who have sexually abused and the reduction of recidivism. They compared the recidivism rates of treated sexual, violent non-sexual, and non-violent offenders to those who had refused or dropped out of treatment. They found the following:

Category	***Treated Recidivism Rates***	***Control Group***
Sexual	*5.17%*	*17.8%*
Violent Non Sexual	*18.9%*	*32.2%*
Non Violent	*20.7%*	*50%*

Their paper also contains a literature review comparing many other recidivism rates for treated vs. untreated populations providing further corroborative data for the efficiency of treatment services. Their research also supports the notion that sexual recidivism is predicted by unique factors unrelated to general (nonsexual) reoffending, thus warranting specific treatment for having sexually abused.

SIATT and NIAP have both demonstrated the treatment efficacy of their services. Of those adolescents treated by SIATT (n = 49), only one is known to have sexually reoffended post treatment, compared to a control group (n = 43) made up of young people who either dropped out or who could not be treated by the service (unsuitable for group, refused to attend, too high risk for community based treatment, etc) of which it is estimated that 14 sexually reoffended, and many more committed non-sexual offences. Additionally, comparison of pre and post treatment psychometric questionnaires completed by the treatment group has demonstrated improvement on key treatment issues (e.g. Victim Empathy, Cognitive Distortions, Anger, Self Esteem, Emotional Loneliness, etc.).

Of the young people treated by NIAP (n=165) three are known to have re-offended sexually. Similarly with SIATT comparison of pre and post treatment psychometric questionnaires completed by the treatment group has demonstrated improvement on key treatment issues.

PROPOSED CONTINUUM OF TREATMENT SERVICES

Following is a National Treatment Model submitted for consideration for Regional provision of Assessment and Treatment services for young people with sexually problematic behaviours and their families. The proposal refers at times to "gaining admissions" from young people who have been accused. This does not infer an assumption that all those accused did in fact sexually abuse; however, is informed

by the high confirmation rate associated when the accused is a young person. The higher confirmation rate pertaining to accused young people is likely an artefact of there being fewer secondary gains (ulterior motives) for victims who have named a young person, as opposed to the much more complicated assessment of sexual abuse allegations in the context of custody and access disputes (confirmation rate averaging 35%).

The proposed service aims to address the range of services which are typically required in working with such families. It is envisaged that services could be developed Nationally, on a Regional level. We propose that aspects of this service be available to both children with sexual behaviour problems and for adolescents accused of having sexually abused. The service would have to be flexible to allow for provision of assessment and treatment of males and females, as well as those with learning difficulties. It should also be noted that assessment and treatment of children with sexual behaviour problems requires many of the same components as for adolescents; however treatment approaches would need to be modified to take cognisance of the child's age and developmental issues.

A separate paper has also been attached which addresses the need to develop Specialist Residential Treatment Programmes for the most concerning group of young people who have sexually abused; those who cannot be safely treated in the community due to their level of risk.

Triage Service:

The ability to provide an effective initial contact with children, adolescents, families, and/or referring agents upon discovery of an allegation and/or admission that a young person may have been involved in problematic/abusive sexual behaviour could positively impact their ability to take on appropriate therapeutic recommendations. In many cases, families who are approached by HSE Social Workers become entrenched with defending their child and may literally close the door to professionals. This complicates matter for the young person and makes it increasingly difficult for the truth to emerge. There is also evidence to suggest that families are more likely to avail of services for their child while there is either external motivation (investigation) or distress. For these reasons it is imperative that initial contact be made by professionals who understand and are skilled in motivational interviewing strategies and issues connected to young people who may have sexually abused. As such, availability of a triage service, which could support HSE Social Workers, would have a positive influence on families allowing services access to their child, thus increasing the possibility of admissions. The ability of HSE Social Workers to contact such a service would have to be developed in light of the Barr Judgement, which indicates that a 3rd party cannot be advised of the accusation until the alleged is made aware. As such, if a Triage Service is to be of use at times of crisis or notification, these types of services may need to be attached in some way to Community Care, as the Service would then not be a 3rd party.

The triage services increased contact with referring agencies and Social Workers would facilitate an increased understanding of the service; as well as a better understanding of this population and techniques used in facilitating admissions from adolescents who have actually sexually abused. Typically, when an adolescent denies having sexually abused, and their parents support that denial, there is little

else any professional can do. The longer an adolescent who has sexually abused maintains that denial, the more difficult it is for them to admit. Alternative ways of managing these types of cases must be explored at community level. With regard to children, it is not as necessary to obtain an admission, due to developmental factors. However those situations wherein it is "known" that they have been involved in problematic sexual behaviours could be linked in to such a triage service.

Assessment:

Assessments would be offered to young people, under the age of eighteen years, when there were concerns that they had exhibited problematic/abusive sexual behaviours in the following circumstances:

- Where abuse specific information is available from the victim or where the young person is making an admission in the absence of a disclosure by the victim.
- When appropriate consent has been provided.
- When Assessment of the young person's problematic/abusive sexual behaviour is an appropriate priority, given their overall life circumstances at the time of referral (e.g. homelessness, psychiatric disorders, drug addiction, child protection, etc).

The purpose of Assessment would be:

1. To determine whether or not the young person's sexual behaviour has been either problematic or abusive.
2. To determine what, if any, abuse the young person himself has experienced.
3. To provide an assessment of the young person's emotional state.
4. To determine and make recommendations regarding they and their parents therapeutic needs.
5. To assess the overall needs of the young person and how they are currently being responded to.
6. To identify areas of potential risk with regards to child protection and the young person's behaviour at home and in the community.
7. To identify whom else in the family should know about these concerns, dependent on outcome of assessment.
8. In those cases where therapy is recommended, that a determination be made as to the young person's current placement and the safety of providing such treatment within.

Assessment would include:

1. Interviews with the young person's parents/caretakers.
2. Interviews with the young person.
3. Review of all relevant documentation and liaison with involved professionals.
4. Administration of Psychometric Questionnaires specific for either children or adolescents.
5. Formulation of opinion and treatment recommendation.

Assessment typically involves approximately 1 hour for case preparation, 6 hours of interview time, 3 hours for administration of Psychometric Questionnaires, 2 hours for scoring and interpretation of Psychometric Questionnaires, and 3 hours for preparation of reports; totalling 15 hours per assessment.

Risk Assessments:

Currently there are no scientifically validated assessments of risk with regards to young people who have sexually abused. Most programmes, both in Ireland and in the UK are currently using the AIM Model of Assessment of Risk. This model provides a broader and largely evidenced-based approach by outlining a continuum of both strengths and concerns. The model draws upon both outcome and recidivism research concerning adolescents who sexually offend and known factors concerning the persistence of problematic and offending behaviour in young people.

This assessment framework requires that information is gathered and assessed within four domains:

1. Offence specific
2. Developmental
3. Family and carers
4. Environment

and across two continuums:

1. Concerns
2. Strengths

Each of these is divided into categories of high, moderate and low. The assessment framework provides a scoring structure for those elements and places young people in one of the following four categories:

1. High concern – high strength

   Young people in this category may have high levels of need, but may be managed safely in the community. They may require placement away from home. They will require specialist treatment involving a range of disciplines, and need inter-agency cooperation.

2. High concern – low strength

   Individuals in this category are likely to include the most worrying of young people. They are likely to have a range of needs across a range of areas. They are likely to need high levels of specialist intensive treatment and high needs for management and supervision.

3. Low concern – high strength

   Young people in this category may require limited intervention. They can usually remain at home and parents/carers are often the best people to help the young person. Parents may need professional support and information. The case should be reviewed after 3 months

4. Low concern – low strength

   Young people in this category are likely to require help in meeting a range of needs and may require a full needs assessment. Intervention may include involvement in a brief programme of education regarding healthy sexual behaviours. Parents/carers are likely to require support. Emphasis may need to be placed on increasing resilience factors, family work, and family support.

Based upon their category, recommendations are then more easily identified as to extent and types of therapy which would be beneficial/required.

Therapeutic Services:

In those cases where a young person makes some form of admission (unless the incident is "known" to have occurred), consideration should be given to the type of treatment required in order to reduce the young person's risk of re-engaging in sexually problematic/abusive behaviours. When a psychiatric diagnosis is suspected, a psychiatric evaluation could be sought from either a Consultant Psychiatrist attached to the service, or at a local child and family guidance service. In cases where a psychiatric diagnosis is not suspected, the service would develop an individualized treatment plan and then provide the appropriate treatment milieu. It is proposed that a range of services be available.

This would include:

1. Individual therapy
2. Group therapy
3. Parents Group
4. Family therapy
5. Aftercare

The following are some thoughts regarding aspects of the range of treatment milieus proposed:

Individual Therapy:

Many of the previously identified services for adolescents who have sexually abused solely provide group therapy. Many young people however are not suitable for group therapy and require individual therapy specific for having sexually abused. Some young people have also been recommended to participate in longer term individual psychotherapy, due to their complex issues and treatment needs (own history of sexual abuse, emotional abuse, physical abuse, neglect, domestic violence, etc.). Additionally, many young people who participate in group therapy are later identified as being in need of individual therapy at various points in their programme. Some adolescents need further individual work in order for them to be emotionally available to the benefits of a group treatment programme. This mode of work is also required during the bridging between an adolescent's assessment and their onset of group work. It must also be considered that we do not want to inappropriately place any young person into a group that is not suitable for them. If such a situation were to occur due to the lack of availability of individual therapy, the young person could be exposed to inappropriate stimuli in the group which could worsen their condition.

Children with problematic sexual behaviour would also benefit from individual therapy. Many of these children cannot be appropriately treated within a group

context due to their attention spans, impulsivity and/or behavioural difficulties.

Group Therapy:

It is recommended that a group therapy programme be devised, which would operate on a rolling basis, with points of entry being dictated by specific treatment modules within the programme. Most adolescents require 18 to 20 months of group treatment on a weekly basis for 1½ hours. Length of treatment however varies dependent on the needs of the client and types of therapy that they are receiving in addition to group treatment. Young people participating in both individual and group treatment may require shorter overall periods of treatment.

Adolescents who are considered high concern regarding their risk of re-offending typically require longer courses of treatment than those who are low/moderate risk. Flexibility should also be available within the group treatment programmes for those young people with learning difficulties, as they may not progress as well in groups of higher functioning young people.

Separate group treatment programmes would need to be developed for males and females, children and adolescents, and for those with learning difficulties. In theory then, the availability of Groups for male children, male children with learning difficulties, female children, female children with learning difficulties, male adolescents, male adolescents with learning difficulties, female adolescents, and female adolescents with learning difficulties could be required, dependent on referrals to the service.

Additionally, shorter specific groups could be developed such as Social Skills, Anger Management or Problem Solving for those young people whose primary mode of therapy was Individual. This would allow for shorter groups to be available which could compliment the young persons individual therapy.

Groups would cover specific Modules that are necessary in sex offence specific therapy, such as:

- Life Story - A chance for the young person to explore the events of their lives, which have helped to shape who they are.
- Feelings - Provides an opportunity to help the young person become aware of their own feelings and how they have handled them in the past, with a view to helping them have more effective coping strategies for difficult emotions.
- Details - To explore the extent of their sexually abusive behaviours. This is done in order to track their cognitive distortions and to assist with identifying when they could be at risk of sexually abusing so that safety plans can be put in place in advance of dangerous situations.
- Grooming & Maintenance - Explores how the young person chose their victim(s) in order to increase their awareness of possible grooming behaviours they may exhibit and then to provide them with alternatives. Also, to explore what things/values might still be in their life which keep them at risk.
- Victim Empathy - To help them understand the impact of their actions on their victim and victims family.
- Dating & Sexuality - A chance to explore where they are at socially; provide

them with accurate information about sex education, alternative lifestyles, interface with their offence history, and issues connected to consent; and what steps they need to take to move forward.

- Relapse Prevention - A chance to tie everything they have learned together, as a means of completing their programme; and with a view to its implementation during and post treatment.

Each group could accommodate no more than 8 young people, fewer if it were a group for young people with learning difficulties. As stated previously, the overall length of the group would vary dependent on the needs of the group.

Attending long term group therapy adds a significant responsibility to the busy lives of families. Many of the families referred to existing services are somewhat chaotic and/or have other problems. This makes it difficult for them to commit to long term regular attendance. In order to alleviate the burden that comes with commitment to their child's treatment, most groups are ran in the early evening so as not to disrupt the young peoples education, and to allow parents to meet the needs of their other children with regards to school collection, dinners, etc. Lastly, staffing issues connected to running several groups a week would need to be costed for both in terms of flexible scheduling, and having adequate staffing levels to ensure groups can be provided on an ongoing basis throughout the year (leave coverage).

Parents Group:

Groups would be required for parents of the young people attending the service, regardless of the form of therapy that the young person was receiving. Parents typically have many complicated feelings about what their children have done. Due to the stigma and shame attached to having a young person who has sexually abused, they often have few, if any, adults to talk to about their concern. It has also been demonstrated that those young people whose parents are actively involved in their treatment make more progress. Parental involvement in the young person's treatment plan is imperative. Having parents attend weekly along side of their son/daughter also "proves" at some level to the young person that their parents still love them; and helps the young person overcome many of the shameful aspects of their behaviour. Whilst the general population may think that the young person should continue to feel shame for what they've done, it is the unresolved burden of carrying around such shame that can stifle their ability to return to a normal developmental path. Parents who have participated in parallel groups for parents have expressed their relief in being able to talk with others who have had similar experiences. Parent groups would be required for adolescent males, adolescent females, and children. It is anticipated that parents of young people with learning disability may be able to be included in the aforementioned groups, however this would have to be monitored.

Family Therapy:

It is essential that ongoing family work be provided to address the effects of the abuse on family relationships. Family work is also seen as an intrical part of the adolescent’s relapse prevention plan, or a child safety plan; and necessary in order to increase appropriate communication between the young person and their parent(s) in order to lower the young person’s risk of future sexual abuse.

Typically, families of young people who have sexually abused have very complicated issues and may have intergenerational issues of sexual abuse. As such, a more focused way of working within families must be incorporated into such a service. The overall impact of the young person's sexually abusive behaviours on the family system and their relationships would benefit from family work in order to increase the family's coping skills and their ability to support their child's treatment.

It is also important to explore relationships between the young person and their siblings, and how the young person's sexually abusive behaviours have impacted on them. Several families do not wish to inform siblings of what has happened. This may result in a risk to their own children being a victim of child sexual abuse by that sibling; or result in extreme distress and further trauma to the family unit if and when it is discovered.

If a victim were also a sibling, this would require specialised counselling and liaison with victim services. Such co-working between victim and offender services is useful to provide information which facilitates the young person's therapy; such as impact on the victim, victim empathy, guilt, and responsibility. Also in the context of family therapy, the young person can apologise (if appropriate) to familial victims, parents and other family members.

In the absence of a parent participating, a suitable adult should be identified to support the young person through their treatment, for example, young people placed in residential care and who have no to limited contact with their parents, could be supported by their Key Worker from their residential programme or another suitable relative/adult.

Aftercare:

Supporting the fact that abusing is not "curable" and is not "cured" at conclusion of treatment, a structured aftercare programme is essential. It is envisaged that such a programme would offer ongoing counselling and support to the young person and their family on a structured basis. This would be done with a view to maintaining their relapse prevention/safety plan.

Young people who have sexual behaviour problems experience a great sense of shame and often social isolation. During the course of their involvement in treatment, support systems are created which are unlike any other. In their treatment "support" systems they can openly address issues connected to their abusive behaviour and risk. More often than not, these young people have nowhere else to talk about their problems, with exception of their family. The sudden loss of such a support system could be detrimental to the young person, thus increasing their risk of re-offending. Participation in aftercare phases out the young person's participation in the programme in an encouraging and supportive manner; whilst also addressing the importance of communication with their family and adherence to their relapse, prevention/safety plans.

It is likely that any aftercare service for children, as opposed to adolescents, would be less intensive. However, each case's discharge plan would be considered in light of that child and family's needs.

OTHER FUNCTIONS:

Training:

The establishment of such services would result in centralisation of skills and knowledge. It would be extremely important for these skills to be communicated to local professionals to further empower their roles in working with young people who have problematic sexual behaviour and their families. As such, provision of trainings for other agencies regarding the needs of these populations and therapeutic approaches should be a part of the services mandate.

Research:

Many of the aforementioned services are already committed to research structures which facilitate interagency collaboration. Any further services which are developed should continue with this commitment and have inbuilt structures to evaluate the efficacy of the treatment programmes. It is recommended that research on efficacy and understanding of these populations being incorporated into all aspects of therapeutic work, regardless of its form.

LOCATION OF SERVICE:

Consideration should be given to the advantages and disadvantages of where such a service should be located and then how it should be staffed. Firstly, their are geographical considerations that must be taken into account as many Regions of the HSE have vast catchment areas. Families need to be able to access the service on a weekly basis, as such if the service is "too far", this would deter the family from attending. Services must be accessible to the majority of potential families in any area.

A second point connected to location has to do with location of the actual service. Some of the current services share space with victim services, and this is both inappropriate and unsatisfactory. It is recommended that any service developments be housed separate from services for alleged victims of child sexual abuse. Housing such services in the same/near services for victims increases the possibility of an alleged victim accidentally having contact with their alleged offender on the same premises. This would have significant detrimental affects on clients and their families. Additionally, the location should also be considered for its safety when young people are travelling to and from appointments; as well as what local businesses are nearby (e.g. one former service was located across the street from an adult sex store).

STAFFING:

It is recommended that the proposed service be developed with its own independent and designated resources. Perpetuation of inter agency models is not conducive to service development. Also, it limits skill acquisition as clinician's are often only exposed to the work one day per week and limits when appointments can be offered. The possibility of inter agency collaboration (in addition to full time personnel) should exist due to the inherent advantages: sharing of skills and

knowledge, direct clinical experience, and inspiring other professionals about the importance of working with this population. The service, however should not be dependent on inter agency personnel for service provision. Appointment of full-time clinicians would alleviate many of these disadvantages. As such, it is recommended that a model which would allow for a Regional Services Clinical Director and several full-time clinicians be selected for implementation.

A Regional Services Clinical Director of a suitably qualified discipline such as a Clinical Psychologist, Social Worker, or Psychotherapist would be required. The Clinical Director's duties would encompass: coordination of the overall programme, service development, supervision, research, evaluation of the programme, collation of data and authoring research based on same, facilitating national research, development of inter-agency policies, liasing with statutory and voluntary organisations, liaison with potential referrers, processing of referrals, development of procedural guidelines, representation of the programme, participation on committees pertinent to this population, case management and direct clinical work. Other responsibilities may be identified following on further development of the service.

In order to meet the demands of this population, full-time clinicians would be required in order to absorb the increased number of cases. A suitable range of Senior and Basic Grade positions in Clinical Psychology, Social Work, Psychotherapy would be essential. Primary responsibilities of such clinicians would be direct clinical involvement with telephone queries, triage, pre-assessment, assessments, individual therapy, family therapy and group therapy; attendance at case discussions/conferences, research, and report writing.

In order to support the needs of such a service, a grade VI secretary and a grade IV receptionist would be required at minimum and should be linked to overall staffing levels. Their duties would encompass coordination of office, answering telephones, appointment letters, making up of files, filing, managing client video registration and storage, taking minutes of case discussions, typing of reports and distributing, general typing, compilations of statistics, data input, and provision of administrative backup to the full clinical team.

With regards to other service needs, a budget to cover weekly therapeutic expenses such as professional journals/books, workbooks, videos, group materials and snacks would be required. An annual training and research budget would be required and should be generous enough to ensure that the training needs of the full team are met annually. Training in this area requires attendance at international conferences both in the US and Europe, which are quite costly (ranging from €800 to €3,500 per person for Conference fees, flights, and accommodation; and not including daily per diem). Another need that should be costed for at the outset would be a Consultant Child & Adolescent Psychiatrist; as well as an experienced Independent Clinical Supervisor who would provide ongoing external clinical supervision for the programme. Lastly, access to legal advice would be required due to the special circumstances of working with young people who have sexually abused.

PHYSICAL REQUIREMENTS:

The physical requirements for premises would also require significant consideration. A minimum of three rooms large enough for group therapy with adjunct observation

rooms would be required. Multiple group therapy rooms are necessary in order to accommodate parallel group treatment programmes for the young people and their parents. A third room facilitates the option for assessments, family therapy, etc., to be conducted at the same time as groups are being held. Observation rooms allow for clinical observation of group dynamics; additionally they provide an opportunity for professionals to observe the work as part of their training. Private offices would be required for clinical members of staff. Other requirements would be for offices which are suitable for provision of family therapy and individual counselling (these could double as clinician's offices); as well as video recording facilities, kitchen, storage for files, videos, therapy and office supplies. When young people have their Reviews regarding progress on their treatment plans, several rooms are required to provide private space for each family. Video recording facilities provide documentation of group dynamics, which facilitate the improvement of clinical skills over time. The amount of staff required in any region would need to be considered in light of the regions population and projected referral rates.

Thank you for your attention and consideration of this Paper.

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Developing Work with Sexual Offenders,
Preventing Sexual Abuse

Position Paper

SPECIALIST RESIDENTIAL TREATMENT PROGRAMMES FOR YOUNG PEOPLE AT HIGH RISK OF SEXUALLY ABUSIVE BEHAVIOURS

Submitted to:
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October 2005

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Developing Work with Sexual Offenders,
Preventing Sexual Abuse

SPECIALIST RESIDENTIAL TREATMENT PROGRAMMES FOR YOUNG PEOPLE AT HIGH RISK OF SEXUALLY ABUSIVE BEHAVIOURS

EXECUTIVE SUMMARY:

The heterogeneous nature of young people who sexually abuse and variation in terms of treatment needs necessitate the availability of a continuum of care. Most young people who sexually abuse should be maintained in their own communities. A small percentage of young people who have sexually abused are considered dangerous within the community. These young people are at high risk of sexually offending, often present with psychiatric diagnosis, such as conduct disorder, oppositional defiant disorder and/or personality traits which complicate their treatment. Specialist residential placements for these youth are urgently required in Ireland.

To date, many young people who require specialist residential treatment have been sent to England. This costs the HSE as much as €330,000 per young person, per annum. Those young people not sent to the UK have been placed in non-specialised residential units, or remand centres all of which are inadequate to varying degrees for the specialised needs of this high risk group.

We propose that Specialised Residential Treatment Units be established regionally. It is recommended that the Specialist Residential Treatment Units be separate and distinct from any established Treatment Service for this population. The Treatment Service would train the residential staff, provide therapeutic input for the young people, and provide supervision and consultative supports to the unit.
The rational for providing a specialist therapeutic residential service to young people and their families in Ireland includes the following:

Financial Benefits.

- Sending a young person to the UK is financially very costly. Setting up a residential unit in Ireland would make good financial sense.

Benefits for the young person.

- A young person's needs can be met in their own community enabling them to maintain contact with their family, wider network and community services.
- Provides continuity of care.
- Research studies have demonstrated a link between family involvement and treatment effectiveness.

Benefits for the Family.

- Enables an integrated systemic approach which enables services to work both with the young person who has abused and the person who has been abused.
- If the young person is sent abroad it is less likely that their family will be engaged in ongoing therapeutic work. If family are not engaged in this work it may contribute to an increase risk if the young person returns to live in the same environment.
- Safety issues can be more effectively addressed with the young person and their family

Benefits to the Community.

- Young person is getting the response they need which will enhance community safety.

Developing Work with Sexual Offenders,
Preventing Sexual Abuse

SPECIALIST RESIDENTIAL TREATMENT PROGRAMMES FOR YOUNG PEOPLE AT HIGH RISK OF SEXUALLY ABUSIVE BEHAVIOURS

INTRODUCTION:

Some young people who have sexually abused cannot be treated safely while in their community. Such young people require Specialised Residential Treatment placement and treatment for their sexually abusive behaviours. Young people who require this type of placement have been assessed as being at high risk of sexually abusing again and unsafe to treat while remaining in the community. At this time no such service is available within Ireland, with exception of the High Support Unit in Kilkenny. Many young people who have met these criteria have been sent to England to attend services such as G-MAP or Glebe House which costs the HSE as much as €330,000 per young person, per anum. There are other young people who have been recommended to attend such services in the UK; however funding has been an issue. Additionally, some young people refuse to go abroad for treatment. This is a worrying sub-group as clearly recommendations were made, and the need for treatment was justified by securement of funds. However as the young people have refused to leave Ireland, they go without treatment because they cannot safely be treated while in the community. The costs are staggering for Specialist Residential Treatment abroad, yet currently unavoidable for those Irish young people who require this level of treatment. If the monies were instead used to establish Specialised Residential Treatment Programmes here, the same monies could be used more efficiently.

CHARACTERISTICS OF YOUNG PEOPLE WHO MAY REQUIRE SPECIALIST RESIDENTIAL TREATMENT:

A small percentage of young people who have sexually abused are considered dangerous within the community. These young people are at high risk of sexually offending, often present with psychiatric diagnosis, such as conduct disorder,

oppositional defiant disorder and/or personality traits which complicate their treatment (e.g. psychopathy, anti-social, etc). They can be extremely apathetic about and/or deny their need for treatment and do not accept responsibility for their behaviour. They may have little to no motivation to control their behaviour themselves; and frequently are not motivated by external factors such as possible prosecution. They frequently have an increased number of victims and have used force or violence during their offence(s). Many of them have a history of other antisocial behaviour including: theft, bullying, drugs, vandalism, assaultive behaviour, etc.
Some of the young people requiring placement within Specialised Residential Treatment Programmes may not be as overt as the ones described in the preceding paragraph. Some can be high functioning in many areas, but pose a significant threat of sexually abusive behaviour; yet others have learning disabilities which impact on their ability to be treated safely at home. In Appendix E, a vignette has been provided to further illustrate the extreme circumstances and treatment needs of this population.

For many young people with excessive behavioural presentations, their families are unable to exert effective controls on their child's behaviour. The families may have other social problems which negatively impact on their ability to be nurturing or effective parents. Their families may even be colluding with their son's behaviour, further increasing their resistance to therapeutic intervention.

PRESENT RESOURCES IN IRELAND FOR SPECIALIST RESIDENTIAL TREATMENT PLACEMENTS:

The High Support Residential Unit in Kilkenny is the only programme currently available in Ireland, providing a service within its catchment area of the HSE. Their unit accommodates four (maximum of five) high risk young people. Their programme highlights further concerns for working with this population, such as the young persons physical growth during puberty, thus increasing their potential to inflict harm when exhibiting dangerous behaviours. Their unit has had to develop restraint techniques and receive training on this in order to deal with the aggressive and dangerous behaviours exhibited by some of the young people who were in their care. They previously described their population as being the most "unplaceable" young people, who are very disturbed, very aggressive and violent, very sexually aggressive and psychiatrically disturbed. They have also noted a strong correlation between the young persons sexual arousal and aggression/violence, which is very concerning. For this reason they ensure that their staff have the physical means necessary to execute approved restraint techniques for everyone's protection.

Again, I must caution, that not all young people who warrant Specialized Residential Treatment present with so many challenging behaviours. As such, options between "types" of Specialist Residential Treatment Facilities should exist, so that young people can be matched to the type of placement which would facilitate the most effective treatment. "Types" of homes might include: one for the more boisterous, one for the higher functioning, and one for those with significant learning difficulties. This is not to say that "only" that "type" could be placed in the home; however having homes with different "personalities" allows for matching the type of home to the young person. Additional factors could also be linked to location, for example some young people might be better placed in the country than in a city. To

knowingly place a young person in a residential facility that might increase their risk is unacceptable. It is our responsibility as professionals in this field to ensure that each recommendation and intervention is carried out in a manner which assists the reduction of risk for the young person; whilst accepting that ultimately, the responsibility to not sexually re-offend rests with the young person.

CURRENT MANAGEMENT OF HIGH RISK YOUNG PEOPLE:

To date, those young people not sent to the UK have been placed in non-specialised residential units; or remanded to centres such as Oberstown, St. Patrick's, Trinity House or Newtownmountkennedy. All of these facilities are inadequate to varying degrees for the specialised needs of the high risk young people who have sexually abused.

These young people who are then placed in non-specialised residential units may pose a threat to other residents, and perhaps even to staff. Typically, other vulnerable individuals are in the same placement, putting them at risk of being targeted and abused by the young person. Additionally, staff may be ill equipped to deal with the intense treatment needs of this population. These types of high risk young people have many cognitive distortions which reinforce the risk they pose. Staff must be able to identify the cognitive distortions when they occur, and respond both consistently and effectively to them. Without the necessary skills, staff may unintentionally feed into the young persons cognitive distortions (e.g. he was only experimenting, he was only messing, etc.).

Those high risk young people who are remanded to the Department of Justice institutions may also be inappropriately placed. It is recognised that these young people have been identified by the legal system and incarcerated. The secure nature of these institutions keeps the community safe from these young people; however the therapeutic needs of the young person may not be appropriately dealt with. When a young person who has sexually abused is released from incarceration, there is currently little expectation that would participate in treatment. Additionally, matching an appropriate treatment service to the young person is complicated by their age as a young adult, as opposed to matching adolescent services. As young adults they can be referred to adult services post release: however they are often "too young" to participate in the existing group treatment services as membership is often comprised of significantly older adults. Delaying therapy until post-release also delays professional's ability to access the best window of time for provision of effective treatment. Therefore, treatment options should also be considered for those who are incarcerated at juvenile level by specialist clinicians.

PROPOSAL FOR THE ESTABLISHMENT OF SPECIALIST RESIDENTIAL TREATMENT UNITS:

We propose that Specialised Residential Treatment Units be established regionally. It is recommended that the Specialist Residential Treatment Units be separate and distinct from any established Treatment Service for this population. However the Treatment Service would train the residential staff, provide therapeutic input for the young people, and provide supervision and consultative supports to the units. It

would be similar to a therapeutic agency having “beds” in residential units specific for their population. Additionally, no other more vulnerable children would be placed there, thus reducing the risk of other vulnerable children in the care of the HSE being abused by the young person.

We would recommend that the units be reserved only for "high risk" young people who have sexually abused and where a determination has been made that they cannot be safely treated while in the community. The units would accommodate the young people on a long-term basis, throughout their treatment or until they are deemed safe to return to the community by the treatment providers or the Courts. Treatment with this specific population requires approximately two to three years of intensive involvement. For some young people the treatment would be longer, especially when considering that adolescence spans from age 13 to 19 years. The young people would require frequent access to individual, group and family therapy. Their parents and/or other family members would also require support and therapeutic input. Many of the recommendations made here are drawn from existing treatment services in the UK. One such service, G-Map, has allowed us to submit their full brochure; along with one of their specialist residential units, Redbank Community Homes. Their brochures are attached in Appendix F.

The number of beds available in the units would dictate staffing levels and a one-to-one ratio of staff to clients would be required. Intensive supervision of the young people is warranted during much of the treatment phase, with supervision being reduced in the context of treatment progress. It is also envisaged that young people who require this type of placement would also require significant interagency cooperation between Community Care, An Garda Siochana, Department of Justice, Juvenile Liaison Officers, educators, etc.

It is recommended that these Specialised Residential Units be separately managed; but as stated previously, would have close links to Specialised Treatment Units for this population. This would allow for close supervised relationships, skill building, enhanced implementation of treatment plans, increased training opportunities, increased communication between the different agencies (both statutory and voluntary) involved, and would maximise the efficacy of all aspects of the service for the young person and the communities benefit.

It is also recommended that the young people’s educational and vocational training needs be provided for at the residential programme. Many such young people have learning difficulties and/or are early school leavers; as, such their educational and vocational needs should be incorporated into their treatment planning and the overall programme. Additionally, many local schools are not equipped to manage the supervision needs of such individuals, especially if they have committed a peer aged rape (as opposed to having sexually abused a younger child).

RECOMMENDATIONS:

For a residential unit such as this to work at an optimum level, and maintain the effectiveness of treatment and intervention, the following recommendations are made:

- That the young people have a one-to-one staff ratio.

- That no more than five young people be accommodated on a residential basis at any given time.
- That a range of "types" of home be available Regionally/Nationally
- That the staff would include a Residential Manager, Childcare Workers, Relief Childcare Workers, Teachers, and administrative support.
- The physical space requirements of such a service would need significant consideration in order to enhance the safety of both staff and clients. Availability of space assists in the reduction of tensions and aggressive episodes, simply by there being adequate space available to the young person to aid in their de-escalation. It is likely that such a home would need to be purpose built with a large self contained garden and sporting resources so that the young people do not have to go to a local green in order to participate in sport. The bedrooms would require individual en-suites, as this is not a suitable population for communal facilities. There would need to be a quiet room to assist young people with de-escalation, containment and/or anger management. In addition to features typically found in residential homes, such as kitchen, dining room, sitting room, game room, a separate classroom would also be required. Appropriate offices, furnishing, and staff facilities are also required. The residential service would be in need of other funding as suitable to residential care, but also an increased training budget in order to facilitate specialised training required for this population.

Thank you for your attention and consideration of this Paper.

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Developing Work with Sexual Offenders,
Preventing Sexual Abuse

Position Paper

Provision of Services by HSE for Adult Perpetrators of Sexual Abuse Against Children

Submitted to:
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Minister of State at Department of Health and Children

October 2005

Submitted by:
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Developing Work with Sexual Offenders,
Preventing Sexual Abuse

Provision of Services by HSE for Adult Perpetrators of Sexual Abuse Against Children

INTRODUCTION:

In his opening address to the 15th annual NOTA Conference in Dublin City University on 13th September 2005 Minister Lenihan outlined some of the work which the HSE is currently undertaking in the treatment and prevention of child sexual abuse. This included the work being done with children and adolescents with sexual behaviour problems and the services available to minors who are victims of sexual assault and their parents.

Minister Lenihan also outlined current developments with regard to adult perpetrators of sexual abuse within the criminal justice system with convicted sex offenders. These include the sex offenders register, the provision of treatment within the prison system and in the community for convicted offenders and the use of post release supervision orders.

I would like to use this very welcome opportunity of the NOTA meeting with Mr Lenihan to refer to another aspect of child protection work, namely, community based treatment of perpetrators of child sexual abuse, both convicted and unconvicted.

RATIONALE FOR PROVISION OF COMMUNITY BASED TREATMENT FOR PERPETRATORS OF CHILD SEXUAL ABUSE – CONVICTED & UNCONVICTED:

It is now recognised that working only with convicted perpetrators is an inadequate response to the prevention of the sexual victimisation of children. We here in the Republic of Ireland are in a unique position to learn from our colleagues in the UK.

There is increasing concern being expressed there that the emphasis to date on the provision of assessment and treatment only to men within the criminal justice system is not a fully effective response to protecting children, and that a more appropriate response is the provision of services to both convicted and unconvicted offenders. This is currently the case in the Netherlands where the Health Service funded "**De Waag Service"** provides outpatient forensic treatment centres to all perpetrators of sexual abuse, both convicted and unconvicted in seven cities.

Here, Irish Criminologist, Ian O'Donnell has estimated that based on 2001 figures,

- only 37% of all sexual crimes are prosecuted by the DPP
- 76% of these prosecutions result in a conviction and
- out of this 76% the chance of acquittal after a trial is 40%.

The vast majority of sexual crimes are therefore never prosecuted and the majority of the perpetrators of sexual abuse remain in communities.

We also now have an abundance of research which confirms that the provision of treatment for men who have perpetrated sexual abuse against children is a worthwhile preventative measure in reducing their recidivism rates. It is essential therefore that we provide this treatment to all identified perpetrators of sexual abuse.

In the HSE NW area, **COSC**, a treatment service for the perpetrators of child sexual abuse, both convicted and unconvicted, has been provided since 1986. An analysis of referrals to the COSC Service between 2002 and 2005 indicates that:

- 56% - no formal complaint to Gardai at time of first meeting.
- 44% - complaint made post prison release/referred from Probation & Welfare Service/referred by the court.

The COSC service was initially provided by professionals from the HSE and the Probation & Welfare Service on a part time basis in addition to their generic case loads. However, in 2000 the HSE NW in recognition of the value of such a service to child protection made it a dedicated one and professionals from Psychology and Social Work Services were seconded on a full time basis to the service.
The service is currently provided by 4 ½ WTE professionals from the HSE. It is funded solely by the HSE, but discussions are taking place with the Probation & Welfare Service in relation to a partnership agreement.

COSC provides the following services in the HSE NW area:

1. **Risk assessment of identified perpetrators of child sexual abuse.**
   The results of these risk assessments are used to inform the decision making of the HSE Child Protection Services in relation to the safety of children to whom identified perpetrators have access.

   Results of risk assessments are also provided to the courts for those men attending the Service who also face criminal prosecution.

2. **Therapeutic Treatment Programmes:**
   COSC provides therapeutic treatment programmes in two locations, i.e. Sligo and Letterkenny, in the North West area. Men who have committed sexual offences attend these programmes for one day per week for up to two years.

3. Aftercare Groups:
These groups are provided for men who have completed the main treatment programmes, on a monthly basis in both Sligo and Letterkenny.

4. High Support Treatment Group:
COSC provides one regional High Support treatment Group in Letterkenny for those perpetrators of child sexual abuse who are assessed as being unable to benefit from placement in the main therapeutic treatment groups. This group meets every two weeks.

5. Family Support Groups:
The families of men who have perpetrated sexual abuse are recognised as being second line victims of the sexually abusive behaviour. Support and educational groups for the family members of perpetrators of abuse are provided in Sligo and Letterkenny on a monthly basis. These groups are open to the family members of all perpetrators of abuse whether the perpetrator is attending the COSC Service or not.

6. Joint partner work:
This work is done by a member of the COSC Team and a Child Protection Social Worker, when the perpetrator of sexual abuse is coming towards the end of his treatment programme. The purpose of this work is to assist the perpetrator to share relevant abuse information and his relapse prevention plan with partner/family member. This increases the protective and monitoring capacity of the partner/family member, and in turn increases the protection of children.

7. Treatment for men at risk of offending:
COSC encourages men who believe they may be at risk of perpetrating sexual abuse to attend for treatment.

The COSC service has recently been independently externally evaluated, and found to be successful in reducing a range of variables associated with sexual offending in adults.

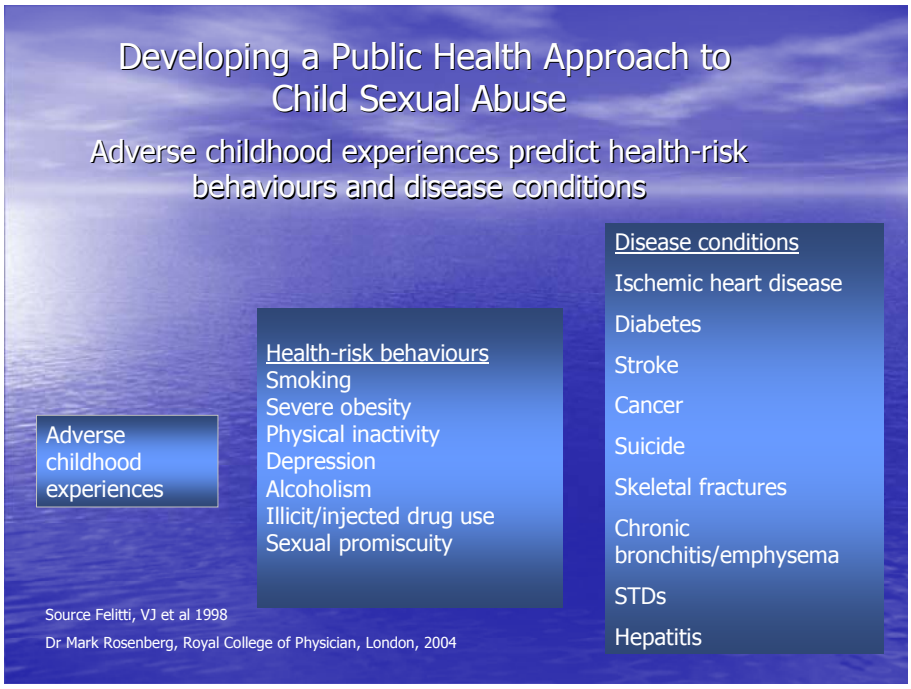
OTHER NON-HSE IRISH SPECIALIST SERVICES:

The only other community based treatment service in the Republic of Ireland for both convicted and unconvicted perpetrators of child sexual abuse is the Granada Institute in Dublin. This service was established in 1993 as a self funding agency under the umbrella of St John of God's Services. They report that about 30% of their clients seen since 1993 have not had any involvement with the criminal justice system.

DEVELOPING A PUBLIC HEALTH APPROACH TO CHILD SEXUAL ABUSE:

There is an increasing international focus on the need to address child sexual abuse by implementing a public health approach. Professor Mark Rosenberg, MD MPP, Executive Director of the Task Force for Child Survival and Development, Georgia, USA is one of the main proponents of this approach.

He outlines (see below) the cost to Public Health Services of adversive childhood experiences such as child sexual abuse.



The power of the public health approach lies in three key components:

- It is science based.
- It focuses on prevention.
- It draws on integrative leadership.

When we apply this to child sexual abuse, we have now all of the information in relation to what the problem is, what the causes are, what works and how we implement those things that work. We need to focus on prevention and stopping child sexual abuse before it happen, through integrative leadership. I believe that the COSC Service is a valuable prototype about how this public health approach can be implemented. The problem of child sexual abuse does not belong to any one sector and the provision of a community based service like COSC results in collaboration between the Health Services, the Gardai, the Probation & Welfare Service and Education. In the HSE NW this collaboration is evident not just through the COSC Service, but in the Regional Child and Family Committee set up as a result of the Children First National Guidelines.
The Sexual Abuse Working Party Sub Group of this committee brings together representatives from all of the different agencies to ensure optimum collaboration in dealing with the issue of child sexual abuse.

Our focus in the Health Services needs to be on prevention. We can define prevention in three different ways i.e.

- Primary - any intervention offered to the general public to prevent abuse
- Secondary - interventions provided to 'at risk' groups of individual.
- Tertiary - Services provided to abuse victims/perpetrators to prevent re abuse.

The provision by the HSE of community based treatment programmes throughout the country for all perpetrators of sexual abuse would enable the HSE to contribute to prevention at each of these levels. COSC already provides both secondary and tertiary levels of prevention in its provision of services to men who believe they are at risk of offending and in its treatment programme for men who have perpetrated abuse. However, it also contributes at a primary level in the provision of education, both through our Family Support Groups and through an emphasis on media and educational work in relation to the prevention of child sexual abuse.

VALUE FOR MONEY:

In the absence of local risk assessment and treatment services for perpetrators the reality is that the only way in which children can be adequately protected is the removal of children to expensive out-of-family placements when the perpetrator remains in the family. In many situations Child protection services have to look to the external sector to acquire the risk assessments they need to inform their decision making. Outsourced assessment and treatment is very costly. A service which is contextually embedded within the local child protection service allows the partners and family members of perpetrators play an integral role in their treatment and child protection.

'STOP IT NOW!'

A public health approach towards the prevention of child sexual abuse would be greatly enhanced by the implementation of the '**STOP IT NOW!'** campaign in Ireland. 'STOP IT NOW!' is a major public health campaign that aims to stop child sexual abuse by encouraging abusers and potential abusers to seek help and giving adults the information they need to protect children effectively. The 'STOP IT NOW!' Project has already been implemented in the UK and the launch of the project in Northern Ireland is taking place on Tuesday, 17th October 2005. It is run in collaboration with a range of statutory and voluntary agencies interested in the prevention of child sexual abuse. Here in Ireland a national 'STOP IT NOW!' Committee has been formed and we are working closely with our colleagues in the UK and Northern Ireland to further the setting up of the 'STOP IT NOW!' campaign here. I would ask Minister Lenihan to consider the benefits of the HSE funding the setting up of the 'STOP IT NOW!' campaign as part of the HSE's contribution towards public health approach to preventing child sexual abuse.

CONCLUSION:

In conclusion, over twenty years after child sexual abuse has emerged as a significant problem in our society which places a strain on the resources of the Public Health Services, I believe that we are now well placed to decide on the optimum intervention strategies to reduce the impact of sexually abusive behaviour. We need to learn from what is happening in the rest of Europe and to take on board the recognition that a public health approach towards preventing child sexual abuse is, particularly in a country the size of Ireland, most effective and is a practical and achievable objective.

Thank you for your attention and consideration of this Paper.

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Appendix A

Measurable Costs & Consequences of Child Sexual Abuse Research References:

1. Two articles that provide a cost/benefit analysis for prevention and intervention are:
   - National Clearinghouse on Child Abuse and Neglect Information. Prevention Pays: The Costs of Not Preventing Child Abuse and Neglect Information – www.casanet.org/library/abuse/pays.htm
   - Donato R, and Shanahan M. The Economics of Child Sex-offender Rehabilitation Programs: Beyond Prentky & Burgess. *American Journal of Orthopsychiatry. 71(1): 131-139, 140-141. Journal 2001*

2. Following are research citings, with excerpts, of research based estimates of other costs resulting from of child sexual abuse:

   Financial Costs
   - "A 1996 National Institute of Justice study estimated that each year child sexual abuse in America costs the nation $23 billion". *Miller, Ted R., Cohen, Mark A. and Wiersema, Brian. Victim Cost and Consequences: A New Look. National Institute of Justice Research Report. January 1996.* www.ncjrs.org/pdffiles/victcost.pdf
   - "Crimes against children were among the most costly of all crimes. For example, child sexual abuse incurred an average cost of $5,800 in mental health care (the highest of any crime) and $1,100 in social services". *Finkelhor, David, and Hashima, P., The Victimisation of Children and Youth: A Comprehensive Overview. Handbook of Youth and Justice. 2001*.

   Eating Disorders
   - "26% of women suffering from bulimia nervosa were raped at some point in their lives, while 13.3% of women with no eating disorder had been raped". *Dansky, B., Brewerton, T., Kilpatrick, D., and O'Neil, P. The National Women's Study: Relationship of Victimisation and Posttraumatic*

Stress Disorder to Bulimia Nervosa. International Journal of Eating Disorders. 21(3): 213-228. 1997.

- "Female adolescent abuse survivors are more likely to develop eating disorders – 18% binge and purge, while 6% of non-abused, adolescent girls do so – and are more likely to use illegal drugs – 30% compared to 13% of teenage girls who were never sexually abused. *Schoen, Cathy. The Commonwealth Fund Survey of the Health of Adolescent Girls. November 1997*.

High Risk Sexual Behaviour

- "Adolescent girls with a history of sexual abuse were twice as likely to have had intercourse by age 15 while not using birth control at last intercourse. They were also 1.4 times more likely to report having more than one sexual partner". *Stock, J., Bell, M. Boyer, D., and Connell, F. Adolescent Pregnancy and Sexual Risk Taking Among Sexually Abused Girls. Family Planning Perspective. 29(4): 200-203, 227. August/September 1997.*
- "Female students who have been physically and/or sexually abused by a dating partner in the 9th through 12th grades are at increased risk for problems with substance abuse, unhealthy weight control behaviours, risky sexual behaviours, pregnancy and suicidality". *Silverman, Jay, Raj, Anita, Mucci, Lorelei, and Hathaway, Jeanne. Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behaviour, Pregnancy, and Suicidality. Journal of the American Medical Association. 286(5): 572-579. August 1, 2001.*
- "Men who reported a history of sexual abuse had a twofold increase in prevalence of HIV infection relative to non-abused men". *Zierler, S. et. al. Adult Survivors of Childhood Sexual Abuse and Subsequent Risk of HIV Infection. American Journal of Public Health. 81(2): 572-575. 1991.*

Mental Health and Substance Abuse

- "Sexual abuse history was significantly associated with dissociation, whereas a history of physical abuse was not. Both sexual abuse and dissociation were independently associated with several indicators of mental health disturbance, including risk-taking behaviour (suicidality, self-mutilation and sexual aggression)". *Kisiel, Cassandra, and Lyons, John. Dissociation as a Mediator of Psychopathology among Sexually Abused Children and Adolescents. American Journal of Psychiatry. 158: 1034-1039. July 2001.*
- "75% - 95% of 14 – 18 year-old girls in the justice system have been victims of sexual abuse. These girls often suffer from a traumatic and profound lack of self-esteem and engage in disempowering and self-defeating behaviours that can propel them into a cycle of prostitution, addiction, drug dealing and violence". *Richie, B., Tsenin, K. and Widom, CS. Research on Women and Girls in the Justice System Series. Research Forum. NCJ 180973. September 2000. www.ncjrs.org/pdffiles/nij/180973.pdf*
- "In a study of sexually abused boys, sequelae included psychological distress, substance abuse and sexually related problems". *Holmes, W.C. & Slap, G.B. Sexual Abuse of Boys: Definition, Prevalence, Correlates,*

Sequelae and Management. Journal of the American Medical Association. 280: 1855-1862. 1999.

- "In an autobiographical study of adult male survivors of childhood sexual abuse, fifteen psychological themes were identified: anger, betrayal, fear, homosexuality issues, helplessness, isolation and alienation, legitimacy, loss, masculinity issues, negative childhood peer relations, negative schemas about people, negative schemas about the self, problems with sexuality, self blame/guilt and shame/humiliation". *Lisak, David. The Psychological Impact of Sexual Abuse: Content Analysis of Interviews with Male Survivors. Journal of Traumatic Stress. 1(4): 525-548. 1994.*
- "Girls who were raped are about three times more likely to suffer from psychiatric disorders and over four times more likely to suffer from drug and alcohol abuse in adulthood". *Kendler, KS, Bulik, CM, Silberg J, Hettema JM, Myers J, and Prescott CA. Childhood Sexual Abuse and Adult Psychiatry. 57. October 2000.*
- "In a nationally representative sample, youth who experienced sexual assault were twice as likely as their non-victimised peers to report past-year alcohol or other drug abuse or dependence". *Kilpatrick, D., Acierno, R., Saunders, B., Resnick, H., Best, C. and Schnurr, P. Risk Factors for Adolescent Substance Abuse and Dependence: Date from a National Sample. Journal of Consulting and Clinical Psychology. 68(1): 1-12. 2000.*

Other Consequences

- "Among children who were sexually abused, the odds are 27.7 times higher (than a control group) of being arrested for prostitution as an adult". *Widom, Cathy Spatz. Victims of Childhood Sexual Abuse – Later Criminal Consequences. Research in Brief. March 1995.*
- "People who reported childhood rape compared with people who did not were four times more likely to be working as prostitutes. Women were nearly three times more likely to become pregnant before the age of 18". *Zierler, S. et. al. Adult Survivors of Childhood Sexual Abuse and Subsequent Risk of HIV Infection. American Journal of Public Health. 81(2): 572-575. 1991.*
- "Research shows that adolescent females with a history of sexual abuse and sexual assault were three times more likely to participate in prostitution, have children at an earlier age and may be more likely to abuse those children. Sexually abused adolescent girls were more likely to show impaired social functioning, bulimia and sexual mutilation". *Wordes, Madeline. Our Vulnerable Teenagers: Their Victimisation, Its Consequences, and Directions for Prevention and Intervention. The National Centre for Victims of Crime. May 2002*.

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Appendix B

Intangible Costs and Consequences of Child Sexual Abuse
Research References:

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APPENDIX C

Developing Work with Sexual Offenders,
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Costs Connected to Private Specialist Assessment & Treatment Services – In Ireland & the UK

ACT – Based in Waterford, Ireland – Conducts Private Assessment & Treatment for young people with Sexual Behaviour Problems

1. Assessment (Adolescents)
    - 1 professional meeting (optional)
    - 1 Agreement meeting (ACT/Parents/Carers/Client/Referrer)
    - 6 Clinical Sessions with Client
    - 3 Psychometric Sessions
    - Comprehensive Assessment Report
    - Psychometric Test Analysis
    - Extra Sessions/meetings at €100 per hour plus travel
    - €1,900 (plus travel)

2. Therapy
    - Individual Therapy - €100 per hour (plus travel)
    - Group Therapy - €75 per hour

Glebe House, Cambridgeshire, England – Provides a Specialist Residential Treatment Programme

1. Residential & Treatment in a "Therapeutic Community" - €3,659.41 per week
2. Annual Total - €190,289.32

G-MAP & Red Bank Community Home – Manchester, England – Provides Specialist Residential Care and a separate Individualized Treatment Programme (as opposed to the Therapeutic Community Model)

3. G- MAP (Greater Manchester Adolescent Project) - €698.93 per week
4. Red Bank Community Home - €5,596.63 per week
5. Total per week - €6,295.56
6. Annual Total - €327,369.12

NB: At the time of writing, there are at least 5 young people placed in the UK and attending a specialist service for having sexually abused. The reader should also consider that typical placement is for 2 years, thus doubling the above annual figures.

APPENDIX D

Developing Work with Sexual Offenders,
Preventing Sexual Abuse

Case Illustration: Summary of a Young Person who was successfully treated in a Group Treatment Programme

(Names have been changed to protect the identity of the families involved)

Joe was 14 when he first sexually assaulted his 7 year old cousin Amy. Her parents had separated when she was 3 due to a history of domestic abuse. Her mother had little to do with her and she was predominantly in the care of her father who was an alcoholic. As a result, Amy was often cared for during the day by her Aunt and Uncle, who were Joe's parents. Joe had been the "baby" of the family, and felt displaced by all of the attention his parents gave to Amy. Joe acted as if he liked having Amy there; but really he was very jealous of her.

As he went through puberty with all of its hormonal surges, and at a time of emotional loneliness he began to act out sexual fantasies with his cousin. They used to play "cops & robbers" together; however one day Joe added things to their game. He told her to pretend walking down a street (in his bedroom). He then would come up behind her, put his hand over her mouth and force her to the bed where he raped her for about 20 minutes. He raped her on approximately 10 different occasions, in exactly the same manner. Many wondered why Amy didn't tell straight away. Amy feared losing her time in her aunt & uncles home, as it was the only place where she had been safe, looked after, and felt loved. Joe took that away.

Amy eventually disclosed to a family friend what had been going on. When her father found out, he stormed over to Joe's parents and confronted them. Joe's parents denied that Joe could have ever done anything like that. They did ask Joe, but Joe denied he had touched Amy and his parents continued to stand by him. Joe's parents ostracized Amy's father from their family and Amy wasn't allowed over by her father.

A Social Worker became involved with Amy and her father. Her father (much later) got sober and began to attend AA meetings. Amy was assessed and her

allegations were confirmed as having happened; Joe continued to deny. By the time Amy was attending individual therapy, a Social Worker was finally able to arrange a meeting with Joe. It was at this time, over a year later that Joe admitted to what he had done.

Joe's parents were devastated, but still unable to forgive Amy's father for how they thought he'd handled things. The family fall out was intense and overwhelming for everyone, and had often resulted in fist fights between younger members of the families, and occasionally adults. The family divided in two, and tensions became unbearable. Joe's mother was very depressed over the whole turn of events, but was particularly upset at the loss of Amy from their lives. Joe was suicidal, and the family was unable to cope with the reality of their situation.

Joe was seen by a specialist treatment service for adolescents who had sexually abused. He was initially under psychiatric care due to the extent of his suicidal ideation. Joe was unable to promise anyone that he wouldn't kill himself. His parents were paralytic with fear for their son's well being and how they could help him. Through support of the treatment service, Joe was able to progress to Group therapy.

In the early stages of group therapy, Joe presented as very attention seeking. Every small injury he received from participation in sports was magnified. For example, if he had an abrasion on his hand, he wore a large bandage over his entire hand. This kind of behaviour completely disappeared as the lines of communication were re-established with his parents and they began to talk about the real issues.

In total Joe attended for 2 1/2 years while his parents both regularly attended a Parents Group ran by the service. It was a long, hard therapeutic road; but the family and Joe took on board everything identified by the treatment team.

In the context of his treatment, Joe was able to come to terms with what had led him to sexually abuse his cousin, his own insecurities and vulnerabilities, his need for power and control, and fears of abandonment/rejection by his parents. His parents worked diligently on communication in their own relationship, but especially with Joe. By the end of treatment, Joe was able to participate appropriately in an apology session with Amy's father. Amy's father was still uncomfortable about Amy being near Joe, so she was not included in the apology session.

It is now 2 years since Joe finished treatment. He finished his leaving cert, has a good job, a girlfriend, and is getting on very well with his parents.

Many professionals had ongoing involvement with both families over the 2 to 3 year period including: Social worker for Amy, Social Worker for Joe, Juvenile Liaison Officer, Victim Assessment Services (4 professionals), Victim Therapy Services (2 professionals), Offender Assessment and Treatment Services (2 Assessment, 1 Psychiatrist, 2 Group Facilitators, 1 Group Observer, 1 Case Manager). Both of these families needed intense support, and thankfully it was available. Without it, Joe could have continued to sexually abuse, and was at risk of becoming an adult rapist. Joe admitted during therapy, he didn't know if he would have ever stopped. By the end of treatment, Joe was considered to be low risk of future sexual offences. He continues to attend an after care service.

APPENDIX E

Developing Work with Sexual Offenders,
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Case Illustration: A High Risk Youth Requiring Specialist Residential Treatment in the UK

(Names have been changed to protect the identity of the families involved)

FAMILY COMPOSITION:
Mother: Mary

Father: Michael Sr.

Children: Marie, 22
Andy, 20
Tom, 19
Rachel, 18
Eoin, 17
Sarah, 15
Liz, 13
Charlie, 11
Adam, 9
Stephen, 7

Eoin's story must begin with a broader family history. Mary, mother of these 9 children was herself a victim of severe sexual abuse as a child. She only disclosed this 2 years ago. Her husband is described as a violent man and alcoholic; but despite this Mary has never been able to leave him for long. The Social Work department has been involved with this family for 15 years.

When Andy was 10, he was seen by child sexual abuse services regarding an allegation that he'd been sexually abused. When Rachel was 8, an anonymous tip to the health board stated that the caller believed Rachel and her sisters were being sexually abused by their father and that many of the children were involved in sexual behaviours with each other. During Assessment, the girls all denied sexual abuse by their father, but acknowledged there had been some sexualized behaviours

between some of the brothers and sisters. The family was referred to their local child guidance service for counseling; however the family did not attend appointments.

The family later attended child guidance around general behavioural problems concerning several of the children. Stephen & Adam were both diagnosed with ADHD. Charlie's behaviour was so extreme, he was sent to a State School for young people with significant behavioural and emotional problems.

When Sarah was 7 she disclosed that Andy had sexually abused her. Andy admitted to that, and also to having sexually abused Rachel in her sleep, and Charlie. Andy refused to attend specialist services which were available and he remained at home.

Eoin, at age 16 disclosed that he was sexually abused by his brother Andy's best friend David. He also alleged that David had sexually abused Adam and Stephen. When approaching Adam and Stephen, they also accused David; but also accused Eoin of having sexually abused them. Adam and Stephen also told their mother that Eoin had been sexually abusing Sarah.

When Eoin's mother was met with regarding these more recent concerns, she denied her own history of having been sexually abused (which she had previously alleged) and also mixed up the family history of sexual abuse. She left out children, believed some previously confirmed had actually not been sexually abused, and appeared psychiatrically disturbed. For example, Eoin had admitted to sexually abusing Sarah; however his mother denied this during interview. Eoin's father did not want Eoin to be met with, but despite his violent history and threats to Mary, Mary brought Eoin for his Assessment appointments.

Eoin was seen to establish the credibility of his own allegations, but also to explore his level of risk and how safe he was to remain at home. During his assessment, Eoin presented as apathetic, blaming, hostile to the community, and unremorseful. He acknowledged excessive drug and alcohol use, being defiant of his parents, stealing over 100 cars and burning them out, history of animal cruelty and fire-setting. Based on inferences he made during assessment, the clinicians involved became concerned that Eoin was continuing to sexually abuse at home, despite his parents knowing what he had done and supposedly supervising him.

The Social Work Department was immediately advised of the professionals concerns regarding child protection. They were also advised of the recommendations for Eoin, in that he would require specialist residential treatment for having sexually abused and that they would need to access services out of the State as nothing suitable was available in Ireland.

An emergency meeting was arranged for the next day with Mary, Sarah, Adam, and Stephen to explore their safety from Eoin. During that meeting Sarah expressed no memory of being sexually abused by Eoin. It became clear he had been doing it in her sleep. Adam and Stephen shared in the meeting that it was because of Eoin that they snuck into Sarah's bed every night to sleep, so that they'd be safe together from Eoin. The children also begged their mother to leave their father during the meeting, due to ongoing violence in the home. The children believed their father would never change. Mary told the children she couldn't leave their father, and he

was just going through a bad patch.

During the meeting Mary received 2 calls on her mobile from the children's father. He was overheard by the professionals (due to his screaming over the phone) that he wanted Mary to walk out of the session with the children, and that she was not to let the children be spoken to. Mary told Michael that she couldn't talk and hung up. Michael rang back, and his performance was repeated. The children were present in the room when these phone calls happened. Mary advised the professionals that Michael was on his way down, that he was really angry, and didn't want professionals talking to the children. Mary indicated that she wanted to continue, and the session resumed.

During the meeting, the professionals were then called out and notified that Michael was on the premises, demanding to be seen. He was described as volatile. When Michael was met with by the professionals, he was threatening and demanded that his children be brought out to him and that the session be terminated. The agency's security department was called and Michael had to be escorted from the premises. Security had been advised to call the Gardai if necessary. The children were further distressed by their father's display of behaviour.

It was clear from other comments made by the children that Eoin had abused them as recently as the previous night. Sarah at this point became homicidal stating that she was going stab Eoin to death with a knife. She was in a complete rage over what he had done to her and her brothers. She was so vehement and determined to kill him that the family's health board social worker and Gardai had to be called for everyone's safety. After several hours, a plan was agreed with Mary that the Gardai would assist her and Sarah, Adam & Stephen to get their belongings out of the family home, while they went to stay at her eldest daughter Marie's house. They feared that Michael would not allow them to leave, or for Eoin to be removed so a Gardai escort was required. The children feared the plan would not work and that their mother would return.

Within 1 week, Mary and the children had returned to Michael. Eoin's profile made him "unplaceable" in any of the local residential services. Due to funding issues, it took a great deal of time for an out of state placement to be secured for Eoin. Approximately a year later he was successfully placed abroad.

It is known that during the time that Eoin remained in the family home, he continued to sexually abuse some of his siblings. Eoin admitted nearly daily abuse of at least 2 of his siblings, 2-3 times a week abuse of 1 sibling, plus 2 other victims over a 2 to 3 year period. It is estimated that Eoin has sexually assaulted at least 5 people and committed over 4,000 sexual offences.

Eoin has only just begun his treatment, and his prognosis is poor. It will take many years to address Eoin's treatment and that is entirely connected to his own motivation which is very low. Eoin is diagnosed with Conduct Disorder and this diagnosis is often associated with adult psychopathy, often referred to as being a sociopath (he has not received this diagnosis, and only can be considered for it after he is 18). Eoin is likely to have lifetime persistent problems with his sexual and criminal behaviour. The prognosis for many of his siblings is also quite bleak, mostly due to parents difficulty maintaining any improvements that are made. Many agencies continue to be involved. Some of the children occasionally attend child

guidance, as well as individual therapy; however it has been difficult for some of the children to engage with the process.

Had the right services been available at the right time, maybe the prognosis would be better; but we'll never know for certain. With inter and intra generational sexual abuse, treatment is very complicated. Where do you start? How do parents get all of the children where they need to be for therapy? If everything was provided all at once, the family would be overwhelmed and unable to cope, so how can things change? How can the cycle of abuse be stopped for this family? How can these children have a different future? Hopefully with Eoin out of the house the children are safer and help can be provided. Hopefully, with their father now attending AA and MOVE (domestic violence service for males who are violent), their home will be safer and the children can begin to benefit from help. Concerningly though, Charlie and Adam refuse to attend therapy and are presenting with violent behaviour. Charlie said, if you make him talk, he'll kill himself. Sarah is also described as sexually promiscuous and out of control.