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A Community Treatment Model for Adolescents Who Sexually Harm: Diverting Youth from Criminal Justice to Therapeutic Responses

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Abstract

The costs of treating youth who sexually harm others can exceed $200,000 Australian (US$220,000) per annum when they are placed in a residential type facility in either Australia or North America. Following the financial meltdown of the past two years, North American based residential-style programs have found themselves under increasing financial pressure, with some well-known facilities in the U.S. having closed their doors. Other facilities have experienced drops in their referral numbers of up to 50%, resulting in substantial staff lay-offs, and shorter lengths of stay for clients.

Community-based programs can offer a low-cost alternative model of treatment that may match or exceed the success and recidivism rates achieved through facility-based residential treatment, dependent on sound assessment and consideration of the viability of the young person to: a) continue to reside in the community, and b) to continue to reside in their family home while undertaking treatment.

This article describes the state-wide community-based Sexually Abusive Behavior Treatment Services (SABTS) operating in Victoria, Australia, driven by the legislatively innovative Therapeutic Treatment Order (TTO) model in effect since 2007. This program, delivered to children and adolescents aged 10-14, is currently being extended to the 15-17 year age group due to its success in accomplishing its goals. The effectiveness of the program demonstrates the capacity to design and implement treatment programs that are able to safely keep and treat young persons with sexually harmful behavior in the community, and at a far reduced cost when compared to residential treatment costs, and with similar to lower sexual recidivism rates.

Keywords

Sexually abusive youth, youth who sexually harm, community-based treatment, sexual treatment programs, problem sexual behaviours

It is only in the past two decades or so that a comprehensive approach to the management and treatment of young people who sexually harm others has emerged (e.g., Australian Crime Commission, 2008; Haaven, Lillte, & Petre-Miller, 1990; Longo, 2001; Rich, 2003, 2006). Indeed, prior to widespread recognition that children and adolescents are capable of sexually abusing other children, other "waves" of understanding about sexual assault and abuse were dominant.

Between the late 1800's and the present, our understanding of adult sexual crimes progressed from early notions of adult sexual offenders as "sexual perverts" through to "sexual psychopaths" (mid-late 20th century) and, in more recent times, "sexually violent predators' (Letourneau, 2011). When it was initially recognized that "kids do this too" (Scott & Swain, 2002), the only available treatment and management models were based on adult, top-down models, effectively resulting in young people being labelled and treated as "mini-pedophiles" (Pratt, Miller, & Boyd, 2010).

The Development of Adolescent Treatment Models

With our increasingly sophisticated understanding of, and responses to, sexual offending by adults came an understanding that, in addition to punishing adults for the sexual crimes they have committed, there is also a need to rehabilitate them and provide treatment to reduce recidivism rates for those who have a history of sexual criminality. Early treatment approaches were criticized for non-uniformity, as well as (somewhat unfairly) "not working" (Martinson, 1974). This notion directly challenged the existing treatment field and resulted in a clearer understanding that treatment did, in fact, have a positive impact on sexual criminal recidivism. At that time, however, there was no understanding that "…juvenile risk assessment and treatment was a different proposition than that of assessing [and treating] risk in adult sexual offenders" (Rich, 2009, p. 60).

The Development of Positions: Ethical Standards and Position Papers

By 1990, there was acknowledgement that adolescents who sexually abused were somehow different from adults who sexually abused; however, still unclear was *how* they were different. Early treatment models used in adolescent programs lacked proven efficacy or were weak due to research derived from small samples, a lack of information about or understanding of normative child sexual behavior, limited expert input from developmental and pediatric specialists, and/or responding to and providing treatment in a climate where moral panic abounded about "sexually violent predators" and "juvenile super predators" (Letourneau, 2011; for an Australian example from the 2000s, see Dowsley, 2006: Melbourne Herald-Sun: *Boy, 4, a 'sex-fiend'*).

By 1993, the U.S.-based National Adolescent Perpetrator Network (NAPN) had released a revised report addressing juvenile sex offending. In part, this report recommended interventions based upon legal mandates, and emphasised youth accountability, electronic monitoring, use of the polygraph, and inclusion of youth on sex offender registries. It can be clearly seen that these concepts and ideas were closely aligned with, and based upon, adult concepts and models of sex offender treatment and management. In a similar vein, in 1997 the Association for the Treatment of Sexual Abusers (ATSA) *Statement of Ethical Standards and Principles* noted the importance of comprehensive assessment of sexual offenders, with no distinction between adults and juveniles. By 2000, however, ATSA's public policy statement noted distinct differences between adults and juveniles who sexually offended.

This understanding of youth who sexually abused, which was based on adult sex-offender theory and treatment models (Creeden, 2006; Rich, 2003) lasted through to the early 21st century. In 2003, Longo asserted that the adult sex offender treatment field ignored developmental stages and moral development. It was only into the first decade of the 21st century that it was recognized that youth who sexually abused were different than adult sex offenders, and also that treatment outcomes for youth with sexually abusive behaviors were generally very positive (Chaffin, 2008). A small number of studies (e.g., Alexander, 1999; Prescott, 2006; Worling & Curwen, 2000) indicated lower recidivism rates for treated adolescent sexual abusers when compared to treated adult sex offenders, with increasing understanding that the influence of adult models may have been keeping youth in treatment far longer than may have actually been warranted or necessary (Prescott & Longo, 2006).

By 2001, ATSA was recommending that assessors take age into account and acknowledged that, compared to adult assessment, far less was known about the meaningful and valid assessment and treatment of juveniles. By 2006, ATSA was not only recognising the developmental differences and uniqueness of adolescents as compared to adults, but also recognising a fairly new category of pre-pubescent children presenting with what was now termed *Sexual Behavior Problems* (Chaffin et al., 2008). Clearly, the field had moved rapidly to an understanding that adolescents and children required different assessment and treatment approaches to those used with adults who sexually offended.

A Developmental Approach to Understanding Young People Who Sexually Abuse

We now understand that child development is not complete upon reaching adolescence. In fact, adolescents are "…still developing physically, emotionally, cognitively and behaviorally" (Pratt et al., 2010, p. 13). Accompanying this understanding of development is a more sophisticated understanding and acceptance of the impact of violence, abuse, trauma, and neglect upon developmental pathways. Indeed, over the past decade much has been written about the impacts of trauma upon brain development and the subtle interactions among trauma, attachment, and brain development (see for example Creeden, 2006; Friedrich & Sim, 2006; Perry, 2006; Rich, 2006, 2011; Schwartz et al., 2006). These interactions can result in a distortion of a youth's belief and values systems, with a resulting deviation from optimal/positive developmental trajectories, and with one potential consequence being the emergence of sexually abusive behaviors.

These behaviors can be viewed in a number of ways through a developmental lens, such as:

- A method of "stimulation seeking" to replicate past intense feelings stemming from a traumatized emotional system
- An attempt to "self-soothe" through the relief of sexual release
- A re-enactment of past traumatic sexual abuse events
- A consequence of dysregulation and the inability to self-manage intense emotion and behavior.

Why would dysregulation lead to a youth committing sexually abusive behaviors? Given the complex interactions between experiencing trauma, attachment styles, and brain development why is it that a youth would engage in sexually abusive behaviors rather than either aggressive or violent behaviour, or perhaps more self-focused negative behaviors, such as self-harm, depressed state, or suicidality? Perhaps in a majority of cases, youth who engage in sexually abusive behaviors are exhibiting one potential negative behavioral outcome out of the myriad of possibilities rather than the only certain outcome.

Creeden (2006) and Perry (2006) state that sub-optimal early life attachment interactions result in deficits in neuro-development, neurological functioning, and language development. The poor quality of the attachment relationships observed and understood in this group of youth result in them lacking in the "…most important mitigating factor against trauma-induced disorganization" (van der Kolk, 2003, p. 294). Difficulties in their ability to regulate emotions, maintain interpersonal connections, and experience intimate relationships (including sexually intimate relationships) result from neurobiological impacts associated with insecure attachment patterns and traumatic childhood experiences (Creeden, 2004; Rich, 2006).

Looking through a developmental lens assists us to understand why youth who sexually abuse are different from adult sex offenders, and provides us with an understanding that punishment and treatment approaches for both populations should be different. By utilizing the developmental lens, youth can be posited to have deviated from a healthy developmental pathway and require a therapeutic response designed to restore them to that healthy track. For a small number, containment may assist in ensuring no further harm is caused to vulnerable people around them. However, in this paper we assert that, for the majority of young people, well-designed treatment and rehabilitation without containment should result in the same outcome. While any committed sexual assault – whether committed by an adult or an adolescent – is one too many, and should not be tolerated, the focus of sanctions for youth should revolve around rehabilitation rather than containment, in the majority of cases. Clearly, a response to youth sexually harming others based solely on criminal sanctions and confinement for all does not adequately allow the incorporation of a developmental lens.

Contain and Treat. A Residential Approach to Treatment: Victoria, Australia and the U.S.

In the United States during 2003, approximately 1.3 million youth under the age of 18 were arrested (U.S. Dept. of Justice, 2004), and over 130,000 were placed in secure residential facilities (Lambie, Robson, & Barriball, 2010). Lambie and colleagues assert that U.S. criminal courts have increasingly relied on residential programs to provide (a) treatment opportunities due to the lack of community based programs, and (b) containment due to fears regarding community safety and management issues in the community context.

In the United States, there seems to be a "see-saw." On one hand, an increasingly punitive "law and order" agenda has led to greater demands on government through its law enforcement agencies to crack down on crime, contain youth, and provide a harsher response to youth who break the law. From this point-of-view, youth who sexually offend may be seen as deviant, and in need of punishment and containment, as well as regulation, through their inclusion on sex offender registers. Additionally, from time to time, particularly heinous sexual crimes committed by youth result in public outcries and campaigns calling for youth to be tried as adults to ensure they receive a higher level of punishment. On the other hand, some regions of the United States have been moving away from this response to youth, instead advocating for and introducing more developmentally appropriate punishment and treatment strategies, such as California, Massachusetts, and Colorado. In this case, such strategies might include trauma-reduction focused treatment in secure group programs (for example, Germaine Lawrence school for girls, NEARI school, MA, and Whitney Academy, also in Massachusetts).

In many instances, U.S. residential treatment programs are semi-secure facilities providing live-in services to between 6 and 200 youth (however, the majority of residential programs tend to be on the smaller size, averaging 20 to 50 youth), with schooling and treatment often provided on-site. Youth may be several hundred miles from their homes and as a result may have limited contact with their families and no contact with their communities. Costs for this model of containment and treatment commence at approximately $130,000 per youth per annum and are more usually in the $200,000-plus per annum pricing range. Clearly, this cost places a high burden on the community as funding is generally provided by government agencies and departments, with money raised directly through the taxation system.

In Australia, during 2008-9 approximately 103,000 youth under the age of 20 years were recorded as criminal offenders (Australian Bureau of Statistics, 2009). Youth offenders comprise nearly one-third of the total offender population, and are over-represented by population by a factor of two. In regard to specific rates of offenses recorded for sexual assault by youth, for those under 20 years of age the offense rate is approximately 50 in 100,000 (Australian Bureau of Statistic, 2009). Currently, it is estimated that approximately 500 youth require treatment for sexually abusive behavior issues each year in the state of Victoria, Australia.

In regard to residential facilities, it has now been several decades since Victoria "de-institutionalized" its mental health and child and youth services. At that time, there was a shift from traditional large scale lock-down residential facilities to a model of "group homes" more representative of a home-based model of care, with small numbers of youth being cared for by professional staff within the community. Among a total of approximately 5000 youth receiving services from the Victoria child protection system, approximately 10% (500) reside in the residential out-of-home-care system on any given day, in which the majority reside in group homes with between 1 and 5 youth, staffed by professional carers on a roster system. The cost of providing such care varies; however, the general cost is between US $120,000-$200,000 per child per annum. While only a small percentage of these 500 youth exhibit sexually abusive behaviors, regular audits of client presenting issues, as well as incident reports received from residential units, make it clear that sexually abusive youth are over-represented in these settings with placement often more related to difficulties associated with housing them within foster care and family based environments due to perceived risk issues.

Unlike American residential facilities, this Australian residential model does not include a treatment component – it is simply focused on housing youth who cannot reside in their own homes, a kith and kin placement, or a foster care setting. Additionally, the model exists within the State Government Child Protection framework as opposed to a youth justice (criminal justice) framework, as in many U.S. and other Australian jurisdictions. Within the model used in the state of Victoria, youth entering the residential housing system do so only if they are at risk to or from others in their former home settings. However, sexually abusive youth who reside in residential settings are able to access treatment, although this is not attached to nor provided by their residential placement.

A Changing Response to Sexually Abusive Behaviors

While Victoria – and generally Australia – tends to follow U.S. trends, a number of reasons explain why therapeutic responses to young people who sexually harm have primarily replaced criminal sanctions in Victoria. Nevertheless, the reasons initially had less to do with "enlightened thinking" based on principles of child developmental, and rather more to do with frustrations arising from inadequate legal sanctions regarding these youth and the practicalities of getting non-mandated youth into treatment.

The Problems of Tying Treatment to Criminal Sanctions

At what age do children understand that what they are doing is right or wrong? Australian jurisdictions have a uniform minimum age of criminal responsibility of 10 years. However, additional to the legal age is a concept known as *Doli Incapax*,

a legal determination of whether youth can be charged, based on their understanding of whether their behavior was *seriously* wrong. For youth up to the age of 14, a determination that they do not understand the severity leads to criminal charges being dropped prior to being tried in court (Australian Institute of Criminology, 2005). Mainly due to *Doli Incapax* findings, the conviction rate for sexually abusive youth aged between 10 and 14 years was extremely low. However, without a criminal justice-mandated treatment order it was unusual for both the families and the youths themselves to commit to treatment, in which the prevailing attitude was "If it wasn't proven in court, it didn't happen." Thus, the system required a better pathway into treatment that was not solely reliant on justice system mandates.

Consistent with adult concepts of crime and punishment, as community awareness of youth who sexually harmed grew (once they reached the age of criminal responsibility in whichever country they resided), these youth became subject to the criminal/juvenile justice system of that country or locale. In Victoria, Australia, this meant that children aged 10 and above who sexually harmed other children faced criminal sanctions. And, up until 2007, this was the *only* way into state-funded treatment programs. This legal process was also their only way into what was then known as a "sex-offender treatment program." Alongside this process, if the young person had assaulted a sibling, or had non-victimised siblings residing in the home, then he or she would have to leave the family home prior to a treatment service accepting the referral. This would occur without assessment, and was ideologically based upon adult models of understanding sexual crime.

Why Focus On Youth Who Sexually Harm?

It is now accepted that child abuse by strangers occurs at a much lower rate than abuse by family, friends, and people known to the victims. Additionally, despite a perception that fathers and step-fathers are the main perpetrators of this abuse, the majority of intra-familial abuse is perpetrated by siblings, with over 70% of sexual abuse perpetrated by first-time adolescent offenders (Rayment-McHugh & Nisbet, 2003). Given these rates of sexual abuse involving children and adolescents, it is clear that treatment and management strategies must address the issue where most needed.

New Legislation: The Children, Youth and Families Act

Introduced in 2005, the CYFA (Victorian Consolidated Acts, 2005) contained important legislative changes to how reports of sexually abusive behavior were processed by the child protection system. Rather than focusing solely on children "at-risk" of physical, emotional, and sexual harm being perpetrated upon them as the previous act had done, the new act had substantially changed to the point where it not only considered physical, sexual, and emotional harm to children, but also importantly incorporated the concept of developmental harm. A young person who had sexually harmed others was now seen as him or herself in need of a protective response by the child protection system and, vitally, that young people who sexually harmed others were in need of therapeutic treatment that would enable them to manage their sexual behaviors and return to a healthy developmental pathway.

Thus, CYFA (2005) established the authority to protectively intervene in situations involving young people with sexually abusive behaviors. While the Act allowed most youth to attend treatment voluntarily, under section 248 of the Act courts were also able to issue a Therapeutic Treatment Order (TTO) directing a young person aged between 10 and under 15 years with sexually abusive behaviors to attend an appropriate treatment program. No criminal order, or indeed, further legal action, was required. The purpose of the TTO legislation was to provide young people with every opportunity to access treatment without criminal justice intervention.

Now You Have the Framework, Set Up the Service System

As previously stated, prior to the TTO (Therapeutic Treatment Order) legislation being enacted, the only formalized pathway into treatment was through a criminal justice order. While the enactment of TTO legislation was obviously a positive shift developmentally, inasmuch as it provided a framework by which to enable treatment, the service system that provided such treatment still did not exist on a scale that would allow a comprehensive response and provision of treatment to several hundred youth exhibiting sexually abusive and problem sexual behaviors per year. By placing the treatment of youth into the realm of government funded programs, there was a clear need to provide a state-wide cost-efficient and cost-effective system that could be set up and maintained over the long term, and was not seen as competing for money with long established victim/survivor focused services. How was this to be achieved?

The state of Victoria has a well-established programmatic response to the needs of victims and survivors of sexual assault and sexual abuse. Initially set up in the 1970s as Rape Crisis Centers, these feminist-based advocacy centers eventually developed into a state-wide system of Centers Against Sexual Assault (CASAs) and child-focused, hospital-based services (e.g., Gatehouse Centre, Royal Children's Hospital) that expanded to offer counseling and therapy, as well as advocacy. Currently, there are 15 such centers across the state, ensuring that access is available in both metropolitan and remote rural regions. The CASAs are non-government organizations funded by the state health system, and as such offer no-cost services to their clients. A small number of not-for-profit children's counseling services also offer no cost counseling to child victims of sexual assault, including the Children's Protection Society (CPS), the Australian Childhood Foundation (ACF), and Berry Street.

Prior to the introduction of the TTO legislation, several CASAs had recognized the link between a history of childhood sexual abuse and later sexual acting out in childhood and adolescence, and had set up community-based programs for youth exhibiting both sexually abusive and problem sexual behaviors. Although youth aged 10 years and over still required a criminal order to access the services, and there were issues when youth resided with sibling-victims or potential victims (leading to "Sophie's choice" type decisions for parents), the programs were – on the whole – very successfully providing treatment to youth with SABs and PSBs. Thus, while somewhat controversial given the feminist ideological underpinnings of sexual assault centers, the CASA system expressed interest in providing sexually abusive behavior treatment services (SABTS) across the state, to both children under 10 years of age (problem sexual behaviors) and youth aged 10-14 years (sexually abusive behaviors) in the legislated TTO treatment model. In this way, the SABTS system ensured a "seamless" response to all children and youth up to 14 years of age.

Actually, placement of treatment services for sexually abusive youth within the CASA system was an inspired idea. Rather than having to re-invent a system and fund stand-alone services for treatment of sexually abusive youth, by placing the treatment within the CASA system a state-wide response was ensured. Additionally, the existing workforce had great expertise in working with children and young people in general, and was immediately able to provide service to very young children through to adolescent youth.

However, there were many more sound reasons to place the TTO response to sexually abusive youth in the CASA system. It allowed the voice of the victims – and their experience – to remain salient within the treatment of the sexually abusive youth. Given the great experience of the CASA workforce in working with victims and survivors of sexual abuse, there was also the ability to have the victim/survivor perspective "in their heads," as well as the needs of the sexually troubled youth. This dual perspective added another dimension to the work with youth exhibiting sexually abusive behavior.

The Assessment and Treatment Model

With the legislation in place it was important to provide a best-practice model of assessment and treatment as suggested by current research (.e.g., Burton, 2013; Prescott & Longo, 2006; Rich, 2006, 2009). Given that treatment was to be undertaken solely within the community, it was important to first adequately assess the severity and duration of the sexually abusive behaviors in order to form an opinion of what treatment was necessary, and what level of risk was posed by the particular youth being assessed.

Niels Bohr remarked that "prediction is very difficult, especially if it's about the future," which helps us to understand that – in terms of risk prediction - we are extrapolating from past events what may occur in the future. Further, risk prediction and assessment of children and adolescents must also consider the additional task of determining what will effectively return a youth to a positive (i.e., non-offending) developmental pathway. As such, in assessment we are considering five questions related to future risk:

1. Who is at risk of being victimized?
2. What are they at risk of?

3. When is the risk likely to be present?
4. Why is there potential risk?
5. What do we need to do to enable the youth to manage the risks identified in questions 1 to 4?

A Brief Description of the Treatment Model

Any selected treatment paradigm must at its core be flexible enough to accommodate the developmental needs of all children and young people and their families; able to include children with learning and language disabilities/difficulties, developmental delays, and intellectual disabilities; and, able to accommodate both mandated and non-mandated clients, and able to provide the same treatment model to both groups.

Providing a detailed description of the treatment model in use in Victoria is beyond the scope of this article. However, work with children and young people with SABs and their families embraces and is an adaption of the *Four Pillars of Trauma-Sensitivity (Sanctuary)* model (see Bloom & Farragher, 2010), a trauma-informed model that emphasizes the development of supportive and safe therapeutic communities. In application, use of this model addresses the deficits that underpin the sexually abusive behaviors rather than just the behaviors themselves.

Delivered to children and adolescents in community-based care (such as natural homes, foster care, community group homes), the treatment model has an expected duration of twelve months broken into several phases, and is comprised of group work and individual work that is dependent on each youth's progression and engagement in treatment. Additionally, it is vital throughout treatment to include family members and/or caregivers whenever safe and appropriate to do so, as in community-based care, much, or most, learning will occur in the youth's living environment, rather than in the 1-3 hours of work with the therapist each week. Therapists must not only see themselves as supporting their clients' learning to manage their sexually abusive behaviors, but also as a support for the family of the young person in treatment.

To Separate or Not: Can Sexually Abusive Young People Stay at Home?

A key issue that has caused consternation for treatment providers and child protection practitioners involves questions about what factors precipitate decisions to either keep a young person who has sexually abused a sibling within the family home versus removal of that youth. However, it is only in the past 5 to 6 years that this choice point has moved from one stemming mainly from the family violence field (in which treatment providers would not work with victims who were still residing with "offenders") to one based on assessment of actual risk, or the potential that the "offender" in the home will re-offend the victim. Nevertheless, at times questions appropriately arise as to what constitutes the framework for assessing risk. Perhaps basic to any question about risk, is risk purely physical and/or sexual, or does it and should it also encompass emotional risk, where, for instance, a child who has been abused sees her or his abuser still residing in the same house as them.

Thus, a first consideration in assessing this situation must be ensuring that the abused child is receiving support and counseling from a professional who understands sexual abuse, and feels safe in his or her home. Nevertheless, it is easy for an inexperienced, uninitiated, or non-savvy therapist to misunderstand how easily a young person can submit to unspoken pressures from adult family members to not "tear the family apart" or cause undue hardship to their family group (see Summit, 1983, accommodation syndrome, for a more comprehensive discussion of the dynamics at play for young children who are abused). These feelings may be based on a quite accurate assessment of the difficulties families face when one child is removed, and thus familial resources are split in attempting to support siblings who may now reside in varying locations.

A second issue to consider is the actual relationship between the child who has sexually abused and the victim of that abuse. While from a top-down, or adult, perspective it may seem that an abusive sibling would not have a positive relationship with his or her victim(s), it may be that the abuse was the unwanted 5% of the relationship, but also that the other 95% of the relationship was quite valued. We – in our roles as treatment providers – have on many occasions heard a child exclaim words to the effect that "I wanted it (the abuse) to stop, but I didn't want this (the separation) to happen." Removal of the sexually abusive sibling may then place the victim of the behavior into a situation in which he or she feels responsible for breaking up the family.

There are still other issues to consider in the assessment of safety:

- What factors, relationships, or circumstances in the home environment might either enable or support a high risk situation in which further abuse may occur, or promote a safe environment for all family members?
- Are parents and other family members aware of the youth's potential for, and actual perpetration of, sexually abusive behaviors?
- What has been the reaction of the parents to the disclosures? Adult family members may have varied reactions, with initial reactions ranging from minimization and disbelief to extreme anger and revulsion regarding the behavior – or directed toward the youth engaging in the abusive behavior. These reactions may change after the initial shock has diminished.
- Is there a highly sexualized family environment (Is pornography accessible by children? Do parents/adults in the home engage in sexual activity in front of children? Are there discussions of sex beyond what is developmentally appropriate for the children?).
- Are there distorted family expectations regarding gender, particularly if family culture links masculinity to positive views of aggressive sexual activity and denigration or devaluing of women and children?
- Have any adults previously been convicted or charged with sex offenses?
- What parenting style is utilized in the home? For instance, is it permissive and disempowering of authority, in which a child may not have learned to respect boundaries and/or lacks caring or concern about the feelings and views of others?
- Is the sexually abusive youth "privileged" within the home, perhaps resulting in a sense of over-entitlement?

More concrete concerns that, of course, must also be taken into consideration regarding safe placement of the sexually troubled youth include the duration and severity of the behaviors, the ability of the youth and his or her parents to manage emotional and behavioral dysregulation, and the ability of the parents to physically supervise the ongoing situation.

Considerations for Success in Community Treatment

Independent of the youth's safety in the home or community, there are a number of other markers for determining whether treatment has a good chance of being successful within a community setting. While it obviously helps when a youth is willing and able to engage in treatment on a purely voluntarily basis, we recognize that the carrot and stick always plays a role in the background in these cases. The carrot is the possibility of remaining in the home, a deferral of criminal charges, and eventually (via treatment) the setting aside/dropping of the criminal matters. The stick is that if a youth does not engage in treatment, criminal sanctions will likely be imposed/re-imposed, and this includes the possibility of facing registration as a sex offender. Factors that foster success are briefly discussed below.

Good assessment assists our understanding of each case. It is vital that assessment formulation accurately outlines the issues to be dealt with in treatment. Assessors should consider that the sexually abusive behaviors are symptoms of underlying issues. Thus, multi-session and multi-source assessment is required, involving the youth, the family, and other key persons and domains in his or her life. All should be explored and considered.

Inclusion and a holistic approach to treatment. Ongoing therapeutic work must place youths within the context of their broader lives. At times, youths who have sexually abused have been treated in a vacuum, placing them, not *at* the center of the issue, but *as* the issue itself. Dysfunction, trauma, and developmental context are not recognized within such a vacuum. Alternatively, holistic therapeutic work provides the best chance of a successful outcome, in which the family – whenever safe to do so - is also included in the therapy.

Attached carers. Effective carers understand the youth with whom they live and whom they will most likely continue to parent. Attached carers provide an emotional "safety net." They "get" the personality and the uniqueness of the youth. Without this type of attached, connected, and caring relationship, youths may feel that the world has given up on them, and so give up on themselves.

A committed treatment tea. A committed treatment team is also vital for success. Committed, understanding, and trauma-savvy treatment providers do not give up at the first sign of resistance or a display of problem behaviors. Rather, they see these moments as windows of opportunity to work with the youth toward a different outcome, and thus help create altered neurobiological pathways.

A "Good Lives" framework. While the Good Lives model (e.g., Ward & Stewart, 2003) is an adult sex-offender treatment model, a good lives philosophy certainly has a place in the successful treatment of youth exhibiting sexually abusive behaviors. Briefly, the good lives model considers that (adult) sexual offenders are most likely to be effectively rehabilitated when a central part of their treatment focuses on social and personal goals that they themselves desire, and acquiring the skills to overcome barriers to pro-social social and personal success and/or satisfaction. Similarly, youths should be taught to meet their wants and needs in a healthy and pro-social manner, in which others are not objectified or abused for personal satisfaction or any other reason, and youths in treatment must themselves be treated with dignity while reaching for these goals.

Considerations for "Non-Success" in Community Treatment

We can not only point to factors that increase the chances for successful treatment, but can as easily point to factors that impede, or even prevent, effective treatment in the community environment.

Outdated or reactive crisis plans. Crisis driven plans should be just that – short interventions designed to moderate and manage a crisis. At times, however, crisis plans are put into place but are not adjusted once the crisis is over. Indeed, the longer-term goal of the crisis plan is not simply to immediately prevent dysregulated behavior, but also to create "teachable moments" by which the youth and treating staff can learn before the behavior arises again.

The tyranny of distance. Rural and isolated settings present greater barriers to treatment success than metropolitan based services. The lack of rural resources, long travel times that inhibit regular treatment meetings, and the sole worker model in rural treatment agency settings are all problematic. This work is difficult and good supervision and peer interaction is vital. The experience with the TTO (Therapeutic Treatment Order) model has been that when a sole worker model is employed in a rural setting, the worker may suffer burnout within a year and leave. The relationships he or she has built up with their clients, as well as their gained experience, is then completely lost and difficult to replace. Good supervision, peer interaction, and ongoing support within their agencies are vital for members of the rural workforce.

Conduct disordered youth. A young person who engages in multiple types of crimes and happens to commit sexual crimes as part of this general pattern of antisocial behavior may require a different treatment approach, and potentially a higher level of containment than offered in a community treatment model. Focusing on sexually abusive behaviors and ignoring all other criminal behaviors may not make sense and reduces the potential for a positive outcome. Assessment should identify what treatment interventions, over and above those aimed at management of sexually abusive behaviors, are required for conduct-disordered youth.

■ Outcomes: 2007-2012

A recent state-wide data audit of clients who entered treatment between the commencement of the SABTS (Sexually Abusive Behavior Treatment Services) program in 2007 and early 2012 indicated the generally promising outcomes accomplished by the community treatment model. Between 2007 and 2012, 1611 children and adolescents were served, the majority of whom fell into the 10-14 year age group and most male. Services were consistently spread across both rural and metropolitan regions of the state, in which almost one-third of clients reside in rural Victoria.

Approximately 12.5 percent of clients were identified as suffering a disability, among whom the four most common and distinct categories were autism/Asperger's syndrome, ADD/ADHD, developmental delay, and intellectual disability. It is a sad fact that these four groups are consistently over-represented in populations of youth who sexually harm others. While work has progressed in regard to treatment for youth with intellectual disabilities (Ayland & West, 2003; Blasingame, 2005; Briggs, 1995; Creeden, 2004, 2006), it is only recently that we have seen the development and emergence of treatment considerations for ADD/ADHD youth and youth whose social functioning falls within the autism spectrum.

Even though the data set is incomplete due to data recording constraints over the time period, with data for a total of 831 served youth, the data set is nevertheless large enough to show trends. The data for case outcome shows that over 92% of clients fully, substantially, or partially reached their goals of treatment (73% either fully or substantially), a figure consistent across gender. When measured across age groups, outcomes indicate that treatment success is highest for the 0-9 year age group, among whom approximately 88% of clients fully, substantially, or partially reached their goals of treatment (79% either fully or substantially). Among the 10-14 age group approximately 91% of clients fully, substantially, or partially reached their goals of treatment (68% either fully or substantially).

While perusing these figures, it is important to keep in mind that the goals of treatment encompass far more than managing to not sexually harm another person, with anecdotally reported low sexual recidivism rates. For example, only 5% of females and 8% of males fall into the "no treatment goals reached" group. If we posit that these youth, who failed to achieve their treatment goals, may also continue to engage in sexually abusive behaviors, these figures sit within the well-established recidivism rates for youth who sexually harm, which, in the United States, is typically in the 10-15% range (see, for instance, Reitzel & Carbonell, 2006). However, SABTS sexual recidivism rates have not been reported because the number of youth who have been re-charged due to recidivism may not accurately reflect the actual recidivism rate, given the issue of underreporting of sexual abuse in the community.

As shown by outcome data, this lower cost, community-based treatment model offers a promising alternative to long term, secure, or "lock-down" residentially-based treatment, which is both expensive and invasive, as well as severely limiting adjustment to community-based conditions, and which itself has never been proven effective. While further assessment is required, it appears that youth who complete treatment in community-based programs are achieving at least similar results to those treated in more secure and more costly settings. Similar results are being achieved for under $10,000 U.S. dollars per annum per youth as those treated and housed at a cost of over $100,000 per annum.

There are a number of issues remaining to be addressed in the community treatment model, particularly in regard to the cohort of clients resistant to engagement with treatment services. In some cases, these youth may not be subject to any further sanction, an unacceptable outcome given their potential to cause further harm. A second group includes those youth who commence treatment and then, for a range of reasons, "slip away." It remains unclear whether youth in this group have completed enough work in most circumstances to equip them to manage their sexually abusive behaviors, although the limited research that is available suggests that they are at greater risk for recidivism than those who do complete treatment (for instance, Worling, Bookalam, & Litteljohn, 2012). Furthermore, the reason why this group does not complete treatment requires further analysis so that that better ways to bring them back into treatment are formulated.

The Future

Through the provision of an extra $7.1 million in funding over the next four years, written into the 2012-13 State Budget, the Victorian State Government has indicated its confidence in the community-based response to youth who sexually abuse. This additional funding effectively doubles available treatment placements to over 500, and also includes a training budget for the workforce.

■ Conclusion

With the enactment of the Therapeutic Treatment Legislation, the Victorian Government has enabled the development and implementation of an integrated system approach that incorporates all youth up to 15 years of age in community treatment for the issues of problem sexual behavior and sexually abusive behaviors. The low cost aspects of the model provide the best possible chance of sustainability, as long as recidivism rates remain relatively low. Importantly, the treatment appears to be at least as effective in reducing recidivism as residentially-based treatment programs commonly utilized in the United States. Indeed, based on the success of the program, sexually abusive youth aged between 15 and 17 years are being considered for inclusion within the SABTS system.

The SABTS provides a state-wide system that is relatively low cost and as such can be funded without

cutting corners, without over-burdening the state. Furthermore, the community treatment model aims at, whenever possible, either keeping families together safely from day one, or reintegrating families safely and in as short a time frame as possible.

Of significance, the successful community-based program demonstrates that treatment for many youth with histories of sexually harmful behaviour can be provided in the community, with neither the costs nor the artificiality of the highly controlled residential treatment environment. The advantages of community treatment are self-evident – as long as the treatment is effective. Results thus far indicate the effectiveness of the Victorian model.

The move away from residential care to community care reflects shifts in our thinking and approach to treatment, especially obvious when we think of where we have come from over a quite short period of time. We have moved from top-down adult models that potentially treated youth as "mini-pedophiles" to a contemporary view in which we see youth who sexually harm others as veering away from a healthy developmental pathway rather than as sexual deviants. This still evolving shift may not only serve treatment outcomes well, but also be of particular importance for adolescents who may have previously carried the burden of a sexual offense conviction with them, as well as the possibility of sex offender registry into adulthood. Through the effective treatment of these youth, we are working towards ensuring not only the prevention of further sexually abusive behavior, but also the possibility of social success and achievement.

Although penned several hundred years ago, the words of William Shakespeare seem so developmentally appropriate as we apply them to behaviorally troubled youth who have the opportunity to successfully engage in treatment, and thus steer their way back onto a positive developmental pathway: *"Presume not that I am the thing I was."*

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