ATSA Blog...
Association for the Treatment & Prevention of Sexual Abuse

Friday, December 29, 2023

Problematic sexual behaviors as a juvenile outcome measure

By **Norbert Ralph, PhD, MPH**

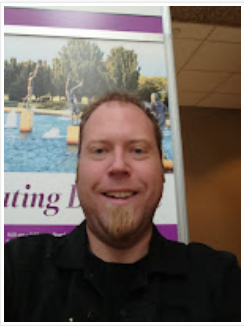
For juveniles who sexually offended (JwSO), sexual recidivism is identified as one of the primary outcome measures. Reitzel and Carbonell (2006) titled their meta-analysis of treatment programs "The Effectiveness of Sexual Offender Treatment for Juveniles as Measured by Recidivism." Methodologically and clinically using this measure has virtues but also limitations. With sexual recidivism rates in some researchers estimated to be about 5% (Lussier et al., 2023) it would be difficult to obtain samples large enough to detect a treatment effect. Also would a reduction from 5% to even 0% be significant enough in terms of real-world impacts and cost/benefit considerations?

Other outcomes have been used. Nonsexual recidivism has been identified as another benchmark to assess treatment outcomes. Lussier et al. (2023) identified general recidivism for this population as 44% and Caldwell (2016) as 27% in meta-analytic studies. General recidivism has been a focus of study, and for example, Abei et al. (2022) carried out a study of high-risk JwSO youth to compare the efficacy of sexual offense-oriented therapy and social skills training in the prevention of both sexual and general recidivism. Further, the Multisystemic Therapy group used out-of-home placements, among other measures (Borduin & Munschy, 2021).

Another benchmark for juveniles who sexually offended is examining problematic sexual behaviors (PSB) that may not result in arrests or formal recidivism. Viljoen et al. (2007) reported a rate of such behaviors in a residential treatment program with 169 JwSO youth of 16.6% and an average JSORRAT-II score of 6.1. Ralph (2015) in a study of another residential treatment program with 129 JwSO youth reported a rate of PSB of 20.6% and an average JSORRAT-II score of 6.3. The average JSORRAT-II scores (6.1 and 6.3 respectively) of the samples indicated that both groups above the average risk levels (Epperson, 2019). In the latter study (Ralph, 2015), any sexual behavior that violated the rules of the setting was classified as misbehavior. Notably none of these behaviors resulted in charges, even though some were serious enough to be charged. Presumably, this was considered not necessary because these youth were already on probation for such offenses and were in court-ordered treatment. For context is important to note findings such as Ybarra & Mitchell (2013) which identified nearly 1 in 10 youths (9%) reported some type of sexual violence perpetration in their lifetime.

Another example including PSB is in Letourneau et al. (2009), which reported an outcome study regarding Multisystemic Therapy (MST) using the Adolescent Sexual Behavior Inventory (Friedrich, Lysne, Sims, & Shamos, 2004) and its Sexual Risk/Misuse subscale. Because of the nature of the scale, specific PSBs weren't possible to separate out, such as coercing others to have sex. Abei et al. (2022) in the study mentioned previously, classified as sexual recidivism not only formal charges but also PSB that may have resulted in a formal charge but

Kieran McCartan, PhD



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did not. However, the rate of such PSB separate from charged offenses was not separately described.

The above information has several implications regarding assessment and treatment for these youth. One is the recommendation that such behaviors be included in outcome studies assessing treatment effectiveness and also for individual programs as part of their quality assurance procedures. These behaviors are important to address since they may have victims too and likely increase the risk of future such behaviors. Once identified, these behaviors are more likely to become an explicit focus of treatment. Notably, the Abei et al. (2022) study has already included PSB. Also, PSB may be tracked systematically in future MST studies

There is another consideration. It might be possible to develop risk measures to assess for PSB that do not result in formal charges. For example, in the study by Ralph (2015) youth examining PSB, who had a male victim and previous mental health treatment had an AUC (Area Under the Curve) of .74. Practically, developing risk measures to assess for PSB might be more possible than developing measures to assess sexual recidivism alone, given the low sexual recidivism rates. Clinically, such measures would be useful to assess the risk of a given youth for sexual acting out at the beginning of treatment, particularly for high-risk youth, so that treatment methods and the amount of treatment could adequately be planned.

Posted by SAJRT Blog at 2:38 AM No comments:

Wednesday, December 13, 2023

Ethical considerations of the financial cost of resources on harmful sexual behaviour services

By **Sophie King-Hill, Ph.D., University of Birmingham**

In many harmful sexual behaviour (HSB) services for children and young people (CYP) how resources are funded, developed, and delivered is coming under increasing scrutiny as frontline and third sectors organisations are having budgets cut and services reduced. Given this context, is it ever ethical to charge for these resources?

Preventing and responding to (HSB) in children and young people forms a significant proportion of the work social services, the third sector and social justice organisations carry out. Due to this there are many tools, assessments and interventions (referred to as resources) that have been developed that make a tangible and positive difference to the lives of CYP and their families. This, and the other points made in this article, also hold true for the adult criminal justice field, but it is beyond the scope of the authors expertise to discuss these in-depth and the focus will be on HSB services for CYP.

When considering HSB the moral philosophy appears to be underpinned by the reduction and prevention of sexual abuse and harm and the promotion of well-being and recovery. So the reduction of harm and the maximising of benefits. Ethics are often highlighted in practice in terms of work carried out with CYP and their families and of the practice that is delivered, and the research that is conducted. Yet these ethical considerations are sparse when considering products that are commissioned and used.

At face value the ethical principles of HSB work may appear clear-cut (i.e., work in a trauma informed way, do no harm, protect the patient/service user). However, after scrutiny, the lines seem blurred. This field is inhabited by professionals from a range of specialisms and fields (i.e., sociology, psychology, criminology, social work, police, probation, prisons, social care); therefore, HSB services are a multi-disciplinary, multi-agency area that exist at a crossroads between practices, policies, and processes. This means that the ethical considerations are somewhat complex as no core set values and principles exist as they do in medicine, law or criminal justice for instance. In social work for example, there is an explicit commitment to human dignity and worth. In medicine there is a framework that is built around doing good and no harm, free choice, justice and fairness. These are ethical principles in which professions are bound - being built around trust and held to account by bodies such as the General Medical Council.

Whilst a multi-agency approach is clearly needed for HSB, a by-product of this way of working is that no steadfast and explicit ethical principles exist due to the range of

The Association for the Treatment of Sexual Abusers (http://atsa.com/) is an international, multi-disciplinary organization dedicated to preventing sexual abuse. Through research, education, and shared learning ATSA promotes evidence based practice, public policy and community strategies that lead to the effective assessment, treatment and management of individuals who have sexually abused or are risk to abuse.

The views expressed on this blog are of the bloggers and are not necessarily those of the Association for the Treatment of Sexual Abusers, Sexual Abuse: A Journal of Research & Treatment, or Sage Journals.

specialisms involved. This lack of a sense of measure, accountability and consistent public pledge has perhaps created an environment where profitable endeavours have gained traction and power without the rigour of adequate ethical questioning. Given that preventing and responding to HSB is both social justice and social care work, and given the rise of health approaches and thinking in the HSB field there is a strong argument that work, including tools and interventions, needs to be framed by social not private enterprises. Therefore, profitability, in its purest form does not seem to align when considering the field of HSB and the underpinning principles of minimising harm and suffering and supporting recovery.

The impact of the financial costs of resources on practice and provision in harmful sexual behaviour services

Consideration needs to be given to the impact of the financial costs of resources. If the costs of resources is not equitable and is the same for all, in HSB services it risks failing CYP and their families for a number of reasons, for example:

If some professionals can access the resource and others can't then this can result in miscommunication and misunderstanding between the differing agencies. Research tells us that multi-agency work is a crucial aspect of positive HSB outcomes, so this has the potential to cause conflict in this space.

If, because of the cost, only a few professionals in one agency can access certain resources then this may also risk the dilution and misuse of what has been paid for. This points to a flawed and unsustainable model – and may also indicate that in social welfare contexts a model based purely on profits may make the overall issues worse, not better.

Training costs will always have to be ongoing if there is a commitment to a certain resource, which again may be unsustainable for agencies with small budgets. High staff turn-over may result in resources not being used adequately as the trained experts will have left. Additionally, when the case loads of those who are trained are full, what then happens to CYP who need support.

The exclusion of CYP and families from accessing services if professionals aren't trained or have knowledge is also inadvertently causing them harm. This runs the risk of a two tier model – even in the same service with some CYP and their families getting good support and others not. When something exists that can make a tangible positive difference to the lives of CYP and their families in an area as damaging as HSB, with no equitable approach, can be measured against ethical principles as inherently morally wrong.

The financial cost of resources can, inadvertently, create a postcode lottery of service delivery and interventions. For example, services in poorer socio-economic areas may not have the resources to pay for resources and therefore CYP and their families maybe excluded from accessing services.

Additionally, consideration needs to be given as to how resources are commissioned and adopted by services and how this is supported by them as well as by government and local authority budgets and spending. If resources are shown to be working and making a measurable difference to the lives of CYP, and their families, then large-scale funding and commissioning should be considered. This may negate the issues with the profiting from damaging social welfare issues that have gained traction.

What can be done?

It is important to consider the role, impact, and purpose of charging for resources on the HSB sector has. If the purpose is to positively support CYP who have sexually harmed or been harmed in an evidence-based way to reduce harm, then of course the materials used need to be based on research as well as expertise. The reality is that costs need to be covered, this is not unrealistic. And to protect their fidelity through this should always be considered. However, questions need to be asked in terms of the level of profitability over social good and where this is ethically situated. A pure profitability perspective still appears ethically flawed in this field and considerations of revenue sacrifice, when bearing in mind the positive impact on people's lives, should be made. Perhaps a case could be made for a 'robin hood' model of working when charging for services in this arena. In its simplest form this means charging those that can afford it more and providing subsidies, resources and free services, to those who can't. This model emerged in the 1970s as can be seen in the work on cataracts by the Aravind Eye Care Hospital in India at this time. Other businesses have followed suit such as Warby Parker (buy one, give one for glasses) and Cotopaxi (donating money for social good from

▼ December (3)

Problematic sexual behaviors as a juvenile outcome...

Ethical considerations of the financial cost of re...

The Second Edition of ATSA's Task Force Report on ...

► November (3)

► October (4)

► September (3)

► August (3)

► July (4)

► June (4)

► May (3)

► April (3)

► March (5)

► February (4)

► January (4)

► 2022 (41)

► 2021 (44)

► 2020 (48)

► 2019 (46)

► 2018 (46)

► 2017 (47)

► 2016 (46)

► 2015 (46)

► 2014 (25)

► 2013 (24)

► 2012 (13)

► 2011 (18)

► 2010 (30)

profits) and is underpinned by increasing social responsibilities of profit-making businesses. With the right policy transfer frameworks in place this application of values and approach can work in the field of resources and interventions that are being charged for in the field of HSB.

Work in field of prevention of and response to HSB is a moral and ethical issue, it is carried out by professionals who, in the main, deeply care and are motivated to help the people they work with, and therefore should be given access to the best resources available, regardless of cost. This is even more relevant in working with children and young people in this space. Therefore, should businesses that trade in this arena be held to account and be bound to shared ethical principles, standards, and safeguards. These principles could be set out in a charter mark for example, that has a clear ethical criterion when making profit in this field that is underpinned by the aim of maximising benefits and minimising harm to CYP and their families. The aim should be geared around considering where they can make profitable sacrifices to maximise benefits and reduce harm - being held to account when this is not evidenced, via an ethical framework. It can be argued that in this field that the outcomes for CYP and their families should be paramount and a recognition first and foremost for the lives of the people who can benefit from services should be at the forefront of any business considerations. That public benefit, as outlined by the Charity Commission, is a key component of work in this area, especially in frontline services (i.e., social work, policing, child protection) that are publicly funded. The landscape, when explored through the lens of ethics, provides a concerning picture of an environment where the lack of consistent ethical principles means there is no bar to measure against. Therefore, when considering maximising benefits and minimising harm, in the field of HSB this lack of accountability runs the risk of becoming incredibly dangerous.

Posted by SAJRT Blog at 10:48 AM No comments:

Friday, December 8, 2023

The Second Edition of ATSA's Task Force Report on Children with Sexual Behavior Problems is now Available

By **David S. Prescott, LICSW & Amanda Pryor**

In 2005 and 2006, I was fortunate enough to be a part of ATSA's task force on children with sexual behavior problems. The task at that time was simple; we would write a report summarizing what is known, and provide recommendations for assessment, treatment, and policy.

Chair Mark Chaffin made the task simpler still. He organized the task force members into three groups, each of which would tackle one of the content areas and produce a section three pages long He would then edit the document and send it on to the board. Not surprisingly, none of the groups could limit their contribution to just three pages, but this clever approach made the process significantly easier, and the result was both comprehensive and concise.

In 2018, ATSA's leadership requested an update to this report. The idea was not to start from scratch, but merely to update the first edition. Again, this seemed like an easy task, but became more complicated along the way, including by significant changes in the office and the onset of the pandemic. The project that started with Phil Rich as the board liaison was then shepherded by Amanda Pryor, who succeeded Phil. Although I had been asked to Chair the task force, the final document reflects collaboration between many players in the task force, the ATSA office,

ATSA's Executive Board of Directors, and its Child and Adolescent Committee.

In other words, both the content and the processes changed over the years, and resulted in a stronger yet more flexible document in an era where the level of scrutiny by stakeholders has only grown higher. This document, which emphasizes person-first language, has been as thoroughly reviewed and considered as any document that ATSA has produced.

What else has changed over the years?

To start, the research in this area has come a long way. Many people are to be congratulated for this. This research has emerged from many areas, from the University of Oklahoma to the United Kingdom.

During the initial review of the first edition, it became clear that we needed more of a focus on trauma and adversity. Anyone working with children and teens has long had an appreciation for the importance of understanding the role of trauma and adversity in the lives of our young clients. However, our understanding of these areas has become much more granular over time. Working with the task force was a great opportunity to reflect on this.

The role of technology has also changed dramatically. When the first task force report came out, the iPhone was still in development, early exposure to sexually explicit media was less common, and social media was in its infancy. Further, the "tube" sites (a generic term for online pornography sites that provide free content) had begun to flourish only at around the same time as the first edition of the task force's report.

It is also important to note that our field's understanding, sensitivity, and appreciation of diversity has also come a long way, in research, professional discourse, and clinical practice. This focus has included considerations related to LGBTQ+ youth and other marginalized communities.

There has been impressive innovation in treatment approaches and modalities. This includes more sophisticated think about family involvement, group-based approaches, and individual therapy. We now have even greater confirmation of the important and very noble role that families and other caregivers can have in helping children emerge into a safer adolescence.

Further, the process led us (and this was really Amanda's contribution) to produce this as a foundational document focusing on assessment, treatment, and placement considerations. Across the coming months, there will be addenda produced to address specific areas. These include considerations in the areas of technology, sexuality, culture, intellectual and developmental disabilities, sibling abuse, policy, and collaboration with Child Advocacy Centers.

Also in the background is knowledge that the document we produced is aimed at primarily North American audiences and that additional materials with more of an international slant would also likely be welcome. While

ATSA is truly an international organization, it also recognizes that North American practitioners can sometimes face unique challenges.

Ultimately, no document can be all things to everyone, but this project, thanks to uncountable numbers and drafts across many years, will hopefully guide many professionals in a more empirically grounded and helpful way.

Download the document: https://www.atsa.com/CSBP-2023

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