# A treatment service for adolescent sex offenders

*David Will*

**A case-note survey was carried out on the first 50 referrals to a treatment service for adolescent sex offenders. The average rate of referral was 10.5 per year and all referrals were male. Of those who attended, 66% showed evidence of psychiatric morbidity, while only a minority had a past history of child sexual abuse. The majority had offended against victims known to them. Treatment was labour-intensive with a mean of 19 sessions being provided per patient. Of those taken on for treatment, 2.6% re-offended, while of those not offered treatment, 25% did so.**

A treatment service for adolescent sex offenders was started at the Young People's Unit, the Royal Edinburgh Hospital in November 1988. The Young People's Unit provides psychiatric and clinical psychological services for young people aged between 13 and 19. Its catchment area, which comprises the City of Edinburgh, East and Mid Lothian, has a population of approximately 700 000. It was decided to develop a treatment service for adolescent sex offenders because research indicated that the majority of recidivist adult sex offenders began their offending careers in adolescence (Abel *et al*, 1987). It therefore seemed appropriate to treat adolescent sex offenders in the hope that their offending behaviour could be nipped in the bud before it became entrenched. Although there is a wealth of information about North American treatment programmes (for example, Becker & Kaplan [1993] and Johnson & Berry [1989]), there is very little published about British programmes.

The treatment philosophy of the service is based on cognitive behavioural principles. The primary aim of treatment is to help young people learn to control their sexually inappropriate behaviour. A variety of cognitive behavioural techniques are used and treatment is provided in both individual and group settings.

## The study

A case-note survey was carried out on the first 50 referrals to the service between November 1988 and May 1993 and information regarding demographic data, referral source, characteristics of the offender, the nature of the offence, attendance at first and subsequent appointments, total number of appointments offered and discharge status was obtained.

## Findings

The average rate of referral was 10.5 per year; 19 were referred by social workers, eight by GPs, eight by the adult legal system, four by Children's Hearings and three by child and adolescent psychiatrists. The remaining eight were referred from a variety of sources including solicitors and parents.

All the offenders were male. Their mean age was 15, with an age range of 13 to 19. Forty-seven offenders attended for at least one appointment; only three failed to attend. Six were referred from outside the catchment area. Forty-eight were white, one was of Pakistani origin and one of Chinese origin. This reflects the ethnic composition of the catchment area (General Register Office for Scotland, 1991).

The commonest types of offences were lewd and libidinous behaviour or indecent assault which had been committed by 34. Ten had committed acts of exhibitionism, three attempted rape, three sodomy, one rape, one incest and one shameless indecency. Three had committed more than one type of offence.

Nineteen had committed only one offence, ten had committed two, five had committed three, four had committed four and 11 had committed five or more. Twenty-eight had either committed other non-sexual offences or showed evidence of a conduct disorder.

Of the 47 offenders who attended, 31 showed evidence of psychiatric morbidity, nine had unsocialised conduct disorder, seven socialised conduct disorder, six were mildly mentally handicapped and two were moderately mentally handicapped. Two had a mixed disorder of conduct and emotions, two schizoid personality disorder, one had a simple paranoid psychosis and one suffered from alcohol dependence. In addition, one had a specific speech and articulation disorder.



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Of the 47 who attended, a definite past personal history of child sexual abuse was present in six and was suspected in a further ten. There was no evidence of a history of child sexual abuse in 20. The remaining 11 were not seen for long enough for a judgement about this to be made.

Twelve of the 47 fully acknowledged their offences at initial assessment. A further 24 partially acknowledged them, while 11 denied outright that they had committed an offence.

The commonest type of victims were girls under the age of 12, who comprised 22 of the victims. Thirteen victims were boys under 12, ten were adult women, five adolescent girls, two adolescent boys and one was an adult man. Three of the offenders had more than one type of victim.

Eleven victims were members of the offender's own family and six were members of the offender's extended family. Thirteen were friends or acquaintances of the offender, four were children whom the offender was babysitting and four were co-residents in children's homes or foster homes. Twelve were strangers.

Of the 47 who attended, treatment was offered to 38 and was not offered to eight, all of whom denied that they had committed an offence. One referral was dealt with on a consultation basis only. Of the 38 taken on for treatment, 21 received individual treatment only, five received group treatment only and 12 received both individual and group treatment.

Of the 38 taken on for treatment, 22 received treatment under compulsion. Of these, 12 were on a supervision order from the Children's Hearings with a condition of treatment and ten were on probation with a similar condition. Sixteen attended treatment voluntarily, without formal compulsion. Nineteen of the compulsory group engaged with treatment while three dropped out. In the voluntary group, 11 engaged with treatment and five dropped out.

Twenty-eight have completed treatment and ten are still in treatment. For those who have completed treatment, the mean number of sessions in treatment was 19 with a range of four to 35 sessions. The mean length of time in treatment was one year with a range of two months to three years six months.

Outcome of treatment as measured by repeated sexual offending was as follows. Of the 38 offenders taken on for treatment, one has re-offended. Of the eight offenders who were assessed and not taken on for treatment because they denied that they had committed offences, two have re-offended. All three re-offenders were mildly mentally handicapped.

## Comment

The number of referrals to the service, an average of 10.5 per year, has been surprisingly low. Home Office figures (1989) report that of all offenders cautioned or found guilty of sexual offences, 32% were under the age of 21 and 17% were under the age of 16. More referrals from the Children's Hearing system (the Scottish equivalent of the Juvenile Justice system) might therefore have been expected. However, since no statistics are available for sex offences referred to the Reporters to the Lothian Children's Hearings over the period in question, this must remain a speculation.

Two thirds of the offenders had a psychiatric diagnosis. Thus, 34% suffered from some form of conduct disorder and 18% were mentally handicapped. This suggests that child and adolescent psychiatric services have an important role to play in providing services for young sex offenders.

No female offenders were referred, despite evidence from North America that a small but significant minority of adolescent sex offenders are girls. This may reflect a lag in professional awareness in Scotland and it will be interesting to see if female offenders are referred in the future.

Less than half of the offenders, who were adequately assessed, had a past history of definite or suspected child sexual abuse. This finding suggests that a past history of sexual abuse is not a necessary cause of adolescent sexual offending. This is in keeping with other studies, reviewed by Watkins & Bentovim (1992), who also provide a heuristically useful 'risk index' for predicting which sexually abused children may themselves become perpetrators of abuse.

Of the adolescents referred to the service, 81% were taken on for treatment. The only major exclusion criterion was denial of the offence. There are some indications that legal compulsion may have facilitated offenders' engagement in treatment.

Only 2.6% of those taken on for treatment re-offended, while 25% of those *not* taken on for treatment did so. This could be interpreted as meaning that treatment reduces the likelihood of re-offending. However, it could equally mean that those offenders who were not taken on for treatment – because they were denying that they had committed an offence – are those at most risk for re-offending. It may also be significant that all three re-offenders were mildly mentally handicapped.

This survey has shown that treatment is labour-intensive, with a mean of 19 treatment sessions being provided per patient. It will be important to explore the possibility of providing treatment more efficiently. Good empirical research into the efficacy of treatment programmes for adolescent sexual offenders is needed before it will be possible to judge what form of treatment is helpful for what sort of patient. To this end, the treatment service is now participating in a



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multi-centre trial, co-ordinated by the York Group, designed to evaluate treatment methods for adolescent sex offenders.

## References

ABEL G. BECKER, J., MITTELMAN, M., CUNNINGHAM-RATHER, J. *et al.* (1987) Self reported sex crimes of non-incarcerated paraphiliacs *Journal of Interpersonal Violence*, **2**, 3–25.

BECKER, J. & KAPLAN, M. (1993) Cognitive behavioural treatment of the juvenile sex offender. In *The Juvenile Sex Offender* (eds H. Barbaree, W. Marshall & S. Hudson) pp. 264–277. New York: Guildford Press

GENERAL REGISTER OFFICE FOR SCOTLAND (1991) *Census 1991*. HMSO.

HOME OFFICE (1989) *Criminal Statistics for England and Wales (1989)*. HMSO.

JOHNSON, T. & BERRY, C. (1989) Children who molest. *Journal of Interpersonal Violence*, **4**, 185–203.

WATKINS, B. & BENTOVIM, A. (1992) Sexual abuse of male children and adolescents. *Journal of Child Psychology and Psychiatry*, **33**, 197–248.

David Will, *Consultant in Adolescent Psychiatry, Edinburgh Healthcare Trust, The Young People's Unit, The Royal Edinburgh Hospital, Tipperlinn Road, Edinburgh EH10 5HF*

# Child in-patient treatment and family relationships

*Jonathan Green*

**Residential child psychiatry units inevitably offer a form of temporary parenting to their patients. This paper explores various effects of this 'parenting' task on the treatment process itself and on a unit's relationship with parents. The potent therapeutic opportunities as well as potential unwanted effects deriving from this role are described. An awareness of the processes involved along with appropriate case management can maximise the benefits and minimise the unwanted effects of this factor within in-patient treatment.**

As with any residential environment for children, the in-patient child psychiatry unit has a number of basic legal responsibilities for care *in loco parentis*. Given our therapeutic task and the fact that so many of the problems we see involve problems in child-parent relationships, this 'parental' role of the ward is bound to become elaborated, and itself a factor in treatment. In addition, the creation of a ward treatment milieu inevitably involves various levels of parent-like activity from ward staff - although there has been debate throughout the history of in-patient units about how this should best be done. (Green 1992, 1993; Wardle, 1991; Hersov & Bentovim, 1985).

While different therapeutic orientations may emphasise or minimise the unit's 'parental' function (for instance recent developments in the theory of child in-patient treatment towards 'minimal intervention' and the shorter stays (Harper, 1989; Nurcombe, 1989) will tend to minimise it), I believe that any in-patient unit which aims to do more than the briefest containment work will be faced with the need to address childrens' often deep attachment to a ward and the effect of this on families and a therapeutic relationship with parents.

Understandably, there is sometimes professional concern about in-patient treatment for children centring around just these issues, including the effect of separating children from their families; staff on in-patient units are often similarly preoccupied by their 'parental' role and the impact of admission on family life. On the other hand, residential treatment is usually undertaken within the context of very serious need, and has the potential for intensive and deep therapeutic work with families as well as children. I want to address these paradoxes in this paper. I outline a number of common stages in the development of the unit's relationship to families observed during admissions in my unit, suggesting the therapeutic potential as well as possible unwanted effects associated with them. I will also discuss steps in clinical management that may maximise the advantages and minimise potential disadvantageous effects of these dynamics.

## Stage 1: admission and engagement

The moment of admission is a major event for both child and family. I do not think any amount



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