Adolescent Sexual Offender Treatment Programmes in New Zealand: A Process Evaluation

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Whiria nga topeki, rarangatia nga kete, kawe mai te hapu, hei ora

Bring together the strands, weave the basket, it will carry the wellbeing of the tribe

Abstract

Adolescent sex offenders are recognised as perpetrating a significant proportion of all sexual abuse in our communities. The results of extensive research in this area have clarified many intervention issues and this has led to the development and implementation of treatment programmes aimed specifically at adolescents. Notwithstanding the publication of a small number of outcome studies, process evaluations of treatment programmes for this client group have not featured in the literature. This dissertation presents the findings of a process evaluation of the three main community based adolescent sexual offender treatment programmes in New Zealand. The evaluation aimed to investigate how the programmes worked so that their strengths and weaknesses could be identified. The findings provided the basis for recommendations aimed at improving service delivery and programme effectiveness. Qualitative methods were employed with data being obtained from in-depth interviews with key stakeholders, direct observation and written documentation across three sites. Results indicate (a) high levels of consumer satisfaction with the programmes; (b) the importance of providing flexible and integrated approaches to treatment; (c) engagement in treatment was facilitated by the quality of the client-therapist relationship, family involvement, culturally appropriate communication, and creative and physical activities; (d) the importance of providing clients with good pre-entry information to reduce barriers to participation; (e) recognition should be given to issues of cultural difference by ensuring cultural services for ethnic minorities are integrated into all levels of programme delivery; (f) the importance of building strong interagency collaborations and public relations; and (g) the importance of strong organisational structure and leadership support for staff. The results are discussed in terms of programme improvement in the New Zealand context as well as their application to programme development and improvement in other settings.

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Chapter One: Introduction

Over the past three decades there has been growing recognition of the extent of child sexual abuse. Accompanying this recognition has been the acknowledgement that the sexual abuse of children is not confined to adult male perpetrators. Adolescents in particular, and also children, are responsible for a significant amount of child sexual abuse (Snyder, 2000) and furthermore, in some cases, go on to offend as adults (Masson & Erooga, 1999). The provision of comprehensive treatment for this population is therefore crucial if we are to reduce the number of victims in our communities. However, despite the fact that the first specialised treatment programmes for adolescent sexual offenders were implemented during the 1980's, there has been little evaluation of these programmes (Prescott & Longo, 2006).

Similarly, in New Zealand, adolescent sex offender treatment programmes have been operating since the early 1990's. Currently, there are ten specialist community based programmes and one residential unit. Services are contracted out to these programmes through the Department of Child, Youth and Family (CYF), a government agency that has statutory powers to intervene to protect and help young people who are being abused or neglected as well as those with problem behaviours. CYF also work with the Police and the Courts in dealing with young offenders under the youth justice system and provide residential and care services for young offenders and for children in need of care and protection (Ministry of Social Development, 2006). Although the New Zealand programmes have been providing specialist treatment to adolescent sexual offenders for over a decade, there has been no systematic evaluation of their treatment services.

In order to address this issue, CYF, in 2003, commissioned a research team (under the auspices of Dr Ian Lambie) to conduct a process evaluation, an outcome evaluation, and a cost effectiveness analysis of the three main community treatment programmes in New Zealand. The programmes are SAFE Network Auckland, WellStop in Wellington and STOP Christchurch (hereafter referred to as Sites 1, 2, and 3 respectively). I was the primary investigator for the process evaluation component of this research project and an author of the final evaluation summary report (Lambie, Geary, Fortune, Willingale, & Brown, 2007). This dissertation arises from my role in that project. As such, I had

responsibility for designing interview schedules, data collection, methods of analysis, and preparation of a report for CYF that specifically focused on the process evaluation (Geary & Lambie, 2005).

This process study aims to investigate how the programmes work so that their strengths and weaknesses can be identified. This is achieved by documenting the operation and characteristics of the programmes, examining clinical practices that seem to contribute to successes and failures, and identifying factors associated with successful programme outcomes. It was envisaged that the process evaluation would provide information to policy makers regarding the quality of the programmes and the extent to which they were meeting the needs of stakeholders. Findings also provide the basis for recommendations aimed at improving service delivery and programme effectiveness.

In the literature, considerable emphasis is given to outcome evaluation to determine programme effectiveness. Despite the growing number of treatment programmes for adolescent sexual offenders, very little outcome research has been published (Chaffin, 2006). While results suggest that interventions can reduce adolescent reoffending behaviour (Fortune & Lambie, 2006a), there are a number of limitations that need to be highlighted. Researchers generally rely on recidivism rates to ascertain treatment effectiveness and this in itself is problematic; recidivism criteria and follow-up periods vary, self-reports are rarely used, reoffending can remain undetected, and there is a lack of matched control groups. Furthermore, the focus on arrests and reconvictions does not take into account any changes that may have occurred in other areas of the young person's life such as improved functioning and relationships.

Our understanding of treatment programmes is further limited by the lack of process evaluations. Process evaluations focus on understanding how programmes work and identifying the particular processes that influence programme operations and outcomes (Dehar, Casswell, & Duignan, 1993). As such, they provide a starting point for assessing the potential effectiveness of programmes (Bouffard, Taxman, & Silverman, 2003). They can also provide information about how or why particular outcomes have or have not been achieved, reveal areas for improving service delivery, and highlight strengths to be preserved. Importantly, process evaluation results can be used to inform other treatment providers who wish to learn from the experiences of the programme (Dehar, Casswell, & Duignan, 1993).

If a programme is found to be successful, detailed information on how it was implemented and what it consisted of is necessary for duplication in other settings. Also, the identification of programme strengths and weaknesses can assist treatment providers in other settings to make decisions about implementing features that worked whilst avoiding those that did not (Dehar, Casswell, & Duignan, 1993). Thus, it is important to publicise findings from process evaluations so that this information is accessible to other professionals working in the field (Wolfe, Guydish, Woods, & Tajima, 2004). However, the paucity of published material in this area is particularly apparent; to the best of my knowledge, there are no published papers in peer reviewed academic journals on process evaluations of treatment programmes for adolescent sex offenders. This study therefore has the potential to make a unique contribution to our understanding and knowledge in this area. As Morrison (2004) points out, in the ever-increasing search for evidence-based practice, the importance of asking young people and their families for direct feedback on their experiences of treatment services and outcomes, may have been overlooked. Process evaluations are particularly suited to provide this kind of information.

My interest in this topic stems from my previous work experiences and an abiding interest in change processes. During the 1980's, I worked for two years in a community agency as a counsellor working with child and adolescent survivors of child sexual abuse. I also worked as a probation officer for 20 years during which time, I interviewed women survivors of child sexual abuse and adult rape for the purpose of writing *emotional harm* reports for the Court. In addition, I prepared Court reports with recommendations for sentencing on adult perpetrators of sexual violence (both male and female), and my caseload responsibilities included the management of high risk offenders, some of whom were sexual offenders. During the course of this work, I had contact with staff from the adult sexual offender treatment programme at Site 1 and for an 18 month period I took on a liaison role between the probation agency where I worked and this particular treatment programme. As a consequence of my work experiences, I came to develop a deep understanding of the effects of child sexual abuse and many of the issues faced by survivors of abuse. While I also learned a great deal about the cognitive and behavioural characteristics of adult sex offenders, I often wondered about the effectiveness of therapy for sexual offending and what therapeutic processes were necessary for bringing about change. This study therefore captured my

interest as it provided an opportunity to gain an understanding of how therapeutic programmes for sexual offenders work through the stories of those involved. Moreover, my knowledge of and familiarity with staff at one site provided ideal conditions for research as this allowed for a direct, personal, and co-operative approach in which status and power differences between these participants and the researcher could be minimised (Patton, 2002a).

Prior to the writing of this dissertation, a comprehensive report of findings (in relation to the process evaluation) was submitted to CYF and the programmes for review and eventual publication (Geary & Lambie, 2005). This dissertation is based on that report. However, it is noted that the report contains site-specific commentary and information about access to treatment for different population groups (specifically, barriers to treatment and possible solutions for removing these barriers) which is not included here. The decision to omit this material from the dissertation was based on the need to take into account the different purposes of and audiences for the report. The current document is intended for a wider audience with a view to informing the direction of best practice for programmes in other settings.

In the following sections of this chapter an overview of the literature regarding adolescents who sexually offend is presented, with a particular focus on theories of etiology and current approaches to treatment. To begin, the problem of adolescent sexual offending is defined and the impact of this on victims is explored. The pathways that lead to such offending are then examined and this provides the basis for understanding the development of current practice with regard to assessment and treatment. Service implementation issues are considered and the chapter concludes by noting the research implications for the current study and outlining its aims.

Defining Sexual Offending

In the literature, the terms abuser, perpetrator and offender are used interchangeably (Calder, 2001). However, in recent years, the particular use of the term *adolescent sexual offender* has been questioned and there have been suggestions that the terms *sexually abusive youth* (Ryan, 1999) or *young people who sexually abuse* (Calder, 2005) are more appropriate. This response reflects concerns that labelling young people as offenders is not only stigmatising but also fails to take into account the developmental

sexual processes inherent in a youthful population. Moreover, from a technical viewpoint, an offender is someone who has been convicted of sexual offences under the Crimes Act (Calder, 2001). At the same time, attention has been drawn to the importance of raising awareness, conveying a strong message to young people who are sexually aggressive, as well as their families, and drawing attention to the serious harm that is caused to victims (Rich, 2003). Some clinicians have favoured the use of the term *offender* for these reasons. Obviously, there is no right answer and the term adolescent sexual offender (ASO) is used in this study in recognition of the threshold that has been reached to warrant inclusion for treatment on a programme. It is used in a generic sense to describe youth whose sexually abusive behaviour is represented by a continuum of behaviours, many of which are prohibited by law (National Adolescent Perpetrator Network, 1993).

In New Zealand, criminal responsibility begins at age 10. Under the provisions of Section 21 of the Crimes Act 1961, a child under the age of 10 cannot be convicted of any criminal offence. Children aged 10 to 13 years can only be prosecuted for murder or manslaughter. When a child aged 10 to 13 years is apprehended for a sexual offence, they may be dealt with by way of a police warning, referral to Police Youth Aid or they may be subject to the care and protection provisions of the Children, Young Persons, and their Families Act (1989). While adolescents aged 14 to 16 years who offend sexually can also be dealt with in a similar fashion, they can also face prosecution in the Youth Court. Serious sexual offending can be transferred to the District Court or High Court for trial or sentencing. On attaining 17 years, young people are no longer dealt with under the provisions of the Children, Young Persons, and their Families Act and any offending is dealt with in the adult court system (Spier & Lash, 2004).

In order to clarify the issue of defining sexual offending for this particular age group, it makes sense to combine legal and clinical perspectives. Experienced consultants, under the auspices of the National Task Force on Juvenile Sexual Offending provide some direction on this subject (National Adolescent Perpetrator Network, 1993). Based on their report, the ASO is defined as a young person aged between 12 and 18 years who engages in sexual behaviour with a person of any age without consent, without equality or as a result of coercion. Consent is an agreement that includes an understanding of the intended behaviour based on age, maturity, developmental level, functioning and experience. It also includes knowledge of social standards for the intended behaviour,

awareness of likely consequences and alternatives, a presumption that agreements or disagreements will be honoured, voluntary decision, and mental competence. Equality refers to issues of power and control. Specifically, two participants engaging in behaviour, with the same level of power and authority so that neither is controlled nor coerced by the other. Coercion involves the exploitation of power or authority, the use of bribes (e.g., money, treats, friendship, favours), intimidation, threats of force or violence to ensure co-operation and compliance.

Adolescent sexual offences cover a wide array of behaviours. *Hands-off* offences include obscene communication (such as phone calls, threats of sexual harm), voyeurism (observing others without their knowledge or permission for the purposes of sexual gratification), exhibitionism (exposure of the genitalia), theft of clothing for sexual purposes, and public masturbation. *Hands-on* offences include frottage (rubbing up against others), penetration (may be oral, digital, anal, vaginal, and involve objects), fondling and molestation which involve touching the genitals, buttocks or breasts for sexual gratification (Ryan, 1991a). In New Zealand, the treatment programmes utilise similar definitions of sexual abuse to inform their work with adolescents who sexually offend (SAFE Network Inc, 1998).

Prevalence

While the exact incidence of sexual offending against young victims is unknown, in the United States it has been estimated that approximately one out of three women and one out of every seven men will have been sexually abused by the time they reach 18 years (American Academy of Child and Adolescent Psychiatry, 1999). Data suggests that a significant proportion of this abuse is perpetrated by adolescents (Center for Sex Offender Management, 1999). Early studies conducted in the United States indicate that around half of adult sex offenders reported sexual offending as adolescents (Abel, Becker, & Mittelman, 1985; Groth, Longo, & McFadin, 1982). While retrospective data from chronic adult offenders cannot be applied as a prediction to all youth who sexually offend, it does highlight an *at-risk* condition (National Adolescent Perpetrator Network, 1993). Alongside recent research indicating that ASO's are distinct from their adult counterparts and that many will not continue to commit sexual offences into adulthood (Center for Sex Offender Management, 1999; Rich, 2003), there appears to be a consistent finding that significant proportions of adult sexual offenders began sexually

offending when they were adolescents (Masson & Erooga, 1999; Rich, 2003). Concomitantly, child sexual abuse victim reports have indicated that between 30% to 50% of all cases of child sexual abuse can be attributed to adolescent offenders (Davis & Leitenberg, 1987). Furthermore, there are indications that many adolescents are repeat offenders (Awad, Saunders, & Levene, 1984; Fehrenbach, Smith, Monastersky, & Deisher, 1986).

Similar to overseas findings, a New Zealand random community study (Anderson, Martin, Mullen, Romans, & Herbison, 1993) found that nearly one out of three women reported one or more unwanted sexual experiences before the age of 16 years. In this study, adolescents aged 18 years and younger were responsible for approximately 25% of the reported sexual abuse incidents. In another New Zealand study, Lambie interviewed 88 adult males who had been sexually abused as children and it was found that 35% had been abused by adolescents (Lambie, 1998). Furthermore, data from New Zealand police records reveal that youth aged 16 years and under, account for approximately 15% of all recorded arrests for sexual offences for the years 2000 to 2005 (Statistics New Zealand, 2005). However, it is difficult to gauge the true extent of the problem given that prevalence statistics rely on reported offences and it is widely accepted that a significant proportion of child sexual abuse is not disclosed. Yet, when we take into account the self-reports of child sexual abuse victims and offenders it is apparent that adolescent sexual offending is a significant and serious problem.

Effects of Child Sexual Abuse

Child sexual abuse (CSA) has profound effects on psychological functioning, both initially and in the long-term. In an early review on the effects of CSA, Browne and Finkelhor (1986) found that in the short-term, the most frequently reported symptoms were fear, anxiety, depression, anger, aggression, and sexualised behaviours. Long-term outcomes associated with CSA included depression, anxiety, self-destructive acts, feelings of isolation and stigma, low self-esteem, inability to trust, substance abuse, a vulnerability toward revictimisation, and sexual maladjustment.

The field of CSA research has since burgeoned and although the conclusions of Browne and Finkelhor (1986) have largely been confirmed, more up-to-date information has enhanced our understanding of the impact of CSA. Documented problems have

included dissociation, withdrawn behaviour, obsessions and compulsions, conduct disorders, interpersonal problems, somatic symptoms, substance abuse, and regressive behaviour (Davis & Petretic-Jackson, 2000; Kendall-Tackett, Williams, & Finkelhor, 1993). Paolucci, Genius, and Violata (2001) conducted a meta-analysis of 37 studies published between 1981 and 1995 involving over 25,000 people. They found that CSA substantially increases the risk for post traumatic stress disorder symptoms, depression, suicide, sexual promiscuity, sexual perpetration, and poor academic performance. In a subsequent review of empirical data published since 1989, Putnam (2003) found that the best documented outcomes associated with CSA are depression and substance abuse in adults and sexualised behaviours in children. Consideration was also given to studies linking CSA to neurobiological alterations.

Although most CSA research has hitherto focused on the impact of abuse on females rather than males, there are indications that both genders respond similarly. A review by Holmes and colleagues, found a high degree of overlap in symptomatology between male and female victims (Holmes, Offen, & Waller, 1997). However, when there are differences, the ones most often reported can be represented by internalising and externalising symptomatology. That is, girls are more likely to adopt internalising behaviours (such as depression and self-injurious behaviour) whereas boys tend to adopt externalising behaviours (such as acting aggressively; Conte, Berliner, & Schuerman, 1986; Gomes-Schwartz, Horowitz, & Cardarelli, 1990; Kendall-Tackett, Williams, & Finkelhor, 1993; Watkins & Bentovim, 1992).

The available evidence makes it clear that there is no one specific sexual abuse syndrome. Sexually abused children vary in their responses to abuse depending on a number of mediating variables. These might include the age and gender of the child, age and gender of the abuser, frequency and duration of the abuse, and maladaptive family processes. There are indications that the use of force, threats, contact sexual abuse, long duration of abuse, close relationship to the perpetrator and being male are associated with more negative outcomes (Putnam, 2003). Notably, some studies have reported that a considerable proportion of victims present with few or no symptoms (Finkelhor & Berliner, 1995; Kendall-Tackett, Williams, & Finkelhor, 1993) whereas others have suggested that asymptomatic children are likely to deteriorate over time (Finkelhor & Berliner, 1995; Gomes-Schwartz, Horowitz, & Cardarelli, 1990).

With regard to the impact of adolescent sexual offending, some of the early commentary suggested that abuse during childhood by an adolescent was less harmful than abuse perpetrated by adults (Davis & Leitenberg, 1987). Significantly, at that time there were no known studies that specifically examined this issue. However, given that sexual offences perpetrated by adolescents typically involve someone known to the perpetrator, genital touching and often penetration, significant coercion or physical force and repetitive offending over time (Ryan, 1997b), the resultant emotional harm caused to victims should not be underestimated.

Although the impact of incestuous abuse by siblings has not received the same attention as that committed by fathers or stepfathers, there are indications that it is a significant problem**.** In one survey involving 1616 sexually abusive youths aged under 21 years, it was reported that nearly 40% engaged in intrafamilial sexual abuse (Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996). In an attempt to shed more light on the harmfulness of sibling incest, Cyr, Wright, McDuff, and Perron (2002) compared three groups of girls who had been sexually abused by either brothers, fathers or stepfathers. They found that penetration was much more frequent in the sibling incest group (70%) than either the stepfather incest (30%) or father incest (35%) groups. Moreover, the psychosocial distress caused to victims of brother incest reached similar (if not higher) levels of clinical severity as victims of fathers and victims of stepfathers. It has been suggested that in some respects, sibling abuse causes greater harm than abuse committed by fathers and other adults (Jones, 2002).

It should be acknowledged that CSA research has methodological limitations in that several of the studies are characterised by design and measurement problems. These include variability in definitions of CSA; biased sampling; under-representation of males in research samples (Watkins & Bentovim, 1992); the use of varying and limited outcome measures (Jumper, 1995); reliance on parental or clinician ratings rather than children's self-assessments (Kendall-Tackett, Williams, & Finkelhor, 1993); the absence of appropriate comparison groups; lack of consideration given to mediating variables (Paolucci, Genius, & Violata, 2001); time lapse between abuse symptomatology and evaluation (Browne & Finkelhor, 1986; Kendall-Tackett, Williams, & Finkelhor, 1993); insensitive measures for identifying symptomatology (Kendall-Tackett, Williams, & Finkelhor, 1993); and combining intrafamilial and extrafamilial abuse.

Nevertheless, despite these limitations present to a greater or lesser extent in the individual studies, the consistency of findings across studies adds strength to the conclusions summarised herein. Although there is considerable variability in the outcomes associated with sexual abuse there is compelling evidence of the negative impact of CSA on psychosocial functioning. Moreover with respect to incest, there are indications that abuse by an adolescent sibling may have an even greater impact on the victim than abuse by older family members.

Offender Characteristics

In the literature, ASO's are invariably described as a heterogeneous group who are present across all socioeconomic, ethnic, religious, and geographic groups (Ryan, 1997b). In order to better understand the etiology and treatment needs for this population, researchers have focused on what distinguishes them from other adolescents (Davis & Leitenberg, 1987). Results suggest that while many ASO's share similar characteristics, there appear to be important subgroups or distinct typologies of offender. Concomitantly, very little is known about adolescent offending patterns and characteristics associated with adolescent sexual offending that has not been reported. Given that research is conducted on identified offenders, reported findings on the characteristics of ASO's are likely to be based on biased samples (Epps & Fisher, 2004). Given the relative dearth of New Zealand research regarding the characteristics of ASO's, we rely on international studies to inform our knowledge in this area.

Male Offenders

Certain characteristics have been identified as prevalent among adolescents who have sexually offended, and a few studies have attempted to differentiate their similarities and differences (Righthand & Welch, 2001). In an early review of the literature, Davis and Leitenberg (1987) concluded that the vast majority of ASO's are male, most victims are females, the victims are usually younger than the offender, ASO's have been subjected to higher rates of physical abuse compared to other groups of adolescents, and ASO's are similar to nonsexual offenders in their histories of behavioural disturbances and problems in school. In a subsequent review, Ryan (1991a) identified an over-representation of behavioural, affective and attention-deficit disorders, and learning disabilities among this group. While approximately one third have a history of

nonsexual delinquency and antisocial behaviours, around two thirds appear to exhibit sexually deviant behaviour in the absence of any other observable behaviours or characteristics that set them apart from their peers.

More recently, Boyd, Hagan and Cho (2000) reviewed the research on the most prominent characteristics of male ASO's and identified a range of factors associated with offending. These include family instability, intrafamilial violence, physical and sexual abuse, neglect, prior convictions for nonsexual offending, low self-esteem, social isolation and social skill deficits, low socioeconomic status, academic underachievement, behaviour problems at school, substance abuse problems, aggressive acts, conduct disorder diagnoses and delinquency.

Obviously, the characteristics mentioned above are not unique to ASO's (Becker & Hunter 1997; Righthand & Welch, 2001). Studies comparing juvenile sexual offenders with violent and nonviolent delinquents across a broad range of variables have found few significant differences between the groups (AACAP, 1999). However, there is some evidence that ASO's experience more physical violence and abuse compared to the other groups. Ford and Linney's (1995) comparison of juvenile sexual offenders, violent nonsexual offenders and status offenders used psychometric instruments to assess intrafamilial violence, social skills, interpersonal relationships and self-concept. Data was also collected on family criminal history, educational status, behaviour problems, exposure to pornography, historical abuse, and childhood memories. While the groups did not differ in assertiveness, self-concept, and family history variables, juvenile sexual offenders had experienced more parental violence and physical and sexual abuse compared to the other offender groups.

Some researchers have examined the relationship between offence and offender characteristics (Epps & Fisher, 2004; Hunter, 2006; Knight & Prentky, 1993; Righthand & Welch, 2001). There is suggestive evidence that offence and victim characteristics are associated with particular types of offender characteristics. Offence characteristics that seem to be particularly relevant are the use of force and violence, level of coercion and violence used, age and gender of the victim, and the relationship between the victim and the offender (Epps & Fisher, 2004). Epps and Fisher suggest that future research should aim to group offenders according to offence and offender characteristics as this could lead to the identification of distinct subgroups of youth. It may then be possible to

differentiate their developmental, personality, and offending characteristics which has important implications for assessment and treatment (Hunter, 2006).

In an attempt to identify the distinguishing characteristics of ASO's, some researchers have devised classification systems. One of the earliest typologies of ASO's was proposed by O'Brien and Bera (1986) who incorporated such factors as personality, victim age, family systems, general delinquency, and sexual history. Their seven-category classification scheme included (a) naïve experimenters, (b) undersocialised child exploiters, (c) sexual aggressives, (d) sexual compulsives, (e) disturbed compulsives, (f) group influenced, and (g) pseudosocialised child exploiters. Although this classification scheme has face validity, there has been no empirical investigation of its reliability or validity (Righthand & Welch, 2001). Furthermore, this typology has been criticised for incorporating too broad a range of characteristics and patterns of behaviour within each category. It therefore fails to provide for mutually exclusive categories and makes it difficult to recognise unique differences among offender types (Rich, 2003). Given the inherent difficulty of devising a typology that takes into account the gamut of offender characteristics, historical influences and offence patterns and behaviours, it has been suggested that a taxonomy (akin to a multilayered typology) might provide a more comprehensive and systematic classification system (Rich, 2003).

Although a number of studies have focused on the background characteristics of ASO's, less attention has been paid to their personality characteristics (Worling, 2001). Noting this, Worling sought to replicate the findings of Smith, Monastersky, and Deisher (1987), who had previously classified a large sample of ASO's according to four personality-based subgroups. Worling categorised 112 male ASO's on the basis of their scores on the California Psychological Inventory (Gough, 1987). Worling's results are notably similar to those of Smith, Monastersky and Deisher in that he also identified a distinct four group typology based on personality functioning; (a) Antisocial/Impulsive, (b) Unusual/Isolated, (c) Overcontrolled/Reserved, and (d) Confident/Aggressive. Worling emphasises the importance of recognising these individual differences as this assists clinicians in their understanding of etiological pathways and developing corresponding treatment strategies.

Building on the earlier work of Moffit (1993) who developed a typology of delinquent and aggressive youth, Hunter, Figureredo, Malamuth, and Becker (2004) developed a

preliminary typology of male ASO's on the basis of their scores on a range of personality constructs (as cited in Hunter, 2006). Three prototypic subtypes of male ASO's were identified (a) Life-Style Persistent; (b) Adolescent Onset, Non-Paraphilic; and (c) Early Adolescent Onset, Paraphilic. Further examination of this typology is currently underway in a study that involves the longitudinal tracking of 330 adolescent males from their enrolment in treatment to posttreatment release (Hunter, 2006). Hunter is optimistic that continued typology research along these lines will eventually lead to the identification of subtype-specific interventions.

Overall, these results provide compelling evidence of the heterogeneity of this population group. While there is no basis for believing there is a typical ASO, researchers have attempted to cluster their characteristics and behaviours in meaningful ways. This appears to have the potential to increase our understanding of their treatment needs.

Females with Sexually Abusive Behaviours

Research indicates that between 2 and 8% of all ASO's are female (Fehrenbach, Smith, Monastersky, & Deisher, 1986; Kubik, Hecker, & Righthand, 2002; Tardif, Auclair, Jacob, & Carpentier, 2005). Despite estimations that females are responsible for around 10% of reported CSA (Blues, Moffat, & Telford, 1999), no conclusions have been reached in relation to the numbers of adolescents who sexually offend as a proportion of all female sexual abusers. While it is possible that males are responsible for nearly all sexual offences, in recent years there has been a developing awareness that female perpetrated sexual abuse may be under-reported (Righthand & Welch, 2001). Confusion about the definition of abuse by females, sexual double standards and normalisation of offence behaviours initiated by females, parental denial about the behaviour, and latitude given to females in caretaking roles are cited as reasons for their lack of visibility (Davis & Leitenberg, 1987; Vick, McRoy, & Matthew, 2002).

Preliminary findings from studies that have focused on the characteristics of adolescent females with sexually abusive behaviours report the following: they typically commit multiple offences against younger family members or children in caregiving situations (Vick, McRoy, & Matthew, 2002); they appear to have experienced much higher rates of sexual victimisation than their male counterparts (Blues, Moffat, & Telford, 1999;

Bumby & Bumby, 1997; Mathews, Hunter, & Vuz, 1997); and they resemble their male counterparts on other dimensions. Specifically, depression, anxiety, post traumatic stress disorder, low self-esteem, difficulty forming healthy peer relationships, suicidal behaviour, delinquency, alcohol abuse, and academic difficulties (Bumby & Bumby, 1997). Some researchers have found that relative to the adolescent males, the histories of adolescent girls reflect more extensive childhood maltreatment and higher levels of family dysfunction (Mathews, Hunter, & Vuz, 1997). Taking these factors into account it has been suggested that a focus on trauma and past victimisation experiences may be an important component of treatment for adolescent females who sexually abuse (Mathews, Hunter, & Vuz, 1997; Vick, McRoy, & Matthew, 2002).

Adolescents with Intellectual Difficulties

It has been proposed that there is an over-representation of learning disabilities (including borderline intellectual functioning) in populations of ASO's (Stermac & Sheridan, 1993). In recent years there have been increasing demands to provide treatment for this group. Researchers have pointed out that there are numerous similarities and some distinct differences between the intellectually disabled and nondisabled sex offender (Lane, 1997b). Both populations demonstrate a similar range of offence behaviours with similar deviant arousal patterns and use thinking errors to support their offence behaviours. It has also been reported that they both exhibit low self-esteem, social skill deficits, various levels of denial, and deficient processing and evaluating skills (Timms & Goreczny, 2002). Studies of sexually abusive adolescents with intellectual difficulties have also found that they engage in nonsexual offending behaviours, exhibit anger and aggressive behavioural problems, have a history of school problems and conduct disorder and often come from multiproblem families (Fortune & Lambie, 2004; Gilby, Wolf, & Goldberg, 1989).

However, there appear to be several characteristics that are unique to ASO's with intellectual difficulties. First, their offences appear to be more opportunistic and impulsive. They are more likely to engage in nuisance behaviours such as public masturbation, exhibitionism and voyeurism (Lane, 1991, 1997b; Stermac & Sheridan, 1993). Next, this group appears to experience higher levels of sexual victimisation, physical abuse, abandonment and family dysfunction (Fortune & Lambie, 2004; Lane, 1997b). Also, their cognitive processes are more concrete and they have a different

learning style. Their reduced capacity for generalisation and abstraction result in rigid and entrenched thinking patterns, and these ingrained thinking errors are more difficult to shift (Lane, 1997b). Finally, these offenders typically offend against known victims, there are fewer reports of grooming and stalking behaviours, and they are more likely to use force or verbal threats (Fortune & Lambie, 2004; Lane, 1997b).

In any consideration of treatment for this population group, there needs to be recognition of their diversity. Adolescent offenders with intellectual difficulties present with varying degrees of cognitive, behavioural and social deficits and may have had varied experiences ranging from institutionalisation to community living with mainstream education (Stermac & Sheridan, 1993). It has been suggested that offence-specific treatment for this particular group be based on the particular needs of the individual whilst taking into account the various factors that have been identified (Lane, 1997b).

Children with Sexually Abusive Behaviours

In response to the identification of a young group of children in mental health clinics with significant sexual behaviour problems, researchers began reporting their findings in the late 1980's (Friedrich & Luecke, 1988; Johnson, 1989). Similarly, clinicians working with adolescents, their families and adult offenders were becoming increasingly aware that the onset of sexually abusive behaviours frequently began prior to adolescence (Lane, 1997b). However, one of the central problems facing researchers and clinicians is differentiating developmentally normal sexual behaviours from behaviours that are sexually abusive. In order to assist practitioners to evaluate sexual interactions and provide treatment for this population, numerous researchers have explored this area. There is general agreement that child sexual behaviour exists on a continuum from normal to abusive and various categorisation systems have been described (Hall, Mathews, & Pearce, 2002; Johnson, 1998, 2002; Johnson & Doonan, 2006; Pithers, Gray, Busconi, & Houchens, 1998; Ryan et al., 1989). It has also been suggested that issues of consent, equality of power, and coercion equally apply to this age group (Ryan, 1991a).

Johnson (1998) summarised some of the characteristics of children less than 12 years of age who sexually molest based on the findings of three studies. These children were

described as having serious sexual problems with disturbed, aggressive behaviours. All could be given a DSM-IV diagnosis (American Psychiatric Association, 1994) with the most prevalent diagnosis being conduct disorder and oppositional defiant disorder. Most of the children in the studies had severe learning problems, very poor peer relations and few satisfying relationships with anyone. Furthermore, positive coping skills were virtually absent. All the children showed a high degree of sexual preoccupation and their sexual behaviours were comparable to those of adolescent and adult offenders. All the girls and most of the boys had been sexually abused and the majority of children displayed signs of severe physical abuse. The families and homes of these children were typically chaotic and harsh, and problematic sexual attitudes and sexualised interaction appeared to be present in virtually all the homes. The fathers of these children were notably absent and descriptions of their mothers indicated the presence of personality disorders, depression, substance abuse, and a history of emotional and sexual abuse. All the children knew their victims.

It is clear from Johnson's (1998) description that these children exhibited behaviours that correspond with the most pathological end of the sexualised behaviour continuum. The treatment issues for this group will therefore be very different from children that have higher functioning families and less entrenched sexual behaviour. In fact, Johnson and Doonan (2006) suggest that most of the children who are referred for treatment exhibit problematic sexual behaviours rather than commit acts of sexual molestation. Careful consideration must therefore be given to the severity level of the child's sexual behaviours and all areas of child and family functioning when determining appropriate intervention.

In summary, it is clear from the literature that ASO's are a diverse group. There appear to be a number of subtypes of offenders who differ in their demographic profile, family backgrounds, social skills and interests, cognitive functioning, psychological and emotional adjustment, sexual interests, and offending behaviour (Becker & Kaplan, 1988). In an attempt to account for this divergence, numerous explanatory theories have been promulgated. In the next section, consideration is given to the key theories that have been developed to explain the pathways that lead to adolescent sexual offending.

Causes of Adolescent Sexual Offending

Acceptance of a single explanatory theory that accounts for the development of such behaviour is always going to be difficult, given that seemingly common developmental pathways, life experiences, and risk factors can lead to different outcomes in different children (Rich, 2003). Marshall and Eccles (1993) suggested that a unifying theory of sex offending is probably unachievable. They proposed that specific theories be developed for each type of offence behaviour so that the different processes that contribute to specific behaviours can be identified. Other researchers have suggested that it might be possible to understand the development of sexually abusive behaviour by focusing on the context of the lives of children and adolescents, in particular their developmental and early life experiences (Calder, 2001; Rich, 2003; Ryan, 1997a). This view takes into account the various influences and factors that shape psychological, sociological and physiological processes. Although the explanation for adolescent sexual offending appears complex and multifaceted, various etiological theories have been proposed (many of which overlap and are inter-related) to enhance our understanding of this aspect of human behaviour.

Family Systems Theory

The family systems approach posits that family interactions, structures and patterns influence the behaviour of each family member (Carr, 1999). Thus, the family system is considered an important influence in the development of adolescent sexuality and offending behaviour. As such, the adolescent's sexual offending behaviour is typically developed and maintained by patterns of family interaction, communication styles, hierarchical boundaries, and lifecycle transitions.

In an early review of the literature Monastersky and Smith (1985) reported on the significant relationship between dysfunctional family systems and sexual offending. In a subsequent review it was reported that chaotic role boundaries, caregiver instability, parental psychiatric disturbance, inadequate father/son relationships, poor supervision, failure to set proper boundaries, violence, emotional abuse/neglect, and growing up in a sexualised atmosphere can lead to sexual misconduct (Bera, 1994). It has also been suggested that parent-child relationships within families of ASO's are either disengaged or enmeshed (Graves, Openshaw, Ascione, & Erickson, 1996), and characterised by

poor levels of communication between parents and children (Duane & Morrison, 2004). However, several studies comparing the family systems of ASO's with other delinquent populations have found no significant differences between them (Bischoff, Stith, & Whitney, 1995; Duane & Morrison, 2004).

Although dysfunctional family systems may have a role to play in the etiology of sexual offending, any direct causal link between ASO's choosing to sexually offend and their family background has yet to be established. It is likely that a wide range of adverse events combine to produce sexual offending (Lee, Jackson, Pattison, & Ward, 2002). Moreover, many of the studies are difficult to interpret because of the variability in methodologies and samples (Duane & Morrison, 2004).

Trauma Theories

In trauma models, consideration is given to the impact of traumatic experiences on normative emotional and personality development and the neural pathways in the brain. For the ASO with a prior history of abuse, sexually aggressive behaviour can be understood as a behavioural re-enactment or trauma-reactive response to the original trauma (Rich, 2003). Obviously sexual aggression is not an inevitable consequence of trauma and a number of etiological frameworks have been developed that take into account the developmental, familial and social context within which the trauma occurred.

Finkelhor and Browne (1986) developed the traumagenic model as a paradigm for understanding the links between the experience of being sexually abused and the variety and diversity of dysfunctional outcomes. The authors describe four traumagenic dynamics (a) traumatic sexualisation, which may result in sexual identity problems, intimacy issues, and inappropriate sexualised behaviours; (b) stigmatisation, which can lead to self-harm behaviours, feelings of isolation, shame, guilt, and low self-esteem; (c) betrayal, which can engender depression, mistrust, extreme dependency, anger, hostility, and antisocial behaviours; and (d) powerlessness, which might lead to dissociation, anxiety symptoms, self-victimisation, delinquency, identification with the aggressor, and difficulties with issues of power and control. While some combination of these factors occurs in other traumatic experiences, it is suggested that it is the presence of all these factors in one set of circumstances that make the experience of CSA unique.

The authors further suggest that different abuse experiences for different children contribute different traumagenic dynamics that lead to different types of trauma and outcomes. They recommend that consideration be given to these trauma-causing factors in clinical assessments for their utility in formulating intervention strategies.

More recently, the Trauma Outcome Process has been put forward as a conceptual model that explains the etiology of sexually abusive behaviour in children (Rasmussen, Burton, & Christopherson, 1992). It also has relevance for ASO's (O'Reilly & Carr, 2004b). This model is based on the premise that there are three possible responses to traumatic experiences (a) recovery (children can express and process the emotions associated with the traumatic experience, thus reaching a point of acceptance); (b) self-victimisation (children can internalise their emotions and develop self-destructive behaviours); and (c) assault (children can externalise their feelings, identify with their aggressor and engage in abusive behaviours towards others). In their attempt to explain why some children respond to CSA by being abusive whereas others might recover or become self-destructive, Rasmussen and colleagues outline five precursors that render some children more vulnerable to offend sexually. These are (a) prior traumatisation, (b) social inadequacy, (c) lack of social intimacy, (d) impulsiveness, and (e) lack of accountability. While this model has contributed to the development of ideas on assessment, formulation and treatment, it has been criticised for failing to identify the distinguishing characteristics of children who recover compared to those who become self-destructive (O'Reilly & Carr, 2004b).

Abused to Abuser

The role of sexual victimisation in the development of sexually abusive behaviour is complex and poorly understood (Ryan, 1999). In their review, Becker and Hunter (1997) reported that 40 to 80% of juvenile sex offenders had a history of sexual abuse. Even so, they cautioned that the rate of abuse can vary depending on how sexual abuse is defined and whether or not adolescent males are willing to disclose. A significant proportion of ASO's also report childhood maltreatment experiences that can include physical abuse and neglect (Ryan, 1999). Yet there is no consistent evidence to suggest that the abusive experiences of this particular group differ significantly from those of other adolescent offenders (Righthand & Welch, 2001). It is also clear that the majority of CSA survivors do not go on to engage in sexually abusive acts (Ryan, 1999).

Furthermore, the question remains as to how we explain the finding that approximately 30% of sexually abusive youth have no history of sexual victimisation (Burton, 2000).

In order to better understand the relationship between CSA and subsequent sexual offending, some researchers have turned their focus to other risk factors. Identified factors include age at the time of victimisation; severity, duration and frequency of the abuse; level of family support following disclosure; number of perpetrators; and age difference between victim and abuser (Burton, 2000; Rich, 2003; Righthand & Welch, 2001). It has also been reported that physical abuse, the witnessing of family violence, and disruptions in care are primary risk factors for CSA victims who do go on to become sexual offenders (Bentovim, 2002). In a study involving pre-teen children, CSA placed children at risk of subsequent sexually intrusive behaviour when predisposing factors such as family adversity, modelling of coercion, modelling of sexuality and proneness to acting out are present (Friedrich, Davies, Feher, & Wright, 2003).

While it is difficult to distinguish between causal factors and risk factors, it is clear that CSA experiences alone do not provide an etiological explanation for adolescent sexual offending. However, an understanding of the role of victimisation in the enactment of sexual offending behaviour appears to be crucial, as this has implications for assessment and the planning of appropriate intervention.

Developmental Theories

From infancy through to adolescence, individuals are introduced to key emotional, cognitive and physical tasks at distinct stages. Success or failure to receive the necessary support whilst accomplishing these tasks affects subsequent psychological development. Early childhood experience is therefore crucial. Childhood maltreatment and trauma, neglect, lack of empathic care, chaotic family organisation, and exposure to sexually explicit materials may contribute to the development of sexually abusive behaviour (Ryan, 1997c). In this context, sexual offending is viewed as the outcome of disrupted and incomplete developmental growth in a social environment that has failed to provide the necessary prerequisites for successful personality development (Rich, 2003).

In examining the research, Marshall and Eccles (1993) concluded that the developmental histories of ASO's render them vulnerable to a variety of influences and

events that would not necessarily affect other individuals. They consider this vulnerability to be a consequence of impaired parent-child attachment during early childhood. Similarly, Marshall, Hudson, and Hodkinson (1993) argue that insecure attachment bonds between parents and their children (caused by poor parenting and disrupted contact) affect subsequent development and influence the capacity for intimacy in other relationships. Secure attachments provide children with an empathic view of others as well as the necessary skills and confidence to achieve intimacy with same-age peers. The failure to establish secure attachments results in poor social relations and vulnerability to other influences that can then lead to sexual misconduct.

Other studies have also reported findings that can be explained by developmental theory and a child-parent attachment process (Becker & Hunter, 1997; Creeden, 2006; Hudson & Ward, 2000; Kobayashi, Sales, Becker, Figueredo, & Kaplan, 1995). It has been suggested that a treatment focus on addressing ASO's trauma histories and attachment disruptions promotes programme progress; young people are then better able to learn and put into effect the skills they are being taught to control or change their problematic and abusive behaviour (Creeden, 2006).

Social Learning Theories

These theories focus on the acquisition of behaviours that are shaped by learning experiences in the environment. In classical conditioning, there is an assumption that a physiological response can be elicited by the pairing of a stimulus (or situation) and a reinforcer. It is through this pairing that a situation previously unable to produce a specific response by itself, now becomes able to elicit the response (Weerasekera, 1996). For example, if sexual arousal (reinforcer) occurred in the context of an abusive situation in childhood (stimulus), this might facilitate the expression of sexually deviant behaviour (because abusive situations produce sexual arousal as a result of the association). Recurrent deviant behaviour would serve to reinforce the original pairing, thus leading to continuation of such behaviour (Ryan, 1997c).

Operant conditioning takes into account the reinforcement and punishment contingencies that are present in an individual's environment. Behaviours are therefore shaped by a person's history of reinforcement. With regard to adolescent sexual offending, a child's early experience of sexual behaviour may or may not have been

accompanied by sexual arousal; or it may have been paired with some nonsexual reward or punishment (Ryan, 1997c). Nevertheless, in their review of the literature, Marshall and Eccles (1993) found little supporting evidence for conditioning theories as an exclusive explanation for sexual offending.

Social learning theories assert that individuals learn how to behave and think by observing role models in their environment. Sexually aggressive behaviour is therefore learned through a process of imitation or modelling. Accordingly, exposure to sexually abusive behaviour in others might lead to the practice of sexually abusive behaviour. This imitative experience might then incorporate a pairing of stimuli (rewards and/or punishment) thus leading to a patterned response (Ryan, 1997c). Several researchers have found support for a social learning hypothesis to help explain some of the etiological questions of sexual offending (Awad, Saunders, & Levene, 1984; Boeringer, 2001; Burton & Meezan, 2005; Ryan, 1997c). It is therefore considered important to explore and understand the early learning experiences of ASO's as this has implications for behavioural change when planning treatment. For example, if a youth has witnessed sexual abuse, experienced physical victimisation and been exposed to domestic violence, a treatment plan that incorporates a trauma focus may be appropriate. This could be aimed at assisting his recovery from such experiences and facilitating an understanding of the link between these experiences and the behavioural choices he made with regard to offending.

Physiological Theories

Physiological theories focus on biologic determinants of sexual behaviour. Physiological investigation has primarily focused on neurological and hormonal factors to explain sexual aggression and deviancy. In the literature, genetic influences on antisocial and aggressive behaviour in children and adults have been reported (Raine, 2002), and there have been suggestions that early traumatic experiences can alter the brain's modulation and regulation capacity thereby increasing an individual's aggressivity and impulsivity (Perry, 1997). Similarly, studies of the relationship between childhood abuse and post traumatic stress disorder have demonstrated that traumatic stressors can have long lasting effects on the structure and function of the brain (Bremner, 1999; Kendall-Tackett, 2000). However, the specific link between

neurological activity and sexually aggressive behaviour has yet to be established (Gerardin & Thibaut, 2004).

Likewise, the role of hormonal factors and their influence on sexual behaviour remains unclear. There have been suggestions that for some individuals, hormones may be implicated in deviant sexual arousal. Such cases might include individuals with paraphilias associated with obsessive compulsive disorders, histories of extreme sexual violence and severe mental retardation (Gerardin & Thibaut, 2004). Yet despite these indications it is important to recognise that sexual offences are often driven by nonsexual needs and there is no compelling evidence to suggest that reducing sexual arousal reduces offending behaviour (Ryan, 1997c).

Sociocultural Theories

Some researchers have highlighted the need to conceptualise sexual aggression within a sociocultural context. In particular, gender role socialisation and stereotyping, power relations and the relative positions of men and women in society have been cited as contributing factors to sexual aggression in males (Stermac, Segal, & Gillis, 1990). It has been reported that sexually aggressive adolescents tend to endorse traditional sex-role stereotypes, rape-supportive myths and to hold negative attitudes about women (AACAP, 1999). Male socialisation might therefore provide some explanation for why it is that males are responsible for most sexual aggression. It has also been suggested that allegiance to a delinquent peer group may lead to sexually aggressive behaviour as a means of gaining peer attention, approval, or leadership (Bera, 1994).

Another area of focus has been the imagery in pornography and mass media as this reflects traditional sex-role ideology and societal norms related to masculinity and aggression. In this context, sexual expression is viewed as a male prerogative (Gonsiorek, 1994). Sexualised images of children in the advertising and film media promote the perception that they have adult sexual needs. Typically, pornographic images depict women as compliant, accommodating and responsive to coercion. Children may also be seen in these images as sexual, seductive and compliant to the wishes of older males. It has been suggested that insecure adolescents may be particularly responsive to the triggering effects of such images; using force to have sex or having sex with a child requires few social skills, it provides an opportunity for

insecurely attached young males to experience power and control, there is a relative unconcern with the possibility of rejection, and it fulfils their needs for immediate physical gratification (Marshall, Hudson, & Hodkinson, 1993).

When Ford and Linney (1995) examined the relationship between exposure to pornography and the occurrence of juvenile sex offending, they found that the juvenile sexual offenders reported earlier and more frequent exposure to pornographic material than juveniles who committed nonsexual offences. They proposed that childhood exposure to media portrayals of inappropriate social, sexual and violent behaviour are significant factors in the etiology of sexual offending. More recently, based on a review of the literature in this area, Burton and Meezan (2005) concluded that exposure to pornography may be a learning path to sexually abusive behaviour for some ASO's.

Multifactorial Models

Multifactorial models combine elements of many theories in an attempt to present a unified theory of human functioning (Hudson & Ward, 2000). Sexually aggressive behaviour is therefore viewed as the culmination of many different aspects of physical, emotional and social development. This takes into account physiology, developmental issues, significant learning events, personality development, and social influences (Rich, 2003). While multifactor explanations have received limited attention and are difficult to evaluate given the number of variables that need to be taken into account, it has been suggested that they allow for a holistic and complex conceptualisation of sexually abusive behaviours (Burton & Meezan, 2005). Knight and Sims-Knight (2004) developed a multifactorial model that they tested on a large sample of adolescents (n=218). The model proposes that early abuse experiences (physical, verbal, and sexual) and personality characteristics combine to produce three underlying traits that define the causal pathway to sexual offending; (a) sexual drive/preoccupation, (b) antisocial behaviour/impulsivity, and (c) callousness/unemotionality. Their findings suggest preliminary support for the model.

In summary, no one theory provides all the etiological answers and several researchers have combined different perspectives to account for sexual offending (Marshall & Barbaree, 1990; Ward & Beech, 2004). Nevertheless, the combination of factors that lead to sexual offending for one adolescent will not be the same for another. If clinicians

are to provide relevant treatment, the uniqueness of each individual needs to be recognised. Accordingly, a developmentally grounded approach that takes into account multiple contextual factors would appear to offer the most useful framework for understanding sexually abusive behaviour and provide the best basis for considering assessment and treatment strategies.

Assessment

A comprehensive assessment that takes into account etiological factors is essential for treatment planning. Given the range of characteristics and developmental needs present in this population group, there has been increasing recognition of the need to adopt a holistic approach to assessment and treatment (Longo, 2002; O'Callaghan, 2002). In broad terms the purpose of assessment is to gain an understanding of the offender's background as well as the processes that might have led to abusive behaviours and their maintenance, gather information for treatment planning, ascertain motivational levels to engage in treatment, and evaluate risk of reoffending (Rich, 2003). This will include the identification of all relevant treatment needs and not just those related to sexually deviant behaviours; it takes into account sexual abuse behaviour patterns, family functioning, differential diagnosis, interpersonal competency, developmental history, victimisation or trauma history, strengths, concerns, and risks (National Adolescent Perpetrator Network, 1993).

A comprehensive assessment will likely include a clinical interview with the adolescent; collateral interviews with family members, significant others and other professionals; and psychometric assessment. The assessment process is therefore completed over a number of sessions (O'Reilly & Carr, 2004a). To further assist this process, information can be gathered from multiple sources such as medical and psychological reports, official records (from police, corrections and social services), victim statements, and school records. It is recommended that this information be requested and reviewed prior to interviewing the adolescent (Lane, 1997a).

Clinical Interview

It is generally recognised that clinical work with sexual offenders presents particular challenges. Given that so few offenders seek treatment willingly, it is perhaps not

surprising that many do not fully participate in the assessment process. This can take the form of outright deception, lying by omission, evasiveness, claims of forgetfulness, and attempts to manipulate the interview (Rich, 2003). It is therefore important to consider the interactional style of the interviewer. Recommended guidelines for interview approaches when assessing ASO's include the provision of a comfortable and safe therapeutic environment; taking time to build a therapeutic relationship; being honest, demonstrating acceptance and support, and being nonjudgemental; confronting dishonesty and challenging contradictions without undermining the adolescent or engaging in power struggles; maintaining control of the process; and being clear about expectations and outcomes (AACAP, 1999; Lane, 1997a; Rich, 2003).

It has been suggested that as the assessment gets underway, initial time is spent obtaining informed consent for assessment and treatment and providing information in a number of key areas. These include limits of confidentiality, nature of questions, overview of assessment and treatment processes, time requirements, the assessment report and feedback process. Keeping ASO's informed from the outset ensures that they are not taken aback by the time demands and content of subsequent treatment (Worling, 2003).

Although initial assessment is not necessarily intended for the purposes of disclosure of sexual offences, it is necessary to determine the nature of the sexually abusive behaviour. Given that it is common for sex offenders to deny and minimise their sexual offending (Barbaree & Cortoni, 1993), this is frequently one of the first challenges that confront clinicians. In one survey involving 1600 adolescents, it was reported that only 20% accepted full responsibility for their offending. Nearly one third admitted little or no responsibility, two thirds expressed little or no empathy for the victim and about half expressed little or no remorse. Moreover, about one third assigned blame for their offending to the victim and nearly half excused their behaviour by attributing it to other sources (Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996).

Usually the denials are expressed as protestations of innocence or claims that the interaction was consensual or nonsexual, despite evidence to the contrary. Not uncommonly, offenders minimise the harm done to the victim and the extent of their previous offensive behaviour**.** Offenders also minimise responsibility for their offending by blaming the victim or attributing blame to external or situational factors beyond their

control (Barbaree & Cortoni, 1993). Failure to disclose can be viewed as a self-protective or avoidant strategy for offenders as they struggle with issues of shame, guilt, the fear of legal consequences and other forms of punishment (AACAP, 1999). Interviewers therefore need to spend considerable time and effort identifying factors relevant to the sexual offence and patterns of sexual arousal. Reducing denial appears to be a gradual process that occurs during treatment (National Adolescent Perpetrator Network, 1993).

Therapeutic Relationship

As mentioned, the assessment and treatment of ASO's can pose particular challenges for clinicians as they endeavour to create a therapeutic alliance. A number of pre-existing factors affect this relationship. They include the involuntary nature of the referral, limited confidentiality, treatment that is mandated, the prioritisation of community safety over client needs and rights, underlying client distrust, and the need for clinicians to confront and challenge unacceptable behaviours and beliefs (Ryan & Lane, 1997b). At the same time the abhorrent nature of sexually abusive behaviour can conflict with the therapist's need to support and respect the adolescent who has offended.

The general literature on psychotherapy, not specific to ASO's, is relevant here. In the search for empirically validated treatments, numerous researchers have concluded that the client-therapist relationship makes a significant contribution to successful outcomes across a broad variety of treatments and client problems (Horvath & Luborsky, 1993; Shirk & Karver, 2003). In fact, it has been suggested that the therapist relationship accounts for as much as, if not more of, the outcome variance than particular treatment methods (Norcross, 2000). According to Lambert (1992), therapy techniques account for less than 15% of the variance in treatment outcome across therapies. While these conclusions have been reached in relation to adult populations, findings from a meta-analytic review involving child and adolescent treatment studies indicated that the therapeutic relationship is related to treatment outcome across diverse types and contexts of child and adolescent therapy (Shirk & Karver, 2003).

In their discussion of the therapeutic relationship with adult sexual offenders Marshall et al. (2003) identified a number of therapist features that influence the therapist-client

alliance. They include empathic concern, noncollusion, appropriate self-disclosure, humour, warmth and respect, authenticity, clear communication, encouraging active participation, confidence, flexibility, open-ended questioning, being appropriately directive, and being both challenging and supportive. Similar therapist characteristics have been described as being important with regard to building effective relationships with ASO's (Rich, 2003).

Assessment Targets

Numerous authors have attempted to define the components of a comprehensive assessment. It is beyond the scope of this review to provide detailed guidelines on the content and structure for assessment interviews, therefore a basic outline of the main assessment areas is presented. The target areas outlined on Table 1 (following page) have been sourced from the reports of recognised experts in the field.

Psychometric Assessment

There are a number of assessment tools that can assist in evaluating intellectual and personality functioning, psychiatric symptoms, trauma issues, sexual attitudes, family functioning, and empathy (Prentky & Bird, 1997). In their resource guidebook on psychometric instruments that practitioners use to assess victims of sexual abuse and juvenile and adult sexual abusers, Prentky and Bird point out that very few of these instruments have been validated for use with sex offenders. They therefore advise caution in their use and recommend that clinicians keep up-to-date with developments in this area. The following list describes some of the tests that are mentioned in the literature as being useful (Becker & Hunter, 1997; Bonner, Marx, Thompson, & Michaelson, 1998; Center for Sex Offender Management, 1999; Prentky & Bird, 1997; Righthand & Welch, 2001).

In order to assist clinicians evaluate the cognitive ability of young people, especially those with mild intellectual disabilities and learning difficulties, the Wechsler intelligence scales are commonly used; namely, the *Wechsler Intelligence Scale for Children-IV* (Wechsler, 2003) for those aged 6 to 16 years, and the *Wechsler Abbreviated Scale of Intelligence* (Wechsler, 1999) which can be used with older adolescents.

Table 1. ***Recommended Assessment Targets***

Domain	Assessment Target
Offence-specific	• Nature of sexual offence or abuse (including frequency, duration, locations, victim selection, offence planning, grooming behaviours, identifiable triggers, thinking errors)[a,b,c,d,e,f] • Personal responsibility for offending behaviour[a,b,c,d,e,f] • Young person & family's attitude to victim, capacity for empathy[a,b,c,d,e,f] • Use of threats, level of aggression during commission of offence[a,b,c,d,f] • Young person's offending & abusive behaviour history[a,b,c,d,e,f] • Placement and treatment history with young person & family regarding offending or abusive behaviours[b,c,e,f] • Level of co-operation with assessment process[a,b,d,e,f] • Motivation to engage in treatment[b,d,e,f]
Developmental	• Resilience factors, personal strengths & interests[c,d,e,f] • Health & medical history, concurrent psychiatric disorders[a,b,c,d,e,f] • Intellectual, academic & cognitive functioning[a,b,c,d,e,f] • History of trauma & victimisation[a,b,c,d,e,f] • Personal characteristics, including temperament[b,d,e,f] • Self-perception, including self-esteem[b,f] • Quality of the young person's early life experiences[a,b,d,e,f] • Exposure to pornography[a,b,c,d,e,f] • History of behaviour problems[a,b,c,d,e,f] • Sexual development, knowledge & attitudes[a,b,d,e,f] • School history & functioning[a,b,c,d,e,f] • Social functioning & relationships[a,b,d,e,f] • Spirituality, connectedness to others[f] • Cultural & ethnic issues[b]
Family and carers	• Family composition, history, functioning & support[a,b,c,d,e,f] • Attitudes & beliefs towards abuser & victim[b,c,d,e,f] • Sexual boundaries[a,b,c,f] • Medical & psychiatric issues[a,b,c,d,e,f] • Cultural & ethnic issues[b,f]
Environment	• Young person's access to vulnerable others[a,b,c,d,e,f] • Opportunity for further offending[a,b,c,d,e,f] • Community attitudes to young person & family[d] • Wider supervisory & support network[c,d,e]

Note. [a]AACAP, 1999; [b]Lane, 1997a; [c]National Adolescent Perpetrator Network, 1993; [d]O'Reilly & Carr, 2004a; [e]Rich, 2003; [f]Worling, 2003.

Assessment instruments that can be utilised to assess clinical symptoms and psychological functioning include the following: for older adolescents (17 years and over), the widely used *Beck Anxiety Inventory* (Beck, Epstein, Brown, & Steer, 1988) which measures severity of symptoms of anxiety and the *Beck Depression Inventory* (Beck, Steer, & Brown, 1996) which was designed to detect and assess the intensity of depressive symptoms; the *State-Trait Anxiety Inventory for Children* (Spielberger, Edwards, Lushene, Montuori, & Platzek, 1973) which was constructed to measure anxiety in children aged 9 to 12 years; the *State-Trait Anger Expression Inventory* (Spielberger, 1999) which provides measures of the experience, expression, and control of anger for adults and adolescents aged 16 years and older; the *Millon Adolescent Clinical Inventory* (Millon, Millon, Davis, & Grossman, 1993) which can be used with adolescents aged 13 to 19 years in the assessment of personality patterns as well as self-reported concerns and clinical syndromes; and the *Hare Psychopathy Checklist: Youth Version* (Forth, Kosson, & Hare, 2003), a 20-item rating scale for the assessment of psychopathic traits in male and female offenders aged 12 to 18 years.

Traumatic victimisation in children and adolescents can be assessed using a range of measures. These include the *Trauma Symptom Checklist for Children* (Briere, 1996) which evaluates post traumatic symptomatology in young people aged 8 to 16 years, including the effects of abuse, neglect, and witnessing trauma to others; the *Childhood Trauma Questionnaire* (Bernstein & Fink, 1998), a 28-item self-report screening tool designed to assess emotional, physical and sexual abuse as well as emotional and physical neglect; and the *Youth Self-Report* (Achenbach, 1991), a popular measure designed to allow adolescents (12 to 18 years) report on their own problem behaviours and social competencies. This instrument is generally used in conjunction with the *Child Behaviour Checklist* (Achenbach, 1991) which is completed by the caregiver.

Several instruments have been developed and used to assess aspects of sexual behaviour, attitudes and interest. These include the *Adolescent Cognition Scale* (Hunter, Becker, & Goodwin, 1991), a 32-item, true-false test designed to determine whether or not the adolescent has any distorted cognitions about sexual behaviours; the *Adolescent Sexual Interest Card Sort* (Hunter, Becker, Goodwin, & Kaplan, 1995) which can be used to determine the presence of deviant sexual interests; and the *PHASE Sexual Attitudes Questionnaire* (O'Brien, 1994) which assesses distortions around sexual

activity and consists of 50 belief statements about sexuality that are rated on a 6-point scale.

In order to assess aspects of family functioning the 90-item *Family Environment Scale* (Moos & Moos, 1986) can be used to measure cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, moral-religious emphasis, organisation, and control.

Risk Assessment

Risk assessments involve the estimation of an individual's potential for reoffending, usually described as low, medium or high risk. The outcome of such an assessment assists clinicians to make decisions regarding treatment intensity, placement, the timing of family reunification and the need for supervision and public safety (Rich, 2003; Worling, 2004b). Although there is no determinative way to predict reoffending risk, two methods have been described in the literature; namely, risk assessment based on clinical judgment and actuarial assessment. In the former, the clinician uses his or her experience and wisdom to assign a risk level based on direct contact and knowledge of the individual. In the latter, individuals are assessed on the basis of a fixed number of risk factors with a fixed scoring system. This involves a statistical calculation that computes the probability of reoffending. Numerous researchers have commented on the relative merits and shortcomings of these two methods (Doren, 2002; Hanson & Thornton, 2000; Litwack, 2001). Even so, it is important to note that while there has been significant progress in the development of actuarial risk assessments for adult sex offenders, well validated actuarial tools are still lacking (Rich, 2003). Furthermore, there is no empirical evidence to support any actuarial risk assessment tool in relation to ASO's. Although research in this area is ongoing, there are a number of useful tools that can assist clinicians. Indeed, there have been suggestions that good clinical practice will combine both structured clinical judgement (guided by the research and empirical evidence) and empirically based risk assessment tools (Hanson & Thornton, 2000; Litwack, 2001; Rich, 2003).

The two best known actuarial tools with any validation studies will be briefly described. The Juvenile Sex Offender Assessment Protocol (J-SOAP) developed by Prentky and colleagues assesses 26 risk items that are grouped into four factors (a) sexual

drive/preoccupation scale; (b) impulsive, antisocial behaviour scale; (c) clinical/intervention scale; and (d) community stability/adjustment scale (Prentky, Harris, Frizell, & Righthand, 2000). The factors and items were derived from reviews of the literature involving clinical and etiological studies of ASO's, and studies that examined risk among adult and ASO's, adult criminal offenders and juvenile delinquents. Although the J-SOAP appears to be a structured checklist of risk factors rather than an actuarial tool (Worling, 2004b), the authors are continuing their research with the expectation that it will eventually become a reliable and valid risk assessment schedule (O'Callaghan, 2002). Meanwhile, some promising results have been reported regarding the predictive validity of the J-SOAP based on archival data (Worling, 2004b).

Noting J-SOAP's reliance on static or historical variables (thereby failing to take into account changes that might result from treatment), Worling and Curwen designed a risk assessment tool that incorporated dynamic variables. It was intended that the inclusion of potentially alterable variables would assist clinicians to identify targets for treatment (Worling, 2004b). The Estimate of Risk of Adolescent Sex Offence Recidivism (ERASOR) is an empirically guided checklist that was derived from recidivism research (adults and adolescents) and expert opinion. This checklist identifies 25 risk factors which are grouped into five categories (a) sexual interests, attitudes, and behaviours; (b) historical sexual assaults; (c) psychosocial functioning; (d) family/environmental functioning; and (e) treatment. While preliminary psychometric data has been described as encouraging, further refinements are likely and independent research is now warranted.

Physiological Assessment Methods

The self-reports of ASO's are not always reliable. As mentioned previously, clinicians frequently encounter denial and minimisation regarding the extent of their sexual offending and their deviant sexual interests. In an attempt to obtain an objective measure of such behaviour and interest, physiological assessment methods are sometimes used (Witt, Bosley, & Hiscox, 2002). These measurements can be used not only to guide treatment planning and inform risk management (Becker & Harris, 2004), but also to provide baseline data against which subsequent measurements can be made (Rich, 2003). Although not in widespread use, the following assessment tools have

received the most attention; the plethysmograph, the polygraph examination, and viewing time testing, namely, the Abel Assessment for Sexual Interest. They are briefly described below.

Plethysmograph

Penile plethysmography is one form of assessing deviant sexual arousal. This procedure involves the measurement of penile circumference changes during the presentation of sexual stimuli in the form of audiotapes, slides, or videos. It is a labour intensive procedure and there have been criticisms that the lack of procedural standardisation and guidelines for administration, scoring and interpretation of data have produced unreliable results (Laws, 2003). Although the penile plethysmograph has been used extensively with adult offenders there is no compelling evidence to suggest that it is a reliable and useful form of assessment for ASO's (Becker & Hunter, 1997; Witt, Bosley, & Hiscox, 2002). Moreover, a number of concerns have been raised about the appropriateness of using this procedure with young people. These include ethical and legal concerns regarding the invasiveness of the procedure (Witt, Bosley, & Hiscox, 2002) and the use of nude photographs or sexually explicit audiotapes (Abel et al., 2004); problems obtaining informed consent; the risk posed to adolescents by exposing them to sexual material beyond their experience (Righthand & Welch, 2001); and reluctance to expose youth to further sexual stimulation (AACAP, 1999). In addition, there are indications that this form of assessment may be particularly limited in its use with adolescents who deny their offences (Abel et al., 2004; Becker, Kaplan, & Tenke, 1992).

Notwithstanding this controversy, a number of tentative conclusions have been reached. In a recent review conducted by Becker and Harris (2004), it was reported that plethysmographic assessment appears to have greater utility with older adolescents who target male victims and who acknowledge responsibility for their offending. The authors recommend that when plethysmography is used with adolescents, it should be in accordance with the *Practice Standards and Guidelines for Members of the Association for the Treatment of Sexual Abusers* (ATSA, 2001). It is not a recommended procedure for very young adolescents. While plethysmographic assessment with young people is rarely conducted in Britain (Will, 1999) and is not carried out in New Zealand, the plethysmograph has been used on adolescent treatment programmes in the United States

(Abel et al., 2004; Becker & Hunter, 1997). However, it is clear that more research is needed to fully evaluate the utility and validity of the plethysmograph with young people (Becker & Harris, 2004).

Viewing Time

Concerns about the invasiveness of plethysmographic assessment led to proposals for alternative measures for assessing sexual interest (Becker & Harris, 2004). These measures are known as viewing time or visual reaction time. In this procedure, individuals are presented with a series of images of males and females of various ages on a computer screen. They are asked to make a subjective judgement in relation to each image shown; this could involve rating the sexual attractiveness of each image or guessing the age of each person. However, the participant is not informed that the computer records the length of time taken to view an image and answer each question. It is assumed that actual viewing time is a better indicator of sexual interest than the recorded rating; a number of studies have supported this hypothesis (Witt, Bosley, & Hiscox, 2002). In response to ethical concerns regarding the appropriateness of using images of actual persons to arouse sexual interest, computer constructed images are now in use (Laws & Gress, 2004).

While there is limited data supporting the efficacy of viewing time in relation to adult offenders, even less attention has been paid to the utility of this procedure for evaluating sexual interest in adolescent offenders. However, in a recent study, Abel and colleagues assessed the validity of the Abel Assessment for Sexual Interest utilising a large sample. Although their results support the use of this assessment tool with adolescents (Abel et al., 2004), further independent investigations are warranted.

Polygraph

Given the problems of denial and minimisation in relation to sexual offending behaviour, polygraphy has been suggested as a means of testing for honesty and deception. The polygraph is a device that measures physiological activity, specifically heart rate and respiration, blood pressure and sweat gland responses. Sensors are placed on different parts of the body, a blood pressure cuff is positioned around the upper arm, electrodes are attached to the fingers, and pneumatic tubes are positioned around the chest and abdomen. While individuals respond to a series of questions, the polygraph

amplifies signals that are relayed from the sensors, thereby measuring any changes in autonomic arousal. There is an underlying assumption that arousal changes are associated with deception (Becker & Harris, 2004).

To date, polygraphy has been predominantly used in criminal court cases in the United States. However, it has also been reported that polygraph tests are frequently used in the treatment and risk management of convicted adult sex offenders who are subject to parole/probation conditions (ATSA, 2001). Polygraphy is not used in New Zealand.

In their review of the literature, Becker and Harris (2004) commented on the inconsistent results from the few studies that have evaluated the use of polygraphy with adult sexual offenders. However, there are indications that this procedure may be effective for eliciting admissions for past sexual offending behaviours and increasing motivation to disclose prior to polygraph testing. Furthermore, when periodic polygraphs are used as part of treatment, offenders are more likely to comply with their statutory parole/probation conditions. Of concern, was the lack of empirically based standards for use and interpretation of polygraphy results (Becker & Harris, 2004). These authors found only one article (Emerick & Dutton, 1993) on the use of polygraphy with ASO's (described as high risk). Although the polygraph enhanced disclosures, it was reported that adolescents tended to acknowledge information that was already known in the public domain. Despite the suggestion that polygraphy may encourage adolescent offenders to be more honest when they know that a lie detector will be introduced into treatment (Rich, 2003), more research needs to be conducted regarding the validity and reliability of this procedure when applied to an adolescent population.

In summary, research suggests that ASO's should be assessed in a number of areas so that appropriate intervention and risk management plans can be developed. A broad based assessment involves families, social services, schools and other agencies and consideration is given to developmental factors. While the clinical interview facilitates an in-depth understanding of the client, the use of psychometric assessment instruments can yield additional information. Risk potential and risk management are critical aspects of the assessment process and there are a number of risk assessment tools that have been developed for this population. It makes sense for clinicians to be aware of these instruments and their properties (Witt, Bosley, & Hiscox, 2002). With regard to

physiological assessment, while viewing time appears promising, evidence suggests that the plethysmograph and polygraph should not be routinely used.

Delivery of Treatment

Treatment is concerned with the protection of the community and the provision of interventions that facilitate interpersonal functioning and wellbeing, so that the adolescent can manage life's stresses and gain control over abusive sexual behaviour (Lane, 1997a).

More often than not, early treatment models were based on treatment programmes found to be effective with adult sex offenders (Veneziano & Veneziano, 2002). Treatment therefore largely favoured cognitive behavioural approaches and relapse prevention models (Rich, 2003). Developmental and contextual issues were often overlooked (Ryan, 1997a). Yet when the National Task Force on Juvenile Sex Offending was set up over two decades ago, their report emphasised the importance of providing a range of treatment services to cater for this heterogenous group so that appropriate intervention was tailored to each individual (National Adolescent Perpetrator Network, 1993). It was envisaged that such services would take into account the needs of both offenders and their families whilst ensuring the safety of the community.

In recent years there has been increasing awareness of the need to provide an integrated, multimodal treatment programme for youth. In view of the consistent finding that ASO's are more likely to reoffend nonsexually than sexually, it makes sense for treatment programmes to address factors relating to other forms of problematic behaviours (O'Callaghan, 2002). Some authors have suggested ways of blending traditional offence-specific interventions with holistic approaches that incorporate developmental issues and humanistic approaches (Longo, 2002; Ryan, 1999). There is a focus on treating the whole person (their mental, spiritual, emotional and physical wellbeing) and not just the sexual behaviour problem. Personal strengths are emphasised and the therapeutic relationship is viewed as the key to effective engagement in treatment (Longo, 2002).

Treatment Targets

It is essential for any treatment programme to have clearly defined goals that inform programme design and content. As a starting point, Ryan (1999) suggests that treatment with ASO's should have three overriding goals (a) development of positive communication skills that facilitate interaction and learning, (b) development of empathic skills, and (c) promotion of accountability through accurate attributions of responsibility. These three goals form a baseline from which specific treatment goals can be derived. Taking into account the diverse treatment needs of ASO's, a number of offence-specific and offence-related goals have been identified as important in the provision of comprehensive and holistic treatment. There is general agreement that the goals outlined in Table 2 are essential components of treatment (Center for Sex Offender Management, 1999; National Adolescent Perpetrator Network, 1993; Print & O'Callaghan, 2004; Rich, 2003; Righthand & Welch, 2001; Worling, 2004a).

Table 2. ***Recommended Treatment Goals***

Treatment Goals
• Accepting responsibility for behaviour without minimisation
• Recognising & interrupting the thoughts, feelings, & behaviours that lead to sexual offending behaviour
• Developing strategies to cope with prior childhood victimisation issues
• Developing empathic thinking & interpersonal awareness
• Recognising & reducing deviant sexual arousal, if present
• Developing prosocial skills, attitudes & behaviours
• Developing positive sexual knowledge, attitudes, interests & behaviours
• Learning strategies to manage anger & impulsivity
• Developing relapse prevention strategies
• Managing concurrent psychiatric conditions
• Building functional family relationships

Treatment Delivery Formats

To accomplish the abovenamed goals, a number of structured interventions are recommended. Treatment approaches typically include individual, group, and family interventions. Historically, group therapies have been described as the treatment of choice (National Adolescent Perpetrator Network, 1993). While there is very little empirical support for this claim (Righthand & Welch, 2001), virtually all programmes for ASO's include group work as a primary component of treatment (Morrison, 2006;

Rich, 2003). Proponents of group therapy have emphasised the importance of peer interactions with regard to confrontation of minimisation and denial; group membership which allows adolescents to address similar experiences and concerns; peer support; and the development of mutually reciprocal relationships (AACAP, 1999; Rich, 2003). In addition to sexual offending issues, groups also focus on problem solving skills, social skills, psychoeducation, anger management, self-esteem issues, and cognitive strategies for behavioural control (AACAP, 1999).

Nevertheless, some authors have warned against the use of certain peer group interventions for adolescents with problem behaviours (Dishion, McCord, & Poulin, 1999). In their study, Dishion and colleagues reported that the aggregation of high risk youth in group interventions resulted in an escalation in problem behaviours and negative life outcomes in adulthood. The conditions that might ameliorate this iatrogenic effect include the mixing of prosocial youth with antisocial youth in group interventions and incorporation of family/caregiver interventions. This further emphasises the need to provide treatment that takes into account all the circumstances presented by the adolescent and his/her family.

Family interventions are considered a key component of any treatment involving children and adolescents. Clinicians assist families to understand the adolescent's sexual behaviour in the context of family patterns and structures (Rich, 2003). A detailed description of this mode of treatment is given below.

Individual therapy is considered a useful adjunct to group and family therapy as it provides opportunities to address issues that are inappropriate for other formats. Although a number of disadvantages have been associated with individual therapy (possible manipulation of therapist, less confrontation, denial more easily sustained, and reduced opportunity to learn from others), many of these issues can be addressed in group therapy (AACAP, 1999). The main advantage of individual therapy is that it allows for the development of a therapeutic relationship in which issues of trust and attachment, unresolved developmental issues, deviant sexual fantasies, victimisation issues, conflicts, and motivational issues can be explored. Taking into account the importance of the therapeutic alliance, individual therapy can also facilitate engagement and participation in other areas of treatment (AACAP, 1999).

Treatment Models

This review outlines some of the treatment approaches that are frequently included in therapeutic programmes, both here in New Zealand and overseas. It is noted that the approaches described should be regarded as individual aspects of a holistic strategy. There appears to be no evidence to support the use of a single model treatment approach for this population (Rich, 2003).

Cognitive Behaviour Therapy

Cognitive Behaviour Therapy (CBT) is based on the premise that cognitions influence emotions, physiology and behaviour in reliable, consistent ways. Therefore, any disturbance in affect or behaviour is attributed to dysfunctional thinking. It is suggested that the identification and modification of maladaptive cognitions and behaviours are necessary prerequisites for bringing about emotional and behavioural change (Weerasekera, 1996).

When applied to the assessment and treatment of sexual offenders, there is a focus on the irrational thought processes which support or justify sexual offending. These cognitive distortions are typically pervasive and characterise interpretations across multiple domains. Cognitive and behavioural techniques are employed to challenge the thinking errors that legitimise behaviours (Ryan, 1991b), and to replace maladaptive behaviours with more functional behaviours. A wide range of CBT strategies may be used during individual, group, and family therapy. These include cognitive restructuring to identify and change problematic thoughts, feelings and behaviours; modifying reinforcement/punishment contingencies; social skills training; self-affirmation; assertiveness; problem solving; and stress management techniques.

In their review of the literature, Veneziano and Veneziano (2002) found that CBT techniques appear to form the basis of most therapeutic options in current treatment programmes for ASO's. In a meta-analysis of 43 studies (only four of which specifically examined ASO's), programmes that provided some form of CBT treatment appeared to be effective for adolescents (Hanson et al., 2002). In another review, the value of providing social skills training, cognitive restructuring, improving problem solving, assertiveness training for ASO's and antisocial youth, and addressing self-esteem was also highlighted (O'Callaghan, 2002). Thus, the importance of incorporating

CBT within a broad treatment framework appears to have merit (Prescott & Longo, 2006). Nevertheless, given that CBT was not designed to address motivational issues, work with underlying victimisation issues, and increase insight; the need to include forms of therapy that address these issues appears to also be warranted.

Behavioural Interventions

Some programmes use behavioural interventions to reduce deviant sexual arousal (Righthand & Welch, 2001). *Covert sensitisation* is aimed at teaching adolescents to interrupt the thought processes and behaviours that lead to offending by thinking of negative consequences associated with abusive behaviours (Becker & Kaplan, 1993). *Satiation techniques* involve either verbal or masturbatory satiation. Verbal satiation requires that offenders rehearse deviant thoughts in a repetitive manner to the point where they become bored or fatigued with the stimuli that had previously aroused them (Becker & Kaplan, 1993). With masturbatory satiation the offender is encouraged to masturbate to ejaculation in response to socially appropriate sexual stimuli. Following this experience the offender is required to masturbate to deviant sexual fantasies. If sexual arousal occurs, the offender is instructed to switch to an appropriate fantasy (AACAP, 1999). However, there is very little support for the use of this technique with adolescents due to practical and ethical concerns (Righthand & Welch, 2001). *Vicarious sensitisation* is a form of aversive conditioning that pairs deviant sexual arousal with negative experiences. The offender is exposed to audiotaped scenarios designed to stimulate deviant sexual arousal which is immediately followed by exposure to an aversive video depicting the negative consequences of sexually abusive behaviour (Righthand & Welch, 2001). Despite reports that these arousal conditioning techniques may be effective in changing patterns of sexual arousal, their use remains controversial and additional research is needed before definite conclusions can be reached (AACAP, 1999; Center for Sex Offender Management, 1999; Righthand & Welch, 2001).

Relapse Prevention

Many treatment programmes incorporate aspects of a relapse prevention model to identify and address risk factors for sexual offending (Morenz & Becker, 1995). Relapse prevention was originally developed for use in the addictions field (Chaney, O'Leary, & Marlatt, 1978) and has since been adapted for other populations including ASO's. This approach is based on the premise that sex offences are not impulsive acts but result from

the culmination of a chain of events. This involves an implicit belief that sexual offending is an habitual behaviour that can at best be managed but not cured (Hunter & Longo, 2004).

In treatment the adolescent is taught to identify the sequence of events (focusing on thoughts, feelings, behaviours, and situations) that lead to episodes of sexually abusive behaviour (Gray & Pithers, 1993). This sequence is often referred to as *offence chains* or *offence cycles.* Utilising CBT techniques, clinicians work with the adolescent to develop and rehearse strategies to escape or avoid these risky cues or situations. These cues can involve boredom, deviant sexual fantasies, and proximity to potential victims (ATSA, 2001). Safety plans are developed through individual, group, and family interventions to assist adolescents to recognise and manage risk factors. In order to assist individuals to adhere to their relapse prevention plans, clinicians enlist the support of the adolescent's wider social network (e.g., family members, social workers, caregivers, mental health professionals, school personnel, neighbours, close friends) so that the behaviours can be monitored in different settings (Gray & Pithers, 1993).

While there is tenuous empirical support for the efficacy of relapse prevention in the treatment of addictive disorders, there is even less evidence for the effectiveness of relapse prevention in the treatment of sexual offenders. Moreover, concerns have been expressed in relation to the applicability of this model for adolescents (Hunter & Longo, 2004). First, deviant sexual arousal may not apply to much of the ASO population. There may be significant differences in the *offence cycles* of particular subgroups; for example, the offending of those who target children (as opposed to peers and adults) may result from rejection, loneliness, and social ineptitude rather than paraphilic interest. Next, for some adolescents, there may not be a high degree of purposeful and planned behaviour involved. Finally, there is no compelling evidence that the majority of adolescents continue to sexually offend as adults. This calls into question the appropriateness of using a model that assumes their sexual offending behaviour is a chronic problem that can be managed but not cured. Although there have been a number of refinements to the model in recent years, considerably more research is needed before definite conclusions can be reached about how relapse prevention can be most effectively used with ASO's (Hunter & Longo, 2004).

Motivational Interviewing

In recent years, a number of models and techniques have been developed to assist clinicians to motivate resistant clients to engage in treatment. Prochaska's transtheoretical model of change was developed to better understand how people change addictive behaviours (Miller & Rollnick, 1991). It has also been applied to work with sex offenders (Calder, 2001). This model posits that individuals move through a series of five changes over time: precontemplation, contemplation, preparation, action, and maintenance (Prochaska & DiClemente, 1992). If clinicians can recognise where a young person is along this continuum, intervention can be tailored accordingly. Treatment failure can occur when the treatment approach does not match the individual's stage of change.

Motivational interviewing is a style of intervention designed to resolve motivation issues and strengthen commitment to change. The principles of motivational interviewing involve expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy. It has been suggested that this approach can be used with young people to enhance the therapeutic alliance and develop readiness to address their problematic behaviours through treatment (Miller & Rollnick, 1991). The usefulness of this approach with ASO's has been highlighted and consideration has been given to the development of specific strategies applicable to this population group (O'Reilly & Carr, 2004a).

Narrative Therapy

Narrative therapy focuses on the stories that individuals construct about themselves and their relationships based on their life experiences (Nichols & Schwartz, 2001). These stories originate in childhood as individuals try to make sense of their early life experiences. Subsequent life events are interpreted in a way that is consistent with the themes of earlier stories. In this way, an adolescent who has experienced trauma and victimisation may have developed negative stories about him/herself and not noticed or overlooked any experiences that contradict those stories. Narrative therapists assist individuals to develop new stories about themselves that are based on hopes, strengths and new possibilities (Adams-Westcott & Dobbins, 1997). The process of separating individuals from negative stories and the problems that dominate their lives is facilitated by the use of *externalising conversations* (White & Epston, 1990). Separating the

problem from the person in an externalising conversation alleviates the pressure of blame and defensiveness (Freeman, Epston, & Lobovits, 1997). Instead of defining a person in terms of the problem, the problem behaviour is located outside the person. Thus, narrative therapists encourage a young person to explore their relationship with the externalised problem.

While narrative approaches have been used extensively with children and adolescents, and their families (Freeman, Epston, & Lobovits, 1997), little is known about the efficacy of this approach with ASO's. A motivational model for engaging ASO's, using narrative techniques has been suggested by Jenkins (1999). Given that many ASO's have abuse-dominated stories, they are invited to explore their experiences of victimisation and injustice, then assisted to express stories of strength, survival and resistance to injustice. In this way, motivation is enhanced through the discovery and construction of an alternative story of identity. As the adolescent is encouraged to discover his personal strengths, he is assisted to identify discrepancies between these and his abusive behaviours (Jenkins, 1999). This motivational approach has been endorsed by other clinicians and adapted for use in a number of treatment programmes (Jenkins, 1999; Lambie, 2005; Print & O'Callaghan, 2004).

Psychodynamic Approaches

Psychodynamic theories are concerned with the unconscious impulses and internal conflicts that influence and shape emotion, cognition, behaviour and relationships. In treatment, underlying issues are brought to the surface, thereby increasing self-awareness and client insight. Although there are many variations of psychodynamic treatment, most are concerned with the exploration of hidden dynamics and the therapeutic relationship (Rich, 2003). It is hypothesised that a positive therapist-client relationship allows clients to experience and develop a different sense of self which can be instrumental in facilitating change (Woods, 1997).

In the treatment of ASO's, there is less focus on unconscious processes and more on learning about feelings and increasing emotional awareness in relation to everyday interactions (Rich, 2003). As adolescents are supported through the process of developing self-awareness and insight, they learn to have empathy for others.

Psychodynamic theory can be applied to individual, group, and family therapies. It also lends itself to expressive treatments involving drama, play or artwork. In group settings, there is a focus on the underlying dynamics present among group members and insight is developed through the experience of being in a group (Rich, 2003). Psychodrama can be used to enact events, relationships, and feelings in a group situation and to enhance victim empathy. In family settings, a psychodynamic approach takes into consideration the dynamic processes that influence family roles, structure, and patterns of interaction (Rich, 2003). Although psychodynamic approaches are not common in the treatment of ASO's and are rarely incorporated as part of the treatment package (Burton, 2003), this does not necessarily reflect that such approaches are ineffective; it suggests the need for further research.

Family Therapy

Consistent with systems theory, family focused treatment recognises that the beliefs and behaviours of young people are largely shaped and maintained by family interactions, structures and patterns. Involvement of the family in treatment is therefore seen as essential for understanding how the sexually abusive behaviour developed and examining the possible role of family members in shaping this behaviour. Moreover, the participation and support of family members can make a significant contribution to the adolescent's involvement in treatment (J. Thomas, 2004). Taking into account the complicated family systems that many ASO's have, family therapy can involve working with biological parents, adoptive parents, foster and group home parents, older siblings, extended family members, social workers, teachers, and any other significant caregivers. Following family assessment and treatment an individualised treatment plan is developed. The provision of a programme specific education pack for family members is recommended as a way of keeping them informed about programme content and expectations (J. Thomas, 2004).

Notwithstanding the uniqueness of each family, a number of treatment issues have been identified as affecting most families. Family therapists might therefore address denial, minimisation, and projection of blame; lack of empathy; abuse of power, powerlessness and empowerment; anger management; intergenerational abuse; blurred role boundaries; divided loyalties; sexuality; and substance abuse. Recommended treatment interventions include individual family therapy with mixed gender cotherapy teams,

multifamily therapy (bringing together several families to discuss mutual concerns), parent support groups, family psychoeducation groups, therapeutic family visitation (home visits in preparation for reunification), family retreats (spending one or two days with other families), and provision of aftercare services (J. Thomas, 2004).

While there has been little evaluation of the use of a family focused approach with ASO's, there are indications that treatment for ASO's is most successful when the family is included (Worling & Curwen, 2000a). Furthermore, there is a considerable body of research that demonstrates the efficacy of family therapy for other adolescent populations (Barnes & Hughes, 2002; Tarolla, Wagner, Rabinowitz, & Tubman, 2002; J. Thomas, 2004). In the research, authors frequently refer to their clinical impressions that the family's inclusion in the treatment of ASO's improves outcomes. This is not surprising considering the importance of family system issues in the etiology and maintenance of problem behaviours.

Experiential and Expressive Therapies

It has been suggested that the provision of expressive and experiential interventions in ASO treatment programmes are essential (Bergman, Hewish, Robson, & Tidmarsh, 2006; Longo, 2004; Rich, 2003; Tyo, 2005). They offer different ways of working with adolescents and allow for the exploration of difficult issues through creative and physical activities. Adolescents can thus engage in a treatment process that is not reliant on verbal communication alone. Experiential treatments can involve participation in games and recreational activities that promote enjoyment, initiative, physical skills and wellbeing; as well as group exercises that build trust, co-operation and self-esteem (Rich, 2003). Wilderness programmes (described below) are another form of experiential treatment. Experiential interventions provide adolescents with numerous opportunities to develop and practice a range of prosocial skills and behaviours.

Expressive therapies include role plays, writing stories, drama therapy, music therapy, art therapy and play therapy. These methods can provide outlets for expressing thoughts, feelings and experiences that are not easily accessible, and as such can provide emotional release (Rich, 2003). Taking into account the range of developmental levels that are evident in ASO's presenting for treatment and the verbal skills required for most therapeutic interventions, it makes sense for programmes to provide alternative

avenues for self-expression. Such approaches can be used to augment the standard cognitive behavioural/relapse prevention models used to treat adolescents who sexually offend (Longo, 2004). However, until the efficacy of these interventions as applied to adolescent sexual offending are examined empirically, we continue to rely on clinical impressions to inform our knowledge in this area.

Wilderness Programmes

Therapeutic wilderness programmes were initially developed as rehabilitative and preventive interventions for delinquent youth (Wilson & Lipsey, 2000). Such programmes provide opportunities for individuals to engage in a range of physically challenging activities (such as kayaking or rock climbing), which are intended to facilitate personal growth. By mastering difficult physical challenges, whilst receiving encouragement and support from team leaders and peers, individuals are expected to learn interpersonal skills that will transfer to situations beyond the wilderness setting. The activities are therefore designed to increase self-esteem, reduce social alienation, increase problem solving skills and build a more internalised locus of control (Castellano & Soderstrom, 1992).

Despite these aims, the efficacy of wilderness programmes has yet to be established. In their meta-analysis of outcome evaluations for wilderness programmes for delinquent youth, Wilson and Lipsey (2000) reported modest overall effects. However, programmes that included a distinct therapy component and relatively intense activities produced the greatest reductions in delinquent behaviour (Wilson & Lipsey, 2000). In another review involving juvenile offenders, the lack of empirical evidence supporting treatment gains over time and lack of data on how these programmes might influence the behaviour of serious offenders was reported (Tarolla, Wagner, Rabinowitz, & Tubman, 2002). Treatment effectiveness with ASO's needs to be investigated before conclusive comments can be made about the utility of including wilderness programmes as part of ASO interventions.

Another intervention that can encompass recreational activities and outdoor adventure experiences is *mentoring* (Evans & Ave, 2000). Mentoring programmes involve the pairing of a volunteer with a young person who is deemed to be vulnerable or *at risk*. While mentors are frequently identified as role models, parental substitutes, and sources

of social support, they have also been referred to as agents of behaviour change in situations where they are paired with delinquent youth. In their review of the literature evaluating mentoring programmes, Evans and Ave conclude that although mentoring is not suited to remedying serious social problems, benefits can accrue to children and youth with regard to education and the acquisition of specific life skills. There appears to be no discussion in the literature regarding the suitability of mentoring programmes for ASO's.

Pharmacological Treatment

The use of psychotropic medications in the treatment of ASO's with comorbid conditions is widespread (Rich, 2003). Such conditions include depression, anxiety disorders, attention deficit hyperactivity disorder (ADHD), obsessive compulsive disorders and psychotic disorders. It is generally believed that the alleviation of symptoms through medication improves overall functioning, thereby enhancing receptivity to psychotherapy. Although little is known about the numbers of ASO's in treatment taking psychiatric medications (Rich, 2003), in one North American survey it was found that nearly 40% of community based treatment programmes for ASO's include pharmacology as part of treatment (Burton & Smith-Darden, 2001). Furthermore, it is likely that the use of medication to treat this population will continue to increase given the reported increases in medication use among young people in the general population over the past decade (Rich, 2003).

Despite these trends, there is very little evidence to support the use of pharmacological treatment with young people. While safety concerns have been raised about the possible negative effects of powerful drugs on normal development and growth, there are indications that psychotherapy alone is just as effective as medication combined with psychotherapy (Rich, 2003). It is not yet known how this form of intervention is best applied in the treatment of ASO's with comorbid psychological conditions.

Medications are also used to reduce sexual drive and sexual arousal. However, the role of drug therapy in reducing sex offending in adolescent offenders has received little attention (Gerardin & Thibaut, 2004). There is suggestive evidence that antidepressants, especially selective serotonin reuptake inhibitors (SSRIs) may be effective in the treatment of adults with paraphilic symptoms associated with obsessive compulsive

disorders. Some case reports suggest that SSRIs also offer promise in the treatment of adolescent paraphilias (Bradford, 1993; Galli, Raute, McConville, & McElroy, 1998), but controlled studies are needed.

Hormonal treatments (antiandrogens) are used to control abnormal sexual drives and desires. Little is known about the use of antiandrogens with ASO's. There have been suggestions that hormonal intervention may be warranted in rare cases when severe paraphilic behaviour is present, when other psychotropic medications (such as SSRIs) have failed and when there is a high risk of sexual violence (Gerardin & Thibaut, 2004). For some adolescents with severe mental retardation and sexually aggressive behaviours, consideration may be given to hormonal treatment when other interventions have failed. However, the adverse effects of this treatment include bone mineral loss so careful medical assessment is required. In view of pubertal development, hormonal treatments are discouraged for use in adolescents under 16 years (Gerardin & Thibaut, 2004).

In conclusion, the pharmacological treatment of ASO's is relatively unexplored and treatment providers are understandably cautious given the ethical and legal concerns that pertain to this age group. As yet, there is no licensed drug for the treatment of ASO's and clinical trials need to be undertaken to establish whether or not pharmacological treatment is effective for particular types of offenders.

Multisystemic Therapy

This therapeutic approach draws on social ecological models of behaviour which give consideration to the interconnected systems of family, school, work, peers, and community. It is proposed that dysfunctional behaviour is maintained by problematic transactions within or between these systems (Borduin, 1999). Multisystemic therapy (MST) aims to promote change by targeting multiple key factors within these systems and by engaging the young person's social network in the task of managing problem behaviours and promoting prosocial outcomes (Borduin, 1999; O'Callaghan, 2002). Interventions are delivered in family or community settings, are based on systemic strengths, fit the developmental needs of the youth, and are tailored to the individual needs of family members. Treatment strategies include structural family therapy,

behavioural parent training, and CBT; pharmacological treatment is incorporated when appropriate (Borduin, 1999).

In recent years, MST has emerged as a promising treatment model for ASO's (O'Callaghan, 2002; Swenson, Henggeler, Schoenwald, Kaufman, & Randall, 1998). In fact, in recent reviews MST has been described as the most promising intervention for this population group (Chaffin, 2006; Veneziano & Veneziano, 2002). Even so, although the effectiveness of MST has been empirically validated for the treatment of serious juvenile offenders (Borduin et al., 1995), outcome studies with ASO's are limited to two small randomised clinical trials (Borduin et al., 1995; Borduin & Schaeffer, 2001). Results suggest ASO's who receive MST have lower recidivism rates for sexual and nonsexual offences than offenders who receive usual treatment services. These findings apply for up to 8 years following referral to treatment. In another study that examined recidivism rates among ASO's following completion of a treatment programme that uses an MST approach, results suggested that this treatment was also effective in reducing the risk of subsequent sexual and nonsexual offending (Worling & Curwen, 2000a). Additional evaluations of MST with ASO's are currently underway (Saldana, Swenson, & Letourneau, 2006).

In summary, while a variety of treatment approaches for ASO's have been described in the literature, very few have been examined empirically. CBT and MST interventions appear to have received the most research attention and support while other methods of treatment (e.g., experiential and expressive interventions, narrative therapy, and psychodynamic approaches) have received little evaluative attention. However, given the need to provide a comprehensive model of treatment for ASO's, it is important for treatment providers to expand the focus beyond a single model approach and to incorporate a range of therapeutic approaches that give consideration to developmental processes and contextual factors (Rich, 2003).

Service Delivery Issues

While treatment programmes for ASO's have now been in place for over two decades, there are no evidence-based treatment manuals or guidelines to inform service delivery in this area (Burton, Smith-Darden, & Frankel, 2006). Treatment providers generally rely on expert opinion and accepted clinical practice in programmes located mainly in

the United States, Canada and Great Britain. Nevertheless, given that process evaluations are concerned with the ways in which programmes operate and are implemented, the following service delivery issues are highlighted as a reference point for this study.

Duration and Intensity of Treatment

Questions remain about the appropriate level of intensity and dosage of treatment required for effective intervention (Prescott & Longo, 2006). However, it is recognised that there is no *quick fix* to the problem of adolescent sexual offending and that satisfactory treatment generally requires a minimum of 12 to 24 months (National Adolescent Perpetrator Network, 1993). Given that not all ASO's require the same level of intervention, treatment duration and intensity will also be influenced by the assessed treatment needs of individuals (Rich, 2003). In an extensive survey of sexual abuse treatment programmes in North America it was found that the length of treatment for adolescents in community based programmes ranged from 12 to 24 months with an average length of time in treatment of around 18 months (Burton & Smith-Darden, 2001). However, Prescott and Longo (2006) have expressed concern that some programmes in the United States have reduced the length of treatment in recent years due to budgetary pressures. Moreover, there has been a recent trend towards reducing the amount of individual and family treatment and increasing the number of group therapy sessions which may also reflect financial constraints and the differential costs of providing such sessions (Burton, Smith-Darden, & Frankel, 2006).

Aftercare

This refers to the aftercare planning and follow-up services that are put in place after clients are discharged from a programme. It has been suggested that aftercare is a critical component of treatment and should be aimed at providing posttreatment support for adolescents and their families, monitoring risk, and assisting young people to apply treatment concepts and strategies in the community (Calder, 2001). However, there is scant mention in the literature regarding the appropriate format, number, and length of aftercare services. Treatment providers have been urged to offer aftercare follow-up for *as long as necessary or possible,* based on the individual needs of clients (J. Thomas, 1997). Suggested strategies include therapist follow-up phone calls, regularly scheduled

individual appointments, check-in appointments for monitoring, and group and family therapy (J. Thomas, 1997).

Interagency Collaboration

Given that no agency has sole responsibility for managing young people who sexually offend, collaboration among treatment providers and agencies involved in health and social services, child protection and youth justice is considered vital (Masson & Erooga, 1999). In recent years, considerable emphasis has been placed on the need for local agencies to work together to formulate a mandate aimed at ensuring there is agreement and mutual understanding between individuals and agencies about their respective roles and responsibilities (Calder, 2001). The quality of interagency collaboration has been described as crucial in order to enhance programme effectiveness (Morrison, 2004).

Most of the research literature in this area comes from Great Britain where treatment services are funded principally through the public sector (New Zealand is similar in this respect), unlike the United States where the private sector accounts for well over half of all services (Morrison, 2004). The reliance on public sector funding therefore has significant implications for interagency collaboration and the identification of key stakeholders. One of the largest examples of a strategic interagency intervention approach in Great Britain is the AIM (Assessment Intervention and Management) project which was implemented across the Greater Manchester area in 2001 (Morrison, 2006). In order to establish an interagency framework for effective service delivery, the collaborative project established the following elements: an interagency set of procedures for assessments, initial decision-making and placements; involvement of social workers and youth justice or health professionals in assessments; a multiagency planning meeting which includes family members; guidance for schools about the recognition, referral and management of pupils exhibiting sexually harmful behaviours; provision of comprehensive training for practitioners and managers from agencies involved in the care of the young person; set of protocol for adapting family group conferences for ASO's; and provision of group programmes in community settings (Morrison, 2006). While this list is by no means definitive, it does provide a broad template for interagency initiatives.

Placement Provision

Providing appropriate accommodation is essential for successful community based treatment (Lambie & Seymour, 2006). Continuum of care models of treatment suggest the need to offer a range of placement options for ASO's based on their level of assessed risk (Bengis, 1986; Righthand & Welch, 2001). The level of placement supervision required therefore corresponds to the level of risk posed by the young person. Remaining at home, living with extended family members, foster care, specialist group homes, semi-supervised accommodation, and locked residential treatment facilities all fall within this continuum (Bankes, Daniels, & Quartly, 1999). Decisions about placements are generally based on safety issues, available options, and the needs of the adolescent and adolescent's family. However, ongoing problems associated with lack of suitable placements, an unco-ordinated approach among professionals and inadequately trained carers have been well documented (Bankes, Daniels, & Quartly, 1999). The need to increase resources to this part of the service delivery system has been highlighted.

Cultural Services

While the importance of providing culturally appropriate treatment for ethnic minorities was highlighted over two decades ago (National Adolescent Perpetrator Network, 1993), the literature reveals a glaring lack of commentary in this area (Tarolla, Wagner, Rabinowitz, & Tubman, 2002). In their work with South Asian ASO's in Great Britain, Abassi and Jamal (2002) noted the impact of failing to address cultural issues in treatment. They described communication and language barriers, noted how lack of cultural and religious knowledge created barriers to assessment and treatment, highlighted the need to take into account clients' different acculturation levels, and emphasised the lack of culturally appropriate treatment material and practices. Noting the current lack of culturally responsive services as well as discussion about services for ethnic minorities, Calder (2006) concludes that this area is in need of significant development.

Treatment Providers

There is a clear need for clinicians working in this area to be personally and professionally qualified (National Adolescent Perpetrator Network, 1993). Personal characteristics include emotional health and wellbeing, respect for self and others, good listening skills, and empathy. Professional qualifications include relevant education, training, knowledge and experience. However, if staff are not well managed and there are not good systems in place to support staff to work within their organisations and across agencies, their knowledge and skills will be underutilised (Morrison, 2004). As part of the induction process to this work, it has been recommended that treatment providers should receive specific training in the area of sexual abuse and thereafter have their training needs evaluated and catered for on a regular basis. Specific training is essential as clinical assessment interviews, risk evaluation and the administration of assessment tools, working with young people and providing sexual offender-specific treatment requires specialist skills. In order to maintain effective practice, staff also require good supervision to process information about clients, emotional responses to the work, and issues related to treatment planning (Morrison, 2004).

The impact on therapists who provide sexual abuse treatment and the need for systems to be put in place to reduce negative effects have long been recognised (National Adolescent Perpetrator Network, 1993). It is challenging work that often requires clinicians to manage their personal abhorrence to sexually abusive behaviour while striving to be helpful (Ryan & Lane, 1997a). In recent years this issue has received increasing attention in relation to practitioners working with trauma survivors (Bell, Kulkarni, & Dalton, 2003) and with sex offenders (Steed & Bicknell, 2001; Way, VanDeusen, Martin, Applegate, & Jandle, 2004). In the literature, the terms *vicarious trauma* and *secondary trauma* have been used to describe practitioners' burnout experiences. In one study involving a large random sample of male and female clinicians who treat sex offenders (both adult and adolescent), the majority reported levels of vicarious trauma in the clinical range. Moreover, higher levels of vicarious trauma were reported by clinicians who had been providing sexual abuse treatment for shorter periods of time (Way, VanDeusen, Martin, Applegate, & Jandle, 2004). These findings highlight the need for organisational strategies to reduce secondary or vicarious trauma. Recommended strategies include the provision of a positive organisational culture and safe work environment, peer consultation, cotherapy and teamwork,

caseload monitoring, resources for self-care, effective supervision, professional training, and education about secondary or vicarious trauma (Bell, Kulkarni, & Dalton, 2003; Bober & Regehr, 2005; Ryan & Lane, 1997a; Way, VanDeusen, Martin, Applegate, & Jandle, 2004).

Implications of Literature for the Current Study

It is clear from this review that the literature on adolescent sexual offending is marked by theoretical discussion and description of established practice. There is a dearth of literature and research about what works. Moreover, most of the material comes from the United States and as such is located within a legislative, policy, and cultural context that is not necessarily relevant for service provision in other countries (Morrison, 2006). While there will be shared challenges and problems across programmes, contextual variables inevitably influence the extent to which material can be applied to different settings. Treatment providers in this country therefore need to be cautious in their use of imported material and give consideration to New Zealand's unique mix of cultural and community factors when delivering treatment. Conceivably, a contextual perspective may increase the prospect for successful treatment.

In New Zealand, the development of specialised treatment services for ASO's got underway in three main cities during the early 1990's. Through a process of networking and collaboration with interested colleagues, the founders of these services shared information and supported each other in the initial development of the programmes. However, concerned by their inadequate resources and the minimal financial support from governmental health and social welfare departments, they lobbied central government in order to secure long-term funding for treatment services. Largely in response to this lobbying, a national strategy for the treatment of ASO's was developed in partnership between the New Zealand government and treatment providers in 1998. The aim of the strategy was to ensure that a continuum of care and treatment services was available in order to cater to the particular needs of the ASO (Lambie, McCarthy, Dixon, & Mortensen, 2001). Community based treatment and residential treatment exist at opposite ends of this continuum. The outcome of the national strategy led to treatment providers receiving adequate levels of funding to enable them to further develop the community programmes. Currently, there is little reliance on residential

treatment and the community programmes continue to receive adequate funding from the government under the auspices of CYF (Lambie & Seymour, 2006).

Initially, the programmes based their treatment services on models that were derived from North America. They incorporated aspects of interventions designed for adult offenders (CBT approaches with a strong relapse prevention component) and for juvenile delinquents (such as therapeutic wilderness programmes; Lambie, McCarthy, Dixon, & Mortensen, 2001). However, the treatment focus broadened over time, as managers and staff furthered their knowledge by visiting *successful* overseas programmes, attending conferences, liaising with recognised experts in the field and keeping abreast with the latest research. At the same time, treatment providers became increasingly aware of the need to give consideration to the applicability of international research to the New Zealand setting and to attend to the cultural context of ethnic minorities.

It is noted that New Zealand has a diverse multicultural population. Maori, who are the indigenous people of New Zealand, make up around 15% of the population whereas Pacific Islands people account for approximately 7% of New Zealand's population (Statistics New Zealand, 2006). Thus, despite an initial reliance on international studies to guide treatment in this area, the programmes began developing their own initiatives to suit the New Zealand context (Lambie, McCarthy, Dixon, & Mortensen, 2001).

As mentioned at the beginning of this chapter, to date, there has been no systematic evaluation of the community based ASO treatment programmes in New Zealand. However, to ensure that certain standards of excellence were being met and maintained, CYF obtained clinical audits of the programmes at regular intervals. These were undertaken by recognised experts in the field from outside New Zealand. Notwithstanding several recommendations for improving service delivery, overall, these audits concluded that the New Zealand programmes were delivering best practice programmes of an innovative cutting edge standard (Lambie, McCarthy, Dixon, & Mortensen, 2001). Similarly, in a comparative description of programme development for ASO's in Australia and New Zealand, Flanagan (2003) commended the New Zealand programmes for their considerable achievements and concluded that in some respects, they were more advanced than the programmes in Australia.

Despite these conclusions, the provision of in-depth information that might assist others to identify what it is that makes the New Zealand treatment programmes stand out appears to be lacking. Documentation obtained from the programmes indicates that the scope of the clinical audits was generally limited to the assessment of performance standards. Typically, information was obtained from programme manuals, information booklets and workbooks, small numbers of treatment files, observations of programme operations conducted during one site visit, and interviews with managers and programme staff. Thus, the lack of in-depth information about programme implementation in New Zealand, coupled with suggestions that the New Zealand programmes were doing exceptionally well (Flanagan, 2003; Lambie, McCarthy, Dixon, & Mortensen, 2001) highlights the need for further investigation.

This study aims to examine the New Zealand variation of ASO treatment by providing detailed information about the characteristics, operation, and services provided by the local programmes. While there is some reliance on information obtained from programme documentation, the main source of information is obtained from interviews with stakeholders. It is intended that the provision of detailed and comprehensive information about the New Zealand programmes may pin-point areas for programme development and improvement that can be utilised by treatment providers in other countries.

Evaluation Objectives

The present study reports on a process evaluation of ASO treatment programmes in New Zealand. It attempts to provide insight into service provision within the New Zealand context and in doing so, provide direction for service improvement in the wider context. As such, this study has the potential to extend existing knowledge and add greater depth to the body of knowledge that already exists in this field.

It is apparent from this review of the literature that much remains unclear regarding what constitutes effective treatment for this client group. Typology research is not yet completed and the effectiveness of different interventions with specific subgroups is not yet known. Furthermore, there appear to be no evidence-based treatment manuals for ASO programmes and any manuals that do exist simply provide guidelines, opinions, structure and a recommended treatment programme to follow (P. Rich, personal

communication, December 19, 2006). In the absence of empirically proven treatment for ASO's, the literature abounds with references to expert opinion and established clinical practice while the perceptions of programme participants are notably absent. Moreover, while this review has referred to several publications that seem to provide clear, informed direction for treatment providers working in this area, on balance, there appears to be very little discussion about the contextual factors that are relevant to programme operations and the processes that influence outcomes. It is therefore suggested that this study is relatively unique in that it seeks to provide this information by examining treatment programmes in a nationwide context from the perspectives of stakeholders. It also examines these programmes *from the inside.* This is achieved by utilising the experiences of clients and their families who attend the treatment programmes, as well as programme staff and staff from external agencies.

Thus, the evaluation design of this study was developed to address issues of process and implementation at the three main community based ASO treatment programmes in New Zealand. Data was collected from four stakeholder groups at three geographical sites between December 2003 and October 2004. The specific aims of the study were to:

1) describe the context, characteristics, and operation of the programmes;

2) evaluate the extent to which the programmes meet the needs of adolescent clients, family members and caregivers, with particular reference to their views;

3) provide information about successful and less successful programme components and processes with particular reference to consumer perspectives;

4) examine the working relationship between the programmes and stakeholders from external agencies;

5) examine programme operations with a view to identifying factors (including systemic issues) that might impact on the successful delivery of the programmes; and

6) identify areas for possible improvements to the programmes.

This introductory chapter has provided the background to the study and outlined its aims. In Chapter 2 an outline of the study design and methodology is presented and this is followed by a description of the New Zealand ASO treatment programmes. The

results of the study are then examined and discussed with reference to consumer perspectives in Chapter 4, and staff perspectives in Chapter 5. Consumer and staff perspectives are reported separately because (a) in general, their views and experiences reflect different aspects of the programme. Consumer perspectives largely reflect their experiences of therapy whereas staff perspectives reflect a main focus on programme operations; (b) it was considered important to give voice to programme participants in a stand-alone chapter so that their experiences could be seen and understood in their own context without *intrusion from the outside*; and (c) consumer and staff perspectives of the same aspects of the programme are derived from their different roles in the programmes - it was therefore considered appropriate to recognise this by separating their stories. However, consumer and staff perspectives are brought together in the final chapter. In Chapter 6, study findings are summarised and their implications for service improvement in New Zealand and other settings concludes the dissertation.

Chapter Two: Methodology

The first part of this chapter presents an overview of the evaluation framework and outlines the qualitative research approach used in this study. The second part describes the research method that was used and includes a description of the participants, the development of the interview schedules and the procedures undertaken. It concludes with a description of data analysis.

Programme Evaluation

This study encompasses recent developments in programme evaluation research. When programme evaluation in the human services field got underway in the United States during the 1960's, evaluators were primarily concerned with whether a programme worked or was effective in order to assist the allocation of limited resources (Sanders, 1998). At this time the scientific method with its emphasis on quantitative measurement and experimental design dominated the research field in general; programme evaluation research also relied on this paradigm to examine programme outcomes. In doing so, evaluators typically used programme goals to test hypotheses about the impact of a programme in order to show causal relationships between certain outcomes and the interventions aimed at producing these outcomes (Sanders, 1998). However, over time, the limitations of the hypothetico-deductive model became particularly apparent. The requirement for strict variable measurement and control generally limited the scope of evaluations to single intervention programmes that operated in relatively controlled environments (Sanders, 1998). It became clear that this model was ill-equipped to generate understandings about the complexities of comprehensive community programmes that operate in real-world settings.

In time, evaluators also became increasingly aware of the limitations of an almost exclusive focus on programme outcomes. Important dimensions of programmes were being missed; little was known about how or why programmes work, for whom they work and in what circumstances (Sanders, 1998). Moreover, there was increasing recognition of the importance of gathering useful information to assist programme improvement. While the pressure to demonstrate programme effectiveness remained,

evaluators began to give consideration to programme processes and implementation issues (Patton, 2002a). This shift in focus led to calls for evaluation designs that not only assess whether a programme is successful but also facilitate understanding about how or why particular outcomes have or have not been achieved, and identify ways of improving programmes (Mears, Kelly, & Durden, 2001; Saunders, Evans, & Joshi, 2005). In order to conduct such enquiry, many evaluators turned to qualitative methods as these illuminate the processes and outcomes of the programme and facilitate study of issues in depth and detail (Patton, 2002a). In this study, qualitative research methods were used and a description of this approach is given later in the chapter.

Alongside the relatively recent trend to include programme processes and implementation issues in programme evaluation, there has been a proliferation of labels to describe different types of evaluation. This has led to considerable confusion as classifications are often based on different considerations. For example, some evaluations are classified according to *their purpose*, whereas others are based on *who the evaluation is for* (Spencer, Ritchie, Lewis, & Dillon, 2003). Patton (2002a) lists nine different kinds of evaluation based on the purpose of the enquiry (e.g., outcomes evaluation, process evaluation, implementation evaluation, evaluability assessments, and prevention evaluation), and points out that this list is far from exhaustive. It is clear that there is no single, *best* approach to programme evaluation which can be used in all situations (Sanders, 1998). However, in order to determine the most appropriate approach to use, evaluators are advised to give consideration to the purpose of the evaluation, the questions that need to be answered, and the methods that yield the most useful information (Patton, 2002a; Sanders, 1998). In this evaluation, a process study was considered to be the most appropriate evaluation approach and this is described below.

Process Evaluation

In broad terms, process evaluation is concerned with what happens during programme implementation (Dehar, Casswell, & Duignan, 1993). In reviewing definitions of process evaluation provided in the evaluation literature, Dehar and colleagues found that authors differed in the emphasis they placed on different aspects of process evaluation and the extent to which they specified the range of aspects that should be included in such evaluation. However, based on their examination of some of the published material

in this area, these authors concluded that the primary aim of process evaluation is to document and analyze the way a programme operates to assist in the interpretation of programme outcomes and to inform future programme planning. They also identified a number of features which they considered to be relevant to most situations, some of which are included in this study, as outlined below.

Process evaluations include an examination of programme origins; programme structure, components, and delivery system; contextual factors relevant to programme operation; and perceptions of programme participants. This study provides a description of how the programmes developed over time; information about programme operations, programme content, and service delivery issues; an elucidation of some of the factors that impact on programme operations through a focus on the quality of the organisational environment and working arrangements with external stakeholders; and a portrayal of how the programmes are experienced by adolescent clients, family members and caregivers.

While these features offer initial insight into the scope of this study, there are aspects of process evaluation that have been given particular emphasis in this study. In his description of process evaluation, Patton (2002a) highlights the importance of elucidating and understanding the internal dynamics of programme operations. This is achieved through a focus on the nature of people's experiences that make the programme what it is, programme strengths and weaknesses from a variety of perspectives, and the nature of provider-recipient interactions. As stated in the first chapter, the primary aim of this study is to document the operation and characteristics of the New Zealand programmes and to identify strengths and weaknesses of the programme and service delivery. This is accomplished by examining the perceptions, experiences, and inter-relationships of four different stakeholder groups, namely, programme staff, adolescent clients, family members and caregivers, and external agency staff.

There appears to be general agreement that process evaluations are particularly useful for providing information to improve programmes, and for dissemination and replication of successful interventions in situations where a programme is shown to be successful (Dehar, Casswell, & Duignan, 1993; Patton, 2002a; Wolfe, Guydish, Woods, & Tajima, 2004). The provision of in-depth information about the functioning of

treatment services and systems can reveal areas where improvements might be made, as well as highlight strengths of the programme that should be preserved (Patton, 2002a). This not only provides useful feedback to treatment providers but also assists them and other stakeholders (such as funding bodies and external agencies) to make informed decisions about the programme. The identification of factors that either impede or promote programme delivery and positive outcomes also helps treatment providers in other settings to better understand and improve their own programmes (Wolfe, Guydish, Woods, & Tajima, 2004). If aspects of a programme are considered to be worthy of replication at other sites, process evaluations can provide vital information for this to be put into effect. Thus, this study not only has relevance for the New Zealand context, but also has the potential to contribute useful information to programmes offering similar services for ASO's in other countries.

Evaluation Framework

As evaluation planning gets underway, it is important to have a framework and model to guide evaluation design, assist with methodological decisions and provide direction for dealing with stakeholders (Patton, 2002a). Despite calls for researchers to make explicit the philosophical or theoretical framework of their enquiry (Patton, 2002a), this is not a straightforward task. To start, research paradigms are labelled and described in different ways and the philosophical positions that underpin different approaches vary between different accounts. Next, research paradigms are frequently presented as dichotomous which tends to stereotype and exaggerate their differences. Finally, the labelling of paradigms infers that researchers consistently operate within these frameworks rather than varying their approach for different projects (Patton, 2002a; Spencer, Ritchie, Lewis, & Dillon, 2003).

With regard to programme evaluation, the relevance of working within a particular theoretical tradition has also been questioned (Patton, 2002a). For example, operating within one paradigm can limit the practical and methodological options available for evaluators. Moreover, taking into account the practical application of programme evaluation, utilitarian evaluation frameworks can be used to guide research design and these do not rely on theoretical underpinnings (Patton, 2002a).

This investigation is therefore based on a *utilisation-focused evaluation* model (Patton, 1997). Utilisation-focused evaluation does not confine itself to any particular evaluation purpose, method, theory or use. It is the particular context of the primary intended users that ultimately determines what kind of evaluation is needed. Appropriate research methods and data analysis techniques are selected when the information needs of evaluation users and the intended uses of findings have been determined (Patton, 2002b).

As mentioned at the beginning of this chapter, in recent years there has been increasing recognition of the importance of conducting programme evaluations that gather *useful* information to guide programme improvement. Utilisation-focused evaluation was originally developed from a qualitative study (interviews with evaluators, funders, and programme managers) that examined how evaluation findings were used (Patton, 1997). Patton refined the model further through evaluative practice and by studying how other reputable evaluators consult with clients and conduct themselves during the research process (Patton, 2002a). He describes utilisation-focused evaluation as a flexible and creative process for interacting with intended evaluation users about their information needs and alternative methodological options. It begins with the premise that evaluations should be concerned with utility and actual use. Evaluators work with intended users (e.g., programme staff, clients, funders, and community representatives) to identify priority evaluation uses as well as the questions and issues that will be addressed by the evaluation.

In this study, I worked in collaboration with a number of intended users to consider these issues. This included the CYF Evaluation Advisory Group which was made up of community and government stakeholders who shared responsibility for overseeing this project, and programme managers. Maori cultural experts were also involved in the design and implementation of the evaluation and the rationale for this is given below. Regular meetings were held to clarify ideas about the methodology and to detail how the research would be undertaken in practice. Programme site visits were undertaken so that the evaluation plan could be presented to managers and staff at each site with a view to obtaining their input and support for the project as well as approval for access to documentation. Thereafter, a consultative process was maintained with the CYF Evaluation Advisory Group and programme staff for the duration of the study. This is described in more detail later in the chapter. Consistent with this evaluation model, the

intended use of findings was to assist with the interpretation of programme outcomes and provide the programmes and CYF with recommendations aimed at improving service delivery and programme effectiveness.

Cultural Consultation

Overall, Maori adolescent clients represent just under one third of the total number of adolescents referred for treatment (Fortune & Lambie, 2006b). Given that one of the objectives of the evaluation was to assess the extent to which the programmes met the needs of adolescent clients and their families, the importance of including Maori perspectives was prioritised. This highlighted the need to be sensitive to issues of cultural difference. Rawiri Wharemate (RW), of Ngapuhi and Tainui descent was therefore employed as cultural consultant and Kaumatua for the evaluation project to provide oversight and ensure cultural safety. Additional consultation involved the Maori programme staff at Site 1 and Karen Clark of Ngati Kahungunu descent, the cultural advisor for the CYF Evaluation Advisory Group. It is noted that Maori terms are incorporated throughout the body of this report. To assist interpretation, a glossary can be found at the very end of the dissertation on page 305.

Regular meetings occurred between members of our research team and the cultural consultants. This was to identify and address any cultural issues that needed to be taken into account to ensure that Maori protocol was observed and that Maori interests were protected at every stage of the research process. Initial discussions focused on developing culturally appropriate questions for Maori participants and identifying a suitable Maori interviewer for Maori participants. The subsequent decision that RW would interview all Maori participants with me in attendance may have been influenced by our former association through having worked together in the probation service, and a strong social connection.

Qualitative Methodology

Qualitative methods are considered particularly appropriate for process evaluation research designs as they facilitate an in-depth and detailed exploration of programme dynamics and processes (Patton, 2002a). Qualitative inquiry helps us to understand people's experiences and perspectives in the context of their settings (Spencer, Ritchie,

Lewis, & Dillon, 2003). Although there are many different definitions of qualitative research, they share several distinctive features. This study shares some of these characteristics which are outlined below.

First, qualitative research is characterised by a concern with exploring phenomena from the perspectives of participants (Merriam, 2002). This study seeks to understand programme processes by taking into account the subjective views of four different stakeholder groups, including adolescent clients, family members and caregivers. Consistent with qualitative approaches, the researcher sought to explain and interpret findings in terms of the meanings that participants ascribed to them (Spencer, Ritchie, Lewis, & Dillon, 2003).

Second, qualitative research employs a variety of methods to explore meanings and behaviour in depth, to capture diverse perspectives and to understand processes and contexts (Spencer, Ritchie, Lewis, & Dillon, 2003). In this process evaluation, data was obtained from in-depth interviews, direct observation and written documentation across three programme sites. Interviews, which comprised the primary source of information for the evaluation, were conducted with 91 participants involving approximately 150 hours of interviewing. This generated a vast array of detailed and thick descriptive data. Observational data involved fieldwork recordings of people's activities, interpersonal interactions and organisational processes that were relevant to the focus of inquiry (Patton, 2002a). Written documentation from programme records was obtained and reviewed.

Third, qualitative inquiry is naturalistic in the sense that it takes place in real-world settings and there is no attempt by the researcher to manipulate the phenomenon of interest (Patton, 2002a). In this study participants were interviewed with open-ended questions in settings that were familiar to them. During data collection, I had prolonged contact with each programme which provided opportunities for informal conversations with research participants and other stakeholders as well as casual observations of informal activities and interactions.

Fourth, qualitative research mainly uses inductive strategies for data analysis (Spencer, Ritchie, Lewis, & Dillon, 2003). An inductive analytical process involves the identification of key issues, concepts and themes within the data. In contrast, deductive

approaches rely on the use of standardised measures to test whether the data are consistent with predetermined hypotheses or formulations. Although there are many forms of inductive analysis that have evolved from different theoretical and philosophical orientations (Merriam, 2002), in this study a flexible qualitative analytic method known as thematic analysis was used. This is described below.

Finally, qualitative reporting is richly descriptive (Merriam, 2002). Words rather than numbers are used to convey what has been learned about the phenomenon studied. This typically involves descriptions of the context, the participants and their experiences in that particular context. This study provides descriptions of the programmes, delivery of therapy, what happens to people involved in the programme, the impact of the programme on participants and organisational aspects of delivery. Quotations from participant interviews are included in this report, thus taking the reader into the experience of the programme (Patton, 2002a).

This study therefore includes some of the key features of qualitative research. In the following section the analytical approach that was used to convert data into findings is outlined.

Thematic Qualitative Analysis

There are a number of different approaches to analysing qualitative data, many of which are linked to particular theoretical frameworks with specific guidelines and procedures for conducting analysis (Bryman & Burgess, 1996). These include grounded theory (Strauss & Corbin, 1990), discourse analysis (Potter & Wetherell, 1994), narrative analysis (Bamberg, 1997), and interpretative phenomenological analysis (Smith & Osborne, 2003). However, some analytic approaches are generic in the sense that they are not linked to any particular tradition within qualitative research (D. R. Thomas, 2004). Thematic analysis fits within this ambit. In broad terms, thematic analysis is a method for identifying, organising, analysing and reporting themes within data (Braun & Clarke, 2006).

This choice of method for data analysis was influenced by a number of factors. First, given the utilitarian evaluation framework of this study, an analytic strategy that was not aligned to any pre-existing theoretical framework was considered appropriate. Second, there was a need to have a flexible and efficient approach to identify themes

and patterns in the raw data that were relevant to the evaluation questions. Although this study relies heavily on the experiences and views of interviewees (an inductive approach) there is a deductive component to the data analysis as the aims and objectives of the evaluation were predetermined. The process of analysis and interpretation was therefore influenced by the original research objectives as well as the themes that were identified in the data. The flexibility of thematic analysis allowed for these dual analytic approaches. Third, it can usefully summarise key features of a large volume of data (Braun & Clarke, 2006).

The suggested procedures for doing thematic analysis are common to many qualitative analysis guidelines. Although there is little consensus among authors about specific techniques and procedures for analysis, some authors have emphasised the need to provide guidelines as opposed to hard and fast rules to ensure that flexibility is maintained (Braun & Clarke, 2006). Braun and Clarke have provided an outline guide describing the six phases of thematic analysis which is reproduced here. In this study, these guidelines were applied flexibly (and not prescriptively) to address the evaluation objectives and the data (Patton, 2002a).

Phase 1: Familiarising yourself with your data. In order to prepare data for analysis, interviews and notes from observations are transcribed to the extent that the information required for the purpose of analysis is retained. The analyst then becomes familiar with the content of the data through repeated readings of the text whilst searching for items of interest. In situations where the analyst was involved in data collection, the process of noticing and looking for themes and issues of interest in the data will have started prior to this phase. During this phase the analyst notes down initial ideas to assist with coding during subsequent phases.

Phase 2: Generating initial codes. The process of coding involves grouping together interesting features of the data in a meaningful and systematic fashion. The analyst pays attention to each data item, identifies issues of interest across the data set and collates data together under different codes. Coding can also be influenced by the need to answer specific research questions and in some circumstances specific codes are likely to be derived from the research aims.

Phase 3: Searching for themes. This phase involves the sorting of different codes into themes. All the relevant coded data is collated together within the identified themes. The analyst begins the interpretive analysis of data by looking at how different codes can be combined to form a theme and giving consideration to the relationship between codes and between themes. At this stage the analyst is likely to end up with a collection of main themes, subthemes and miscellaneous themes.

Phase 4: Reviewing themes. At this point, there are two levels of reviewing and refining themes. Level one involves checking whether the themes form a coherent pattern in relation to the coded data extracts. Level two involves reviewing whether the themes reflect the meanings evident in the entire data set. This reviewing process is likely to involve recoding from the data set, reworking themes, identifying new themes and discarding themes that do not work. At the conclusion of this phase the analyst should be able to identify the different themes and how they fit together, and have an understanding of the overall story of the data.

Phase 5: Defining and naming themes. During this phase, the specifics of each theme are refined so that the content of each theme can be presented as a coherent story that takes into account the broader research questions. The analyst searches each theme for any subthemes and makes sure there is not too much overlap between themes. The scope and content of each theme is clearly identified and clear definitions and names for each theme are generated.

Phase 6: Producing the report. The writing of the report involves the final analysis. In the report, vivid and compelling quotes are included to illustrate the meanings of the themes and these extracts are easily identifiable as an example of the point being made. The accompanying analytic narrative goes beyond description and relates the analysis to the research question and the literature.

Quality Criteria in Qualitative Evaluation

Given the many different approaches and traditions within qualitative and evaluative research, it is not surprising that authors have generated different sets of criteria for assessing quality and credibility (Patton, 2002a). Nevertheless, despite these differences, four guiding principles that underpin notions of quality have been identified (Spencer, Ritchie, Lewis, & Dillon, 2003). First, defensibility of approach concerns the

importance of designing a study that addresses its aims, with appropriate methods (fitness for purpose) and a sampling strategy aimed at providing depth and insight.

Second, rigour of conduct involves the collection and careful recording of in-depth data, thorough documentation of the research process and account of the analysis procedure. The importance of conducting an in-depth analysis is highlighted and consideration is given to the training and experience of the researcher. A strategy for enhancing the quality of analysis includes the use of more than one researcher to code data.

Third, credibility of claims involves methods for enhancing the validity or credibility of findings. Triangulation is a frequently discussed strategy for contributing to verification and validation of findings. It can involve comparing and crosschecking the consistency of information across different data sources, methods and researchers. Other strategies involve member checking which involves checking findings with research participants, peer review (involving an external reviewer), and searching for and analysing negative or atypical cases. In terms of the presentation of findings, readers are given access to the original data, there is a demonstrable link between data and conclusions and in-depth discussion of the data.

Fourth, the broader impact and contribution of the study concerns the relevance and utilisation of findings as well as the involvement of users in the research design. Utilisation-focused evaluation is clearly compatible with this guiding principle. Consideration is also given to the accessibility and wider relevance of findings, linking findings to existing research and generating new insights and understanding.

Although not all the aspects of quality mentioned above are included in this study, these guiding principles informed the decisions that were made during the design, implementation and interpretation of the evaluation. This is made explicit in the next section.

Method

This section begins with background information on the researcher and the research settings. It is followed by an explanation of the methods used in carrying out the study and a description of thematic analysis as applied to this study is given.

Researcher Orientation

As mentioned in the previous section, rigour of conduct is a major factor in the credibility of qualitative findings. Given that *the researcher is the instrument* in qualitative enquiry, it is necessary to provide some information about the researcher as this has implications for the way in which findings are received (Patton, 2002a).

I wish now to give consideration to my experience, training and prior knowledge in order to lend support to the credibility of the findings. In this study I had prime responsibility for collecting, analyzing and interpreting data. As indicated in the first chapter, my previous work experiences included counselling child and adolescent survivors of sexual abuse and 20 years practice as a probation officer. In addition I trained as a primary school teacher and taught young adolescents (11 and 12-year-olds) in New Zealand and in East London, Great Britain. This experience greatly assisted me in relating to a range of young people from different backgrounds and in understanding issues related to sexual offending. It also made me aware of some of the issues faced by treatment providers working with *difficult* populations.

As this project got underway, the advantage of my previous contact with and knowledge of staff at Site 1 was immediately apparent. Staff were welcoming, familiar and generous with their time and knowledge. However, as a researcher, it is important to examine such experiences and identify any potential areas for selective perception and bias. My previous involvement with the adult programme at Site 1 was predominantly positive and I was aware that my probation colleagues held similar views. I had been impressed by the integrity of the programme and the ability of staff to work with seemingly intractable adult clients. However, I also held a preconceived view that adolescent male offenders were notoriously difficult to engage in therapy.

In order to identify and monitor personal factors that could affect my response to ethical issues and influence data analysis I attended regular peer debriefing sessions with an

independent expert and clinician familiar with this field of research. For example, in these sessions discussion took place about my obligation to include negative participant feedback that could be distressing for staff at Site 1. We also discussed the weight to be given by me to negative feedback from a small number of participants which did not reflect my previous impressions of Site 1.

Settings

Data was collected from four stakeholder groups at three geographical sites between December 2003 and October 2004. As mentioned in the first chapter, the programmes at each site are given numerical reference in this report as follows: Site 1 (SAFE Network Auckland), Site 2 (WellStop in Wellington), and Site 3 (STOP Christchurch). Although seven smaller satellite programmes currently operate in other regional centres, Sites 1, 2 and 3 cater for almost half the ASO's in New Zealand (Fortune & Lambie, 2006b).

The following demographic information is based on statistical data that was collected from Sites 1, 2, and 3; it covers an 8 year period from 1996 to 2004 (Fortune & Lambie, 2006b). The age of the children and adolescents referred to the programmes ranged from 8 to 19 years, with the average age being 15 years. The vast majority of young people referred to the programmes were male (98%) with only 13 females being referred overall. With regard to ethnicity, most youth (around 56%) referred to the programmes were of European origin, while almost one third were Maori and around 8% were of Pacific Islands origin. In this report, the Maori word *Pakeha* is used to describe New Zealand European peoples. This word was originally used by Maori to describe the European settlers in New Zealand and is now in widespread usage.

The managers of all three programmes were among the founders of these treatment services. A range of staff were employed by the programmes including psychologists, psychotherapists, psychodramatists, family therapists, and social workers. In recognition of the need to make special treatment provisions for Maori clients, the programmes had employed Maori clinicians to address the cultural needs of their young people (Lambie, McCarthy, Dixon, & Mortensen, 2001). The programmes provided individual, group, and family interventions. Specific detail about the services provided by the programmes is given in the next chapter.

Participants

In-depth interviews with *purposefully* selected informants (n=91) provided the primary source of information for the evaluation. The four stakeholder groups comprised programme staff (n=22), adolescents (n=24), family members and caregivers (n=23) and external agency staff (n=22). The distribution of each sample group across programme sites is shown in Table 3. For inclusion in the study, all participants had been involved with the programme for a minimum period of 6 months. To reflect the proportion of Maori clients involved in the programmes, there was agreement that Maori participants should represent approximately one third of the total numbers interviewed.

Table 3. ***Distribution of Interviews by Programme Site***

	Programme staff	**Adolescents**	**Parents & caregivers**	**External agency staff**	**Total**
Site 1	8	9	7	6	30
Site 2	6	6	5	10	27
Site 3	8	9	11	6	34
Total	22	24	23	22	91

Programme Staff

A total of 22 interviews were conducted with programme staff, including managers (n=3), clinical staff (n=17), and social workers (n=2). Following discussions with the clinical team leaders at each site, Pakeha clinical staff were identified and selected on the basis of their involvement in a range of programme activities. This involved individual, group, and family therapists, and social workers. Following cultural consultation, all available Maori staff (n=6) participated in the study. Table 4 shows the ethnicity and gender of staff across sites.

Table 4. ***Distribution of Staff Interviews by Ethnicity and Gender***

	Total interviewed	**Gender**		**Ethnicity**	
		Male	**Female**	**Pakeha**	**Maori**
Site 1	8	5	3	5	3
Site 2	6	3	3	5	1
Site 3	8	4	4	6	2
Total	22	12	10	16	6

Adolescents

A sample of 24 adolescent clients with an age range of 10 to 19 years was purposefully selected to ensure variation on dimensions of interest; namely, *engaged* and *resistant* participants, Maori, young people with intellectual difficulties, and females. Following consultation with a recognised expert in evaluation research, a sample size of approximately 9 participants at each site was considered adequate.

Programme staff were asked to approach every young person on the programme and ask if they would agree to participate in the research. However, given that a simultaneous research project was being conducted at Site 3, staff did not approach clients who were taking part in that study. Following consultation with senior clinicians at each site, potential participants were allocated into the categories developed for sampling. Participants were then selected for maximum variation. Sampling stopped once the planned numbers were reached. On three occasions, when participants did not turn up for their interviews, I consulted with the clinical team leader and as clients turned up for programme activities, they were asked if they would take part in the study (if they met the category criteria). On two occasions, consent was obtained and the interviews went ahead.

Table 5 shows the demographic details of the adolescents interviewed. Of the 24 adolescent clients interviewed, only one was female. It was not possible to recruit others, as there were only two girls in treatment at the time. Furthermore, given the low referral rate at Site 2 during the previous year, numbers of all clients taking part in the programme were also low. The sample from Site 2 (n=6) therefore represents all those who agreed to take part in the study. The majority of adolescent clients were in the 13 to 17 years age group with just over 25% identifying as Maori. The length of time on the programme spanned 6 to 24 months and over. Those who had been in the programme longer than 24 months had required greater intensity of treatment due to comorbid mental health issues. Approximately 25% of the sample were deemed *resistant* (by programme staff). The majority of the participants were at school or undergoing some form of training and most were living in caregiver situations away from home. A range of mental health issues was represented in the sample.

Table 5. ***Characteristics of Adolescent Clients by Programme Site***

Characteristic	Site 1 (n=9)	Site 2 (n=6)	Site 3 (n=9)	Total (N=24)
Male	9	5	9	23
Female		1		1
Maori	2	1	2	5
Pakeha	6	3	6	15
Mixed ethnicity	1	2	1	4
10-12-yrs-old		1		1
13-17-yrs-old	8	3	8	19
18-19-yrs-old	1	2	1	4
6-12 mths on programme	3	1	4	8
12-18 mths on programme	3		1	4
18-24 mths on programme	3	2		5
24 mths & over		3	4	7
Engaged	6	5	8	19
Resistant	3	1	1	5
School or course	7	5	6	18
Employed	2	1	2	5
Benefit			1	1
Living with parents	3	3	1	7
Living with caregivers	4	2	3	9
Residential care	2	1	3	6
Living independently			2	2
Intellectual difficulties	1	3	4	8
ADHD		2	1	3
Conduct Disorder	1	2	2	5
Autism		1		1
Drug/alcohol abuse	1	1	2	4

Family Members and Caregivers

Interviews were conducted with 23 family members and caregivers. Programme staff approached all family members and caregivers (whether or not they were linked to a client interviewed) to seek agreement for their inclusion in the study. I planned to interview six caregivers at each site, including two Maori and equal numbers of foster placement caregivers and biological parents/extended family members. Table 6 shows

the characteristics of caregivers across programme sites. Approximately one third of the caregiver sample were male and nearly one third were Maori. A range of caregiver roles was represented in the sample with over half being family members.

Table 6. ***Characteristics of Caregivers by Programme Site***

Characteristic	**Site 1** (n=7)	**Site 2** (n=5)	**Site 3** (n=11)	**Total** (N=23)
Male	3		5	8
Female	4	5	6	15
Maori	3	1	3	7
Pakeha	4	4	8	16
Parent		3	6	9
Extended family	1	1		2
Step-parent	1	1		2
Placement caregiver	4		5	9
Residential social worker	1			1

It was not possible to reach the sample size at Site 2 given the low client numbers at that site. Thus, a decision was made to make up the numbers at the other two sites. Additional interviews were conducted at Site 3 as I took advantage of the opportunity to do an impromptu interview with the parents of a boy who had been interviewed. The social worker assigned to him had also been interviewed and this family had been discussed as a difficult case during a staff interview. It was seen as an opportunity to get a 360-degree perspective on the programme. A senior clinician approached the parents following a family meeting and they agreed to be interviewed.

Staff in External Agencies

The evaluation team were interested in obtaining the perspectives of those involved in the adolescent clients' wider social network. A total of 22 participants were recruited for this sample. This included 14 CYF staff (comprising social workers, youth justice workers, supervisors and managers), residential facility staff (n=5), police personnel (n=2), and a resource teacher of learning and behaviour (n=1). The characteristics of external agency staff across sites are shown in Table 7.

Table 7. ***Characteristics of External Agency Staff by Programme Site***

Characteristic	Site 1 (n=6)	Site 2 (n=10)	Site 3 (n=6)	Total (N=22)
Male	3	4		7
Female	3	6	6	15
Maori	3	3	2	8
Pakeha	2	7	4	13
Pacific Islands	1			1
Known negative views	2	2	1	5

I sought to interview six external agency staff at each site, including two Maori and 1 or 2 participants with *known negative views* about the programme. Following discussions with programme managers, clinical team leaders, clinical staff, and CYF staff, a list of external agency staff was generated. This list comprised all those staff that had some involvement in the adolescents' treatment on the programme. Using this list as a guide, I met with senior clinicians at each site to prioritise the list according to the amount of interagency contact and to include participants with *known negative views* about the programme. Those interviewed were typically experienced staff who had been employed in their current roles on average for around 7 years (range 6 months to 30 years).

Following discussion with the programme manager at Site 2, additional interviews were carried out at Site 2 in order to obtain further clarification about issues relating to the low client referral rate during the previous year.

Interview Schedule Development

Initially, interview guides were prepared for each sample group that listed subject areas derived from the research objectives. These interview guides were reviewed by members of the research team to ensure that the topic areas corresponded with the purpose of enquiry. They were then adapted to fit a more standardised open-ended interview format. This decision was made for a number of reasons: to enable programme staff and the CYF Evaluation Advisory Group to see and review the instrumentation used in the evaluation; to ensure consistency across both interviewers (RW and myself); to provide comparability across the three sites; and to ensure that important evaluation issues were not inadvertently omitted.

A literature review was undertaken regarding assessment and treatment of ASO's to guide the development of items for the interview schedules. Several drafts of the interview schedules were undertaken and each draft was reviewed by research team members. The first set of schedules was then sent to programme managers, clinical team leaders and the CYF Evaluation Advisory Group for comment. Programme managers and staff were not provided with staff interview schedules due to concerns about the possibility of primed responses in subsequent interviews. Written feedback was received and incorporated into subsequent revisions as appropriate.

Interview schedules for each sample group followed a similar format with five or six sections that corresponded to the key areas of enquiry. Each section contained questions designed to explore strengths, weaknesses and suggestions for improvement. Adolescent clients, family members and caregivers were asked about the referral and assessment process, the level of information provided to them, programme delivery (including their opinions of staff), programme effectiveness and outcomes of treatment. Programme staff and external agency staff were asked about the referral and assessment process, availability of treatment for different types of ASO's, programme goals, programme effectiveness and outcomes of treatment. Programme staff were also asked for comment on training, supervision, organisational support, therapeutic approaches, and programme operations.

Each interview schedule contained a cultural services section with four questions aimed at eliciting responses about the ways in which the programme met/did not meet the cultural needs of Maori. Only Maori participants answered this section. These interview items were derived from cultural consultation involving RW and the manager of the Maori team at Site 1.

The final revision of all interview schedules took place after pilot testing. The pilot study was carried out on the first 3 participants of each sample and preliminary data analysis was undertaken to check the quality of data being collected. The pilot study highlighted some sequencing issues, redundant items on the staff schedules and the need to obtain information from managers. A manager's schedule was constructed by adapting a staff schedule to include questions about programme development and changes over time, quality assurance mechanisms, and decision-making processes.

As the remaining interviews got underway, concurrent analysis of data suggested the need to explore further lines of enquiry with adolescent clients, caregivers and external agency staff. Additional questions were generated and attached to the appropriate schedules. (Refer Appendix A for the interview schedules and additional questions).

Procedures

The study was approved by the CYF Research Access Committee and ethical approval was granted by the University of Auckland Human Participants Ethics Committee. This included approval for a payment to adolescents and family members for participation which is discussed below. In carrying out the research design, several procedures were used which are now outlined.

Programme Documentation

Programme managers at each site were approached and asked to send their clinical, procedural and human resource manuals, previous evaluations and audits. Following examination of these materials, additional documentation was requested and received. Programme data such as meeting agendas, brochures, information sheets and programme handouts, were also collected during site visits. Additional information was sourced from agency websites. These documents provided information about the programmes' activities and processes and served a basis for generating interview questions and inquiry through direct observation.

However, noting the lack of information in a number of key areas, statistical information from each site was requested from programme managers. Information sought included the demographic characteristics of clients, numbers of clients accessing the programme, referral sources, staffing levels and staff-client ratios.

Interviews

Following discussion among research team members, programme managers and senior clinicians at each site, it was decided that programme staff would approach adolescent clients, their families/caregivers and external agency staff to seek their participation in this study. This decision was based on privacy concerns, the delicate nature of sexual offending, and the increased likelihood that programme staff would be more successful at recruiting participants given their pre-existing relationship. The clinical team leaders

at each site were given participation information sheets and consent forms for each sample group. Potential participants were then given a brief outline of the nature and aims of the evaluation, and provided with information sheets by programme staff.

In order to compensate participants for their time and effort, adolescent clients were given movie vouchers, and caregivers received petrol vouchers (at Sites 1 and 2). This information was recorded on the information sheets (refer Appendix B). Compensation was justified on the basis that this study involved a *reluctant population,* there was no coercion and it was intended as a gesture of reciprocity. Staff at Site 3 were concerned that any form of compensation would reduce the ability to recruit participants for a simultaneous research project, so this offer was not made available to participants at this site. Although Site 3 participants were not compensated, there were no discernible differences in the data collected from this site compared to the other sites. There were also no differences in the numbers recruited as a consequence.

Senior clinicians at all sites contacted external agency staff to inform them about the evaluation and seek their inclusion in the study. They were also provided with information sheets (refer Appendix B). At Site 1, the names and phone numbers of those agreeing to participate at this site were forwarded to me and I phoned participants to go over the nature and aims of the evaluation and set up appointment times. At Sites 2 and 3, the senior clinicians set up appointment times with all participants (including programme staff). The reason for these different arrangements stem from the fact that I live in the same geographical area as Site 1 and there were anticipated problems created by my distance from Sites 2 and 3.

All interviews with Pakeha participants were conducted by me. While the Kaumatua for the project (RW) interviewed all Maori participants, I observed, took notes and recorded what was being said. Most of the interviews were conducted face-to-face at the programme site. However, one interview was conducted in the staff member's home; six interviews were conducted in the caregivers' homes; 10 interviews involving caregivers and external agency staff were conducted by phone (due to distance barriers); and eight external agency staff interviews were conducted at their workplace (at their request). There were three group interviews involving Maori participants; one with external agency staff and two with programme staff.

Interview length ranged from 45 minutes for adolescents and up to 3 hours for programme staff. At the start of each face-to-face interview, interviewees were provided with a second copy of the participation information sheet, given verbal information about the evaluation and an explanation of the bounds of confidentiality. Written consent was obtained (refer Appendix C) and all participants gave permission for the interview to be audiotaped and for me to take handwritten notes. Verbal consent was obtained at the beginning of phone interviews and this was recorded on the consent form.

Interviews with Maori participants generally followed the same format. However, more time was taken at the beginning and end of the interview to establish and maintain connection and rapport. Each interview commenced with a mihi and karakia and closed with a karakia. A similar format was followed in the three group interviews with Maori participants.

Each participant was interviewed according to the interview schedule with additional questions being asked in order to follow up particular avenues of interest. At the conclusion of each interview, the interviewer summarised the gist of what had been said so that interviewees could correct misinterpretations or factual errors. As the interviews progressed, participants were also asked to verify interpretations and data gathered through observations and earlier interviews.

Several participants (adolescent clients and caregivers) were interviewed immediately after their attendance at individual, family, and group sessions. This provided an opportunity to engage in casual conversations about their experiences during formal session times and get a *behind the scenes* look at the programme (Patton, 2002a). The interviewers also engaged in informal conversations with programme staff, adolescent clients and caregivers during between-session times. Relevant data was recorded as memos on the interview schedules.

Participant Observations

Participant observations facilitate an in-depth understanding of the context within which the programme operates (Patton, 2002a). In this study, I spent approximately 3 weeks at each site conducting the interviews. Data was obtained from daily observations with a

focus on physical and social environment, presenting issues and informal interactions. This was recorded in a research journal.

A range of verbal and nonverbal communications involving stakeholder groups was observed. It has been reported that unobtrusive measures such as casual observations are a useful way of capturing what is really happening on a programme (Patton, 2002a). On numerous occasions, participants were observed during unstructured time as they exchanged views and talked to each other and reception staff about what they were experiencing on the programme. This information was used as part of the process of validating and checking what was being reported in interviews.

Literature Review

As outlined in the first chapter, there was reference to international literature regarding the theoretical foundations of adolescent sexual offending, as well as the assessment practices and interventions that are associated with successful treatment. This provided a reference point for comparing findings to practices and interventions that are associated with effective treatment programmes in other countries. The literature for the review was accessed through the electronic databases, books, treatment manuals, and publications from the Association for the Treatment of Sexual Abusers and the National Task Force on Juvenile Sexual Offending. Additional material was received from the Association for the Treatment of Sexual Abusers Research and Treatment Conference held in St Louis, Missouri, United States (October, 2003), personal communications with recognised experts in the field (both in New Zealand and overseas) and programme staff.

Data Analysis

All data was analysed by flexibly applying the method of thematic analysis which was outlined at the beginning of this chapter. In this section, specific detail about how it was applied is presented.

Programme Documentation

An initial coding system was developed that reflected the focus of enquiry and issues of interest in the data. Using a word processor to organise this system, the coded extracts

of data were entered into different documents. Each document was labelled with a preliminary theme that was linked to the research objectives.

In consultation with my primary supervisor, I reviewed the quality of the data obtained, noted incomplete, limited and selective documentation and explored similarities and differences between programme sites. Additional information (including statistical information) was requested from programmes as deemed necessary and where relevant, this data was entered into the appropriate documents. Further refinement of the coding system followed so that the most important themes (given the research objectives) were identified. The data within each theme was then summarised in narrative form and tables. Member checks were carried out as a way of verifying data interpretations (D. R. Thomas, 2004). Each programme manager was provided with a copy of the summarised information. Written feedback was received and incorporated as appropriate.

Interviews

As data analysis proceeded, I was guided by RW in relation to interpretations involving Maori participants. Additional consultation involved the cultural consultant from the CYF Evaluation Advisory Group. This was aimed at ensuring that data involving Maori participants was interpreted in such a way that represented and acknowledged Maori experiences and that reported findings were derived from a consultative process.

Consistent with a thematic analysis approach, all the taped interviews were listened to in their entirety. At the same time, handwritten notes (recorded on each interview schedule) were corrected and extended where necessary. Potentially usable quotes were transcribed in full. Each interview was then summarised according to the salient points on each of the target questions. This process served as a preliminary form of data analysis (Ezzy, 2002) by providing an opportunity for familiarisation with the content of the raw text and the development of ideas about themes and concepts in the text (D. R. Thomas, 2004).

Following transcription and close readings of the text, I met regularly with my primary supervisor to try out a variety of conceptual labels for the initial codes and subsequent themes for each data set. In this study there were four data sets that corresponded to the interviews with each stakeholder group. The initial coding of the interviews was completed manually by writing notes in the margins beside the relevant text. *Coding*

c*onsistency checks* (D. R. Thomas, 2004) were carried out during this process. My supervisor independently coded four interview schedules (one from each stakeholder group) and we merged our combined set of initial codes. An independent coder was given 12 uncoded interview schedules (three from each stakeholder group) with an accompanying list of potential themes. The coder then assigned sections of the raw text relevant to each theme. Negative cases and outliers were identified and incorporated into the coding system which was then further refined.

At regular intervals, I contacted programme staff and external agency staff to check whether the tentative findings accurately reflected their experiences. These member checks led to further refinement of themes. The data was then entered into four different documents (one for each stakeholder group) in a word processor. Each document contained all the relevant coded data extracts within the identified themes.

Once all the data had been entered (approximately 300 pages of single-spaced text), discussions took place among team members to further refine and revise the coding system. This included discussion about the meaning of outliers and negative cases which did not fit within the classification system. Many of the themes were subsequently combined, some discarded, and tentative relationships between themes across the data set were identified. Important themes and subthemes were identified by referring to the raw data as well as the research objectives. There was consensus between my supervisor and me regarding the identification, naming and definition of the final themes and subthemes. Separate documents were then created for each individual theme which contained a written description of the meaning of each theme and incorporated relevant quotations. This involved combining information from the four data sets.

Prior to writing the final report, the overall themes were reviewed by our research team and there was discussion and consensus about the organisation and presentation of findings. As the findings were being written up, member checks were carried out with programme staff and external agency staff. Before submitting the final report to CYF, a complete draft copy was reviewed by the programme managers and the CYF Evaluation Advisory Group. They were invited to submit comments which were then incorporated into the final report as deemed appropriate by the CYF Evaluation Advisory Group and the research team.

Participant Observations

At the conclusion of each interview, the interview data was summarised and I included any observational data as part of this summary (e.g., impressions, insights about what was happening on the programme and what it might mean). Thus, participants were asked to verify interpretations of observational data and this was recorded in memos on the interview schedule. At regular intervals, I met with a senior member of the research team to explore and test possible interpretations of observational data.

Information from observational data was amalgamated into one document and read through several times to gain an understanding of the primary patterns in the data. Notes were recorded in the margins alongside the relevant data passages. Themes were identified and consideration was given as to how they fitted with interview data interpretations. This provided a basis for making decisions about interpretation of findings.

Triangulation

In this study, multiple sources of information were used to gain an in-depth understanding of the programmes. Triangulation involved comparing the perspectives of programme managers, programme clinicians, adolescent clients, caregivers and external agency staff; comparing observations with interviews; comparing what participants said in formal situations with what they said in casual conversations; and checking for consistency between programme documentation and information obtained through interviews and observations.

Chapter Three: Programme Descriptions

This chapter presents a description of the three adolescent programmes as they operated at the time of the evaluation. The descriptions are based on information obtained from policy and procedural manuals, pamphlets and brochures, and agency websites. Additional detail was derived from interviews with programme managers and staff. Information has been organised into seven main categories (a) overview of the adolescent programmes, (b) programme goals, (c) referral procedures, (d) assessment processes, (e) therapeutic approaches, (f) interagency co-ordination, and (g) specialised services.

In order to represent the prevalence of themes in the data, I have used such descriptors as *all* participants, *many* participants, and *several* participants (Braun & Clarke, 2006). Participants' quotes are reproduced word for word in italics. In general, short quotes are incorporated within the text of the report whereas longer quotes are indented in a freestanding block of text. Sometimes, at the end of a quote, the identity of the participant is given by referencing their stakeholder group when it is not clear who is being quoted. At other times, when the identity of the participant is obvious, no such references are given.

Overview of the Adolescent Programmes

Generally speaking, the adolescent programmes offered treatment for up to 2 years for 10 to 18-year-olds. However, programme duration and intensity sometimes varied depending on the particular needs of the offender. The majority of adolescents accepted for treatment by the programmes were regarded as medium to high risk. Those adolescents who had been referred to the programmes and subsequently considered to be low risk were often referred to counsellors and psychologists in the community for individual and family counselling.

The programmes catered for male and female adolescents, individuals with intellectual difficulties and developmental delay, and children, and additionally offered cultural services for Maori (detailed information about specialised services is provided at the end of this chapter). For adolescents with intellectual difficulties or developmental

delay, treatment often extended to 3 years and some remained in the adolescent programme during early adulthood. Treatment approaches included individual, group, and family interventions. There were also therapy-based outdoor pursuits camps involving a mixture of intensive therapy and outdoor activities.

At the onset of treatment, adolescents, parents and caregivers attended education groups for up to 12 weeks, aimed at orienting them to treatment and providing information about sexual abuse. At 4 to 6 monthly intervals, system review meetings were held with the young person, family members and support people, members of the clinical team, and professionals such as social workers, police, and probation officers. At these meetings the young person's progress was reviewed and goals evaluated. At two sites, social work support was offered (in-house) to assist adolescents with safety plans (designed to help them make good decisions about keeping themselves safe in their home and in the community), employment, education, transitioning, and placement. Family workers were also available to parents, family members and caregivers to assist them with difficult situations and provide personal support. None of the programmes provided aftercare services for clients who had completed treatment.

Programme Goals

The managers reported that programme goals were largely derived from those of successful programmes operating overseas. They referred to the influence of such publications as the *Preliminary Report from The National Task Force on Juvenile Sexual Offending* (National Adolescent Perpetrator Network, 1988), *Invitations to Responsibility* (Jenkins, 1990; 1999), and *Pathways: A Guided Workbook for Youth Beginning Treatment* (Kahn, 2001).

Managers and most staff reported that goals were constantly changing as the ASO treatment programmes evolved. They talked about the trend within their agencies towards placing more emphasis on prosocial behaviour alongside the core goal of addressing sexually abusive behaviour.

> *We're not just trying to highlight risk but to enhance kids' development, emphasising prosocial behaviour. We're more inclusive of strengths based goals.*

Our programme is designed to target goals and generalise these to other areas of the young people's lives … we look at the context in which the abuse occurs and consider social discourse on what it is to be male and have relationships.

The programme works to enhance their communication skills - that's a big part - looking at body language and communication styles.

We're in a state of flux … we're moving away from cycles (of offending) and from sexual arousal and deviance unless it's definitely present.

Programme goals at all three sites appeared to reflect holistic approaches as outlined in the literature (Ryan, 1999). At one site, the programme's aims and objectives were clearly outlined in their clinical manual as follows: to change sexually inappropriate behaviour; to foster sexually appropriate behaviour; to ensure that participants become responsible for their own behaviour; to develop equal relationships rather than ones built on power over others; to develop appropriate behaviours in other areas of the participants' lives; and to educate and support parents. Each goal was then more fully described in bullet-point format. The treatment programme was designed around these goals to address the lifestyle problems that precipitated the offending, deviant sexual fantasies and thought patterns, empathy for victims, control over impulses, problematic behaviours, relapse prevention, their own victimisation and trauma, family difficulties, and communication and relationship problems.

While it was not a straightforward task to find a documented list of goals at the other two sites, they could be ascertained from treatment module workbooks and individual treatment plans. Treatment goals, as they appeared on the treatment plan template included attendance/participation, honesty about sexually abusive behaviour, responsibility, feelings, sexual awareness, safety issues, social skills, sexual abuse cycle, victim impact, and own victimisation.

Referral Procedures

Most adolescents on the programmes were referred by CYF while the remaining referrals were made by family members, child, adolescent and family mental health services and nongovernmental community agencies. Treatment for the majority of adolescents was fully funded under contracts the agencies had with CYF. A small number of adolescents were funded on a fee-for-service basis, usually by their families. When CYF was the referrer, CYF social workers initiated phone contact with

programme staff, filled out referral forms and provided background information on the young person and the family. This was faxed through to the programmes. CYF generally maintained contact with the programmes during the assessment process and arranged family group conferences and meetings involving family members, social workers and programme staff as necessary. This was aimed at determining what needed to be done to make sure a child or young person was safe and well cared for.

Assessment Processes

Assessments were undertaken with information obtained from referrals (including police statements and evidential reports) and clinical interviews with the young person, family members and/or caregivers. Interviews were conducted over a number of sessions (between one and six sessions) and were usually carried out by two therapists. Additional information was obtained from psychometric testing, reports from other sources, and discussions with others such as foster carers, social workers, counsellors and teachers. Although clients with complex mental health issues underwent the same assessment process as other adolescents, they were more likely to be seen by a psychologist and undergo psychological testing. At the end of the assessment, a detailed clinical and risk assessment was written with recommendations to family and key professionals regarding treatment appropriateness and options.

Clinical Risk Assessment

Most clinicians reported that in determining clients' level of risk, they combined empirically based risk assessment tools with structured clinical judgement and used a range of psychometric assessment measures. With regard to clinical risk assessment, most staff said they *talked to as many people as possible* about the offender's developmental history, offence-specific behaviours and environmental circumstances to build up a comprehensive picture of the young person. This involved the offender, family, caregivers, and people from the adolescent's wider network such as school guidance counsellors, employers, social workers and police. Some staff also commented that they drew on their *years of experience* to assess a client. *I don't just rely on instruments. I talk to the young person and listen to what others say*. Several staff referred to the importance of identifying clients' needs and strengths throughout the assessment phase.

In relation to offence-specific behaviours, staff reported they focused on the extent of the abusive behaviour by taking into account the *number of victims*, the *number of times person has offended, access and opportunity* to vulnerable others, *arousal patterns and thinking patterns at the time of abusing*, age differentiation between offender and victim, use of *threats, bribery, coercion, level of aggression* during commission of offence, and *where the abuse occurred (e.g., parks, school, home*). Staff also took into consideration *living situations*, *attitudes and antisocial issues, motivation,* family/caregiver functioning and support, *current relationships*, *drug and alcohol use*, and *support networks*.

Assessment Tools used by the Programmes

When staff were asked to recall the various tools used in assessment some were confused as to which tools were risk assessment tools and which were psychometric. The following list has been compiled from the tools nominated by staff.

Table 8. ***Tools used in the Assessment of Adolescent Sexual Offenders***

Domain	Assessment Tool
Psychometric testing	Beck Depression Inventory-II (Beck, Steer, & Brown, 1996)[3]
	Family Environment Scale (Moos & Moos, 1986)[1]
	Child and Adolescent Risk Evaluation (Seifert, 2003)[3]
	Child Behaviour Checklist for Children (Achenbach, 1991)[1,2,3]
	Millon Adolescent Clinical Inventory (Millon, Millon, Davis, & Grossman, 1993)[1,2,3]
	PHASE Sexual Attitudes Questionnaire (O'Brien, 1994)[2]
	State-Trait Anxiety Inventory (Spielberger, Edwards, Lushene, Montuori, & Platzek, 1973)[3]
	State-Trait Anger Expression Inventory (Spielberger, 1999)[3]
	Trauma Symptom Checklist for Children (Briere, 1996)[1]
	Wechsler Abbreviated Scale of Intelligence (Wechsler, 1999)[3]
	Wechsler Intelligence Scale for Children (Wechsler, 2003)[3]
	Youth Self-Report (Achenbach, 1991)[1,2]
Risk assessment	ERASOR (Worling & Curwen, 2000b)[1,3]
	J-SOAP (Prentky, Harris, Frizell, & Righthand, 2000)[2,3]
Cultural assessment	Te Whare Tapa Wha[1,3]
	Powhiri and Poutama[1,2,3]

Note. [1]Site 1; [2]Site 2; and [3]Site 3.

The best known risk assessment tools with any validation studies are the ERASOR and the J-SOAP which were both used by the programmes. While very few psychometric instruments have been validated for use with ASO's, many of the psychometric instruments used by the programmes are mentioned in the literature as being useful (Prentky & Bird, 1997).

Therapeutic Approaches

The therapeutic approaches used by the programmes (refer Table 9) were similar to those used by programmes in other countries (e.g., Longo & Prescott, 2006; Print & O'Callaghan, 2004; Rich, 2003). These included CBT, family systems, narrative therapy and psychodynamic models. All staff made particular reference to the emphasis on family work on the programmes.

Table 9. ***Dominant Therapeutic Approaches as Documented and Reported (2004)***

	As Documented	Reported
Site 1	Behaviour Therapy	CBT (including relapse prevention)
	CBT (including relapse prevention)	Behaviour Modification
	Family Systems	Family Systems
	Psychodynamic (including psychodrama & role training)	Psychodynamic (including psychodrama & role training)
		Motivational Interviewing
		Experiential approaches
		Gestalt
		Transactional Analysis
Site 2	Not documented	CBT (including relapse prevention)
		Family Systems
		Good Way Model
		Motivational Interviewing
		Narrative Therapy
		Play Therapy
		Psychodrama
		Transactional Analysis
Site 3	Action Methods	CBT (including relapse prevention)
	CBT (including relapse prevention)	Family Systems
	Family Systems	Narrative Therapy
	Motivational Interviewing	Psychodrama
	Narrative Therapy	Art Therapy

Table 9 indicates that programme staff reported using a wider range of approaches than was documented in their clinical treatment manuals. At one site, treatment protocols and therapeutic methods were not documented at all. While many of the treatment models mentioned here have been described in the first chapter, the programmes also incorporated models that are unique to the New Zealand context, namely, the Good Way model (Ayland & West, 2006) and Maori health models (Durie, 1994). These are described in the next section. Similarly, given the programmes' focus on family involvement in treatment, their model of family therapy is also described.

Good Way Model

The Good Way model was developed by two clinicians at Site 2 originally for use with adolescents with intellectual difficulties. At the time of the evaluation it was being adapted for use with other populations and introduced across the programme at Site 2. This model is strengths based, uses narrative therapy approaches, encompasses relapse prevention, and incorporates language that is accessible for individuals with a concrete thinking style. The Good Way model employs a dualistic approach (*Good Way/Bad Way*) and was developed using the language and concepts of the young people themselves. The model encourages therapists, clients and families to be creative and resourceful in exploring and finding solutions to abuse-related and other problems. There are two streams to the model. The first (*Good Way*) focuses on the young people understanding the consequences of their actions, including their abusive behaviour, and developing their strengths and ability to choose the *Good Way* in any given situation. To facilitate learning, there are a number of characters that represent good and bad behaviours. The *Gang* are three main players on the *Bad Side; Mr Sneaky, Mr Bully* and *Mr Just Do It*. The *Three Wise Men* encapsulate key qualities of the young person's *Good Side*. The second stream (*Good House/Bad House*) deals with their own experience of loss and trauma and assists them to do their own healing, to appreciate the impact on others of their abusive behaviour, to take steps to repair relationships, and to develop the skills needed for their *Good Life*.

Family Therapy Model

In recognition of the importance of engaging family members in the treatment process, the programmes provided a range of services for families. These included a family

assessment (both separately and together with the adolescent), family education groups, individual family therapy sessions, individual work with family members (as appropriate), multifamily groups, and system reviews. With Maori whanau, Maori therapists coworked with the primary clinician. Utilising a family systems approach, the overarching goal for treatment was the identification and remediation of relevant family issues that may have contributed to the abusing pattern. Family therapy sessions were held every 3 to 4 weeks and were attended by the adolescent, family members and/or any other significant caregivers, and sometimes included multiple family systems.

Maori Health Models

Although there are no known evidence-based indigenous models of practice that can be applied to the specific area of adolescent sexual offending, staff incorporated Maori health models such as Te Whare Tapa Wha (Durie, 1994), Powhiri and Poutama which provide concepts and guidelines for working with Maori.

Te Whare Tapa Wha: This model represents the holistic nature of Maori health by making a comparison with the four cornerstones of a house. Maori concepts of wellness emphasise strength and balance across these four dimensions.

- *te taha hinengaro;* the psychological and emotional wellbeing of the whanau, including individuals within the whanau.
- *te taha tinana;* the physical aspects and symptoms of health.
- *te taha wairua;* the spiritual health of whanau, including the practice of tikanga Maori.
- *te taha whanau;* the social relationships within the whanau environment and the relationship of the whanau to the wider community.

Wellbeing occurs when all of these areas are strong and intact. Weakness in any one of these areas compromises an individual's health in other areas. Similarly, if therapeutic intervention undermines any one of these areas, it is less likely to be effective.

Poutama and Powhiri models: These models provide process oriented frameworks for therapeutic intervention within the Maori whanau. As such they take into account the factors that contribute to the processes of attaining wellbeing. The powhiri poutama model is a stepped framework that begins with a karakia and mihi where personal

relationships are acknowledged and established. This is followed by a process of information gathering and clarifying everyone's relationship to the issue. Issues are acknowledged, feelings are expressed and there is an opportunity for family members to grieve. Issues are then addressed by enlisting the support of family members who contribute to goal setting and strategic planning. The process concludes with whakaotinga which involves the maintenance of relationships beyond physical sight. This may involve family members taking on an oversight role to strengthen family bonds and ensure solidarity.[1]

Interagency Co-ordination

In order to meet the multiple needs of these adolescents and provide a continuum of care, programme staff worked in collaboration with community and government agencies. These included CYF, police, youth justice, health organisations, residential placement facilities, schools, workplaces, and youth groups. At two sites where social work services were provided in-house, the programmes' social workers advocated for and accessed community resources and services for adolescents, particularly schools, courses, employment and recreational activities.

Given CYF's key role as a funding and client referral source and their statutory responsibility for child care and protection, programme staff spent a significant proportion of their interagency time liaising with CYF social workers. The most intense liaison period that the programmes had with CYF was during the referral and assessment phases. CYF were also responsible for providing placements for young people while they attended the programmes. To be accepted on to the programme, ASO's were required to be in a secure environment, away from victims and young children. This could involve placement within the immediate or extended family, specialist foster home placements where one client is cared for by two house-parents, and small specialist homes where a number of adolescents are cared for by a team of caregivers (Lambie & Seymour, 2006). CYF social workers managed the placements of young people and provided social services support as needed. The young person was assigned a social worker who was invited to attend programme meetings and system

[1] This model was sourced through the Kaumatua for the project from the Iwi of Te Arawa; specifically Te Ngaru Learning Systems and Phyllis Tangitu, General Manager, Maori Health Lakelands, Rotorua, New Zealand.

reviews. Ideally, the CYF social worker would maintain regular contact with the adolescents during treatment and arrange financial assistance if appropriate.

Specialised Services

In recognition of the need to provide services for young people whose needs were not being met on mainstream programmes, the programmes introduced cultural services for Maori and specialised services for adolescents with intellectual difficulties, children and females. As one manager commented:

> *We've specialised a lot more - special needs, younger kids, also culturally - we've got four Maori staff - we want to start a group for Maori kids - we have individualised treatment - it's no longer a case of "one size fits all".*

This section describes the services offered by the programmes for these groups and includes comment on cultural services for Pacific Islands clients and high risk adolescents. As Table 10 shows, the programmes offered similar specialised services.

Table 10. ***Specialised Treatment Services Offered by the Programmes (2004)***

	Site 1	Site 2	Site 3
Maori	Specialised Maori Group planned for 2005.	No specialised programme. Maori staff were involved in individual, family & group work.	Maori clients were allocated kaimahi workers & attended a weekly support group (Rangatahi Tautoko).
Pacific Islands youth	None. Pacific Islands consultant/interpreter engaged on a needs basis.	None.	None. A specialist clinician had been assigned to develop this work.
Youth with intellectual difficulties	Special Needs Programme involving individual, group, & family therapy.	Warriors Group, individual & family therapy.	Changing Directions. High level of social work input. Individual & family therapy.
Children	Specialised programme for 10 to 13-yr-olds; individual, group & family therapy.	Boys' & Parents' Group. Individual & group work. Groups not run in 2004 due to insufficient referrals.	Specialised 20 week programme started 2004. Family & home-based sessions with Strengthening Families component.
Adolescent females	Individual & family therapy.	Individual & family therapy. Referred to victim services.	No referrals. However, individual & family work available.

Maori adolescents: There were no specialised programmes for Maori at any of the sites. In this instance, a specialised programme is defined as a parallel service that is devoted specifically to Maori, offering clients access to Maori therapists and kaimahi, with rich cultural content and using treatment models that are appropriate for Maori. While no such programme existed, specialised services were available and clients identifying as Maori were offered varying degrees of cultural input depending on availability and circumstances. Some sites provided more integrated services than others, as outlined below.

At Site 1, not all Maori clients were assigned Maori workers as there were insufficient numbers of Maori staff. At the time of the evaluation, the ratio of Maori staff to Maori adolescents was 1:15. All Maori referrals were vetted by the Maori team who then made decisions about allocation of clients to staff members in consultation with their peers. The majority of Maori clients were allocated Maori therapists who worked with them individually and with their whanau. There were no specialised groups for Maori adolescents.

At Site 2, Maori staff conducted assessments with Pakeha cotherapists and worked with whanau (as well as Pakeha families). They did not do individual therapy and there were no specialised groups for Maori clients. At the time of the evaluation, the ratio of Maori staff to Maori adolescents was 1:5.

At Site 3, services for Maori were explained thus:

> *Maori clients attend regular treatment. They are allocated kaimahi workers at assessment, attend a Maori group weekly, and have individualised packages, e.g., they deal with particular issues such as trauma with a Maori therapist. Staff work with course providers and identify whanau. They make links, involve whanau; e.g., they provide individual sessions for Maori mothers. There are also home visits, community visits, and kai for meetings.*

Despite intentions to match all Maori clients with Maori staff, this did not always happen as the ethnic background of clients was sometimes overlooked during the referral and assessment phase. At the time of the evaluation the ratio of Maori staff to Maori adolescents was 1:11.

Pacific Islands adolescents: There were no specialised services for Pacific Islands clients. However, at Site 1, Pacific Islands youth represented approximately 11% of all

adolescents referred for treatment between 1996 and 2004 (Fortune & Lambie, 2006b). This compares with 8% at Site 2 and 5% at Site 3 during the same period. There was general agreement among programme staff and external agency staff that this client group was not being identified and that their cultural needs were not being met by the programmes. Pacific Islands youth, when compared with adolescents of other ethnicities, were more likely to drop out of treatment (Fortune & Lambie, 2006b). There were references to difficulties experienced by the programmes recruiting Pacific Islands clinicians and insufficient networking with their communities. At one site, an interim solution had been to engage a Pacific Islands consultant and interpreter on a needs basis.

Youth with intellectual difficulties: All sites had developed specialised programmes for youth with intellectual difficulties. During the period 1996 to 2004, this client group represented approximately 19% of those in treatment (Fortune & Lambie, 2006b). At Site 2, staff had focused on this area of treatment and this was reflected in the development of the Good Way model by two of their clinicians (Ayland & West, 2006).

Children: The programmes offered special services for children, although the lack of referrals at one site resulted in these services not being operational in 2004. Higher numbers of children were referred to Site 1 (n=29) compared to either Site 2 (n=4) or Site 3 (n=2), from 1996 to 2004. Their ages ranged from 8 to 13 years with the majority of referrals (60%) being children aged 12 (Fortune & Lambie, 2006b). Some programme staff questioned the appropriateness of having younger children attend the same venue as adults and adolescents.

Adolescent females: While there were no specialised programmes for adolescent females at any of the sites, individual and family work was reportedly available. However, this work had not been put into effect at Site 3 as there had been no referrals. Overall, only 13 females were referred for treatment by the programmes between 1996 and 2004 with Site 1 (n=10) having the highest referral rate. One manager commented: *we have not pushed the issue of female sexual offenders as a major issue…it's a matter of prioritising problems.* Many programme staff expressed concern about the appropriateness of providing treatment for females at the same venue as male sexual abusers: *it's not appropriate to have females here with male abusers when they're victims too.*

High risk clients: High risk offenders were generally placed on mainstream programmes with higher levels of input from experienced clinicians and closer monitoring in the community compared to other clients. While the aggregation of high risk youth in group interventions can be problematic, the risk of contamination to others when mixing prosocial youth with antisocial youth also raised concerns. Staff reported that when these risks were considered too great, high risk offenders received individual and family work only.

Chapter Four: Consumer Perspectives

As mentioned in the first chapter, consumer and staff perspectives are reported separately. The rationale for this was the recognition that their views and experiences reflect different aspects of the programme which are derived from their different roles on the programmes. For example, as treatment providers, staff have knowledge of treatment models whereas consumers rely on their experiences of therapy and therapists. Furthermore, separating their stories enabled the unique perspective of programme participants to be presented and retained. This chapter presents adolescents', parents' and caregivers' experiences during referral, assessment, and treatment. Taking into account the proportion of those interviewed who were Maori (nearly one third) and the priority given to evaluating the extent to which the programmes meet their needs, findings derived from interviews with Maori participants (which sometimes provide a different perspective) are noted throughout.

Participants' responses were organised into six main categories, some of which were determined by the research questions and others by the coding process. The order of categories mirrors the process that an adolescent would follow in the programme (a) the process of initial engagement (prior to and during assessment), (b) engaging in treatment, (c) perspectives on therapeutic approaches, (d) perspectives on treatment modalities, (e) treatment components that facilitated change, and (f) treatment outcomes. These six categories include themes and subthemes; to illustrate their meanings, examples of participants' responses are given. Each category is summarised with reference to recommendations for improving programme delivery.

The Process of Initial Engagement

Adolescents, parents and caregivers were asked to comment on the referral and assessment process with a specific focus on what was helpful and unhelpful, what was difficult and what would have made it easier, and the level of information provided to them (for specific questions, see Appendix A). Four themes were identified. For clients to be receptive to treatment it was helpful if they were given good programme

information prior to assessment, welcomed appropriately, assessed in an inviting physical environment, and given refreshments.

Provide Good Programme Information Prior to Assessment

For all adolescents and family members, approaching an agency that treats sexual offenders was a daunting prospect. Many adolescents referred to fears about confidentiality, being *teased,* not knowing what to expect and what would be required of them while attending the programme. Being reassured and provided with this information right at the outset helped to ensure that treatment got off to a good start: *being sent the starter's pack was reassuring. I got to know more about the programme, what they were hoping to achieve.*

However, most adolescents, parents and caregivers reported that they would have liked more information prior to contact with the programmes than they received. There were many references from parents and caregivers about the lack of quality information provided by the programmes and referral agencies such as the Police or CYF: *no information sheets were handed out … there was only vague verbal information*. One parent reported she tried to find out about sexual offending on the internet. However, while she came across lots of advice for victims of sexual abuse, there was very little information about offenders. When parents from one site requested additional information from the programme, they were sent one pamphlet but it was deemed insufficient. Caregivers who had a particularly anxious adolescent said they did not know how to support him because they had so little information about the programme.

Adolescents, parents and caregivers said they wanted information on:

- **Programme duration**. How long would the adolescent be on the programme?
- **Placement**. Where and with whom would the adolescent be living? *I wanted to know where I'd be based.* Worries about placement were linked to fears the adolescent had about being separated from family or having to move to the city where the treatment programme was based.
- **Information about their therapist**. Who would their therapist be? *Would the therapist be male or female? I find it easier to talk to males. It makes a big difference.*
- **Confidentiality**. Would personal information remain confidential? *I was afraid the personal stuff wouldn't be confidential.*

- **Programme content**. What would the programme involve? *I wanted to know more detail about the programme.*

- **Expectations or requirements of them**. What questions would they be asked? What would they be expected to do?

In addition, parents and caregivers wanted:

- **Information about the programme's effectiveness**. Did it prevent reoffending? Is there any statistical information? Does the programme work? Was there hope that their child's behaviour would change and that life would be better for him/her after completing the programme?

- **Information about the victims of sexual abuse**. How could they help their own children and others who had been sexually abused?

Several parents and caregivers would have preferred a programme staff member to visit them in their homes during the referral phase to explain information. One parent commented: *pamphlets don't help me – being verbal is more my style. My reading isn't the greatest – it takes me twice as long to read as most people.*

For most parents and caregivers, once physical contact with the programmes had been established, their questions were answered satisfactorily. For example, at one site, parents and caregivers were given a 28 page booklet about the programme and its content. Similarly, many adolescents felt reassured when given programme information: *what I found the most helpful was knowing what was going to happen to me - the groups, going on camps.* Some adolescents expressed relief when confidentiality was no longer an issue: *I knew people wouldn't go out of the programme and tell others why we were here.* One adolescent provided a detailed explanation of the procedures staff observed in order to ensure personal information remained confidential. The comment, *all my worries were pretty much put to sleep*, summed up the feelings for most. All parents and caregivers were also reassured that change was possible after they had talked to therapists and/or other parents and young people who had been on the programme longer than they had.

> *What was really helpful was having another boy present on the education programme, someone who'd been through the programme, seeing what he'd achieved, it really helped us and our boy. We could see that the programme really does work; it really does make a difference.*

Nevertheless, some adolescents considered that information regarding the length of time they would be on the programme was still lacking during the assessment phase. Similarly, some parents reported they did not receive sufficient information at assessment on how to help victims of sexual abuse when the victims were their own children: particularly, information on how to protect victims and prevent them from imitating inappropriate sexual behaviour and becoming abusers themselves. One parent described this lack of knowledge as *walking into the situation blindfolded.* Being informed was empowering for parents, and one described how the knowledge she eventually acquired while her child was on the programme had enabled her to help victims of sexual abuse in the wider community.

A Welcoming Atmosphere is Important

For all adolescents, having positive interactions with staff during the referral and assessment phase was crucial in putting them at ease and reducing anxiety. Most adolescents found it extremely difficult to talk about their sexual offending, especially in a group situation, and many could still recall their initial feelings and reactions:

> *I found it really difficult talking and staying still - fidgeting about the sexual abuse. I was nervous.*
>
> *… admitting the abuse had taken place, admitting what I'd done, giving the details … it was embarrassing.*

Entering the programmes' premises and meeting staff for the first time was also difficult for many parents and caregivers, especially for those who were survivors of sexual abuse. Some parents and caregivers thought they might be considered inferior in some way, *illiterate* as one described it. While many spoke of feeling *nervous* and *emotional,* most had their nervousness eased by therapists and receptionists, whom they described as *friendly*, *welcoming*, *warm, open, wonderful*, and *polite*. Smiles were deemed *enough to create a different atmosphere when you bring a boy in.* For a mother who had been sexually abused, being attended to promptly by a therapist who was welcoming made first contact easier. Similarly, when young people talked about feeling nervous or anxious, they nearly always followed this by saying staff had alleviated their fears by talking to them and by being friendly and approachable. Adjectives and phrases they used to describe therapeutic and reception staff were *nice*, *friendly*, *kind, helpful, they were OK, good, cool, happy, nonjudgemental,* and *understanding.* One adolescent

commented: *you didn't feel as if you had anything to hide - you didn't need to put on airs and graces.*

Once the assessment process got underway, getting to know the therapist played a central role in helping adolescents to open up: *sometimes I don't get along with people when I first meet them but once I got to know them, they were pretty cool people.* The ability of staff to communicate *on the same level* helped to open up channels of communication.

> *During my first interview, the staff were helping me with questions - I didn't really understand them but I could answer them once they were explained (adolescent).*
>
> *They're very clear, easy to understand, they put things in different perspectives, they change the wording so we - boys and parents - can understand (parent).*

Physical Surroundings Matter

Comments from adolescents, parents and caregivers suggested that physical environment can have an impact on the way in which clients respond and participate in a programme. When asked for comment on their initial impressions of the premises, most adolescents referred to the buildings' physical appearance and described their emotional responses. Some commented on the anonymity that a *nondescript* building provided. While many parents and caregivers had similar responses, they highlighted concerns about convenience and practicalities such as proximity to public transport and parking.

Two settings were described as *hospital-like,* sterile and needing refurbishment. One was further described as lacking a *warm, therapeutic feel* and the other as drab and *awful* with *bad vibes.* In contrast, premises at another site were considered to be *welcoming, friendly, inviting* and *comfortable.* Suggestions for improving premises included: *there could have been more pictures, it could be a bit brighter, have mirrors;* and *I'd redecorate, put nice chairs in the waiting room and up-to-date magazines.* At two sites, several adolescents were impressed with items such as *nice bouncy furniture* and a fish tank at reception.

Privacy was valued by all interviewees and there was a preference for discreet buildings. There was comment that when families visited one site, *everyone knows*

you're there for sexual offending. Parking and the distance involved in travelling to the programme were major concerns for parents and caregivers at two sites.

Several Maori parents and caregivers expressed concern about one setting. There was comment that having the programme on the 5th floor created a feeling of disconnection, as *in Maori tradition the whare is attached to piles in the ground.* They would have preferred interview rooms to be on the ground floor. There was also no room available for larger meetings which could accommodate about 12 people in a marae setting. For one caregiver, a Maori presence within the agency could have been made more visible by putting artwork on the walls and displaying Maori pamphlets more prominently. At another site, the caregivers of a Maori adolescent said *he would have felt safer* if he had been assessed in their home. They described feeling intimidated on their first visit to the agency's premises.

> *It was quite intimidating when we got there. The building needs to be refurbished – it's not an inviting place. It feels like an institution. Like a hospital. When you deal with a person you need to get away from the idea that this place is for sick people, is an institution. Moving (the boy's) therapy away from (the programme's) environment would have really helped (Maori caregiver).*

Receiving Refreshments is Important

Irrespective of ethnicity, the vast majority of adolescents, parents and caregivers (at two sites) talked about the importance of programme staff providing them with hot drinks and biscuits, especially at referral and assessment. Being offered something to drink helped to create a welcoming atmosphere and *break the ice*. Comments about being offered refreshments irrespective of when, nearly always occurred together with a positive comment about a therapist or another member of staff.

> *There was a nice happy reception lady. They were welcoming. I was offered a cup of tea and Milo. There were staff walking through who were going "hello" (adolescent).*

> *The staff are very friendly - they're great. A smile when you walk in, offering cups of tea (caregiver).*

Summary

Providing the right conditions to facilitate initial engagement was deemed crucial by adolescents, parents and caregivers. The provision of educational material as soon as an

adolescent is referred for treatment reduces family stress and can enhance participation in treatment (Schladale, 2006). It was therefore suggested that an education pack be developed for distribution to prospective clients during the referral process, which contains information about programme content, expectations and treatment outcomes. For some families, engagement may have been enhanced if this introductory material had been delivered verbally in their homes. This suggested a need for the programmes to make provisions for therapists to establish initial contact with prospective clients in their homes, if deemed appropriate. This may be particularly relevant for Maori clients.

Although the way in which therapists approach clients in the first few sessions has been recognised as determinative with regard to the development of a constructive relationship (Marshall et al., 2003), little attention has been paid to the identification of factors that facilitate initial engagement, particularly for those from different cultural backgrounds. While all clients responded positively to the warmth and hospitality of staff, Maori clients identified cultural differences in their process of engagement. These included being given time to establish whanaungatanga, having the option of being assessed in their home, and a preference for environments with physical characteristics and an ambience that are conducive to Maori.

Findings suggested the need for therapists to work in family and community settings. While this may be particularly relevant for Maori clients, it could also alleviate the parking and transportation problems faced by some families. It was further recommended that premises be refurbished and/or decorated to create a warmer, more therapeutic atmosphere and to acknowledge a Maori presence within the programmes.

Engaging in Treatment

Throughout their interviews, adolescents, parents and caregivers were asked questions about what was helpful and unhelpful at various stages of treatment. Of central importance in their accounts was the weight given to engagement across all points of contact with the programmes, so this was identified as a core category. Three themes were identified from participants' comments. Engagement in treatment was influenced by therapist characteristics, attending to the cultural context for Maori, and family support.

Therapist Characteristics Influence Engagement in Treatment

Most adolescents, parents and caregivers made positive comments about therapists and they identified therapist features that helped to generate good alliances. They valued therapists who were understanding, caring, encouraging, respectful and nonjudgemental. They also appreciated therapists who were available outside session times, had a sense of humour and who showed a genuine and personal interest in the young person. For adolescents, it was particularly important that therapists were trustworthy, down-to-earth, and patient by allowing sufficient time so they could progress at their own pace. There were a number of comments about the importance of therapists communicating in a way that they could understand. This included and also went beyond the choice of vocabulary and syntax to include the ability of the therapist to relate to the young person at his or her level.

Being understanding, caring, and encouraging: Adolescents frequently used these words to describe their therapists and they appreciated the unconditional support they received: *the staff encourage you wherever they can, no matter what you've done.* Offering tea, coffee and Milo also served to demonstrate caring for the young people, their parents and caregivers. When they talked about being offered a hot drink, they made reference to a positive therapeutic relationship and the feelings this generated.

> *We have Milos. I get on well with my therapist (adolescent).*
>
> *The staff offer me drinks and treat me normally (adolescent).*
>
> *The staff make nice cups of tea - they're very respectful towards me (caregiver).*
>
> *The boy hasn't got much family support. The therapist makes him Milo and biscuits, cares about what's happening to him, makes him feel special and spoils him. It's not just the therapy. He feels valued (caregiver).*

Many parents and caregivers also referred to the therapists as caring, supportive, understanding and thoughtful. Their comments suggested that this was particularly significant for adolescents who may have been unaccustomed to receiving this level of care and attention.

> *He feels valued and cared for and this is what he has lacked in his life. He's had no stability.*

He's found that the therapists here care for him. He's found someone who gives a damn - actually everyone. He knows he is worth saving. He is worth it.

Several parents and caregivers also commented on the support and encouragement they received from staff in relation to their own difficulties which enhanced their engagement in the treatment process.

The therapist was so supportive, provided love, hugged me, listened to me through my tears even though this had nothing to do with our boy. There was total love and support. It was great.

Being challenging and supportive: Several adolescents referred to occasions when they had been challenged by therapists in a supportive way which had helped them work through difficult issues. This was valued by parents and caregivers as it provided adolescents with a secure base from which to make changes.

They've pushed him and challenged him. They won't put up with his shit. He always fought back but they never gave up on him. They've always been there. People have given up on him in the past.

Being respectful and nonjudgemental: Several adolescents described times when they felt valued by therapists who behaved in a respectful manner towards them. This included being greeted politely, being informed if a session was running late, and not being judged for their offending. Many parents felt nervous and embarrassed at the prospect of having to talk about and listen to the details of their children's sexual abusing in front of a stranger. They also worried their child might be judged negatively. However, once they had contact with the therapists most were reassured. Showing respect and being nonjudgemental were frequently used together to describe therapists: *the boys are not looked down upon because of their offending. They're treated with respect and understanding. They're not being judged.*

Being available: For several clients, it was important that therapists were contactable by phone should issues arise outside of session times. There was mention of therapists who made themselves available for extra sessions and phone contact following completion of the programme: *I can just ring up and ask for help*. Being able to have access to the therapist at short notice was appreciated and reassuring.

I could ring the staff and get answers when I need them. The receptionist always put me through and the therapist always returns my calls.

> *If our boy had any queries or worries, they've made themselves available, even on their cell phones. They've provided back-up plans. They've thought ahead.*

Having a sense of humour: There were several references by adolescents, parents and caregivers to therapists who had a sense of humour: *he does psychodrama, he's a funny guy, the kids like him. They enjoy the programme and its delivery – they look forward to it.* Therapists with a sense of humour put them at ease, created opportunities for therapeutic fun and assisted them to deal with difficult issues. One therapist had *made it fun even though they were going into deep waters.*

Showing a personal interest in the young person: All adolescents responded positively to therapists who showed a genuine interest in them. Some parents and caregivers reported that therapists took a personal interest in the adolescents which often exceeded what one would normally expect from a therapist. At one site, a therapist lent a young person thermal underwear for a camp. The parent remarked: *normal therapists wouldn't loan you thermal underwear would they?* She went on to say that the therapist was *always showing our boy positive stuff, and always had time for him.* Another parent related how helpful it had been for her son when the therapist talked about shared interests.

> *The therapist talked to my son about when his dog had puppies. He liked that and told us about it. Being able to communicate was really important - he hadn't had many conversations with people.*

Some therapists put time and effort into finding out what interested a young person and then used this to explain difficult material and bring therapy to life. They used language and concepts that would strike a chord with the young person. For example, an adolescent who was *mad on cars* reported that his therapist helped him to explore his angry feelings by referencing his interest in cars; when the adolescent *lost it and reached boiling point*, the therapist likened the feeling to an engine dropping a piston and a radiator blowing. Similarly, he was encouraged to use a distraction technique in high risk situations which involved reciting to himself the alphabet linked to makes and models of car … *A - Alpha Romeo, B - Bedford* and so forth.

Being allowed time to progress at their own pace: For many adolescents it was important that therapists were patient and that they were given sufficient time to

complete assignments, grasp concepts and express feelings: *he made it easier for me … let me do it in my own time, not badgering me.*

Trustworthiness: Several adolescents spoke of the importance of confidentiality and trust in the therapeutic relationship. This created a feeling of safety which helped them to open up and talk about difficult subjects.

> *I trust (my therapist) – if I can't handle the pressure I'm under – like being teased at school – I can tell somebody.*
>
> *I didn't trust anyone till I really got to know them. Now I pretty much trust everyone here. I can come here and talk about stuff and I know that they listen.*

Being down-to-earth: This characteristic was valued highly by several adolescents: *I like my therapist - he's down-to-earth*. They described close bonds with therapists who could speak the same language *(my therapist uses my language)* and relate to them at their level *(the therapist puts himself at my level to explain things)*. One adolescent referred to the way staff dressed as a reflection of how they related: *they don't come in a suit and tie, "big as" stuff.* In some instances, parents and caregivers spoke about the therapists as if they were friends, using first names and sometimes, nicknames. There was no indication that therapists were perceived as less professional for their familiarity and informality.

Negative therapist behaviours: Although the comments received from adolescents and their families about the therapist relationship were predominantly positive, there were a few negative comments. Some young people spoke negatively about therapists who were repeatedly late for sessions. At one site, a few adolescents spoke of the double standards of some staff who used swear words when adolescents were not allowed. Adolescents also felt less affinity to therapists who expressed anger, *talked heaps,* were not down-to-earth and who communicated in ways that were difficult to understand: *my therapists are not down-to-earth, they speak a different language*.

There were a few comments from parents and caregivers about staff at two sites not keeping them informed about changes of session times and appointments. They expressed frustration that programme staff seemed unaware of the impact the changes could have on them such as taking time off work or rearranging weekend activities.

Attending to the Cultural Context is Important for Maori

Most Maori adolescents, parents and caregivers appreciated the same therapist characteristics as non-Maori. Maori adolescents liked having a therapist who communicated with them at an appropriate level during formal sessions and informal activities: *my Maori therapist is cool to hang around with and talk to.* They mentioned Maori and Pakeha therapists who played guitar, took them tenpin bowling and played soccer with them. These remarks were inevitably followed by positive comments about the therapists: *they're nice people - they make me feel comfortable.*

When identifying the factors that contributed to effective therapist-client relationships, Maori participants referred to the importance of having a Maori therapist, being given sufficient time at the beginning of treatment to establish whanaungatanga, and communicating in culturally appropriate ways.

Having a Maori therapist: Having a Maori therapist and cultural input was highlighted as crucial by most Maori adolescents, parents and caregivers. One adolescent commented: *having contact with Maori therapists is awesome – it's like speaking another language.* Most whanau members and caregivers identified positive changes in the adolescents that they attributed to the input from Maori therapists. Comments suggested that the young people felt more comfortable with Maori therapists and that the cultural elements they introduced into therapy made a difference: *the therapist introduced tikanga to him - it's a calming influence.* One parent said it helped keep her son safe as the Maori therapist had *challenged him around respect for others' bodies and his own body.*

Several caregivers and parents commented on the differences they observed in their children following the change to a Maori therapist.

> *Having a Maori therapist has made a huge difference. He had a quicker response to the Maori therapist. He tended to shut off with the European guy even though he was good. He opened up more with the Maori therapist.*

Some referred to their disappointment and regret that Maori therapists were not introduced earlier: *staff could help whanau feel more comfortable by just putting Maori workers in place at the beginning - they should just be there.*

A few adolescents commented on the difficulties they experienced with Pakeha clinicians: *we did not get on very well - we don't agree on things*. In one situation, the counsellor was *too forward* and *it took him a while to put stuff in a way that would help me understand*. Another Pakeha therapist *talked too fast* at the assessment interview. The adolescent would have preferred a Maori therapist, as he understood *more Maori than Pakeha*. Some Maori parents and caregivers referred to feeling traumatised and powerless at the start of treatment which *was not recognised* by Pakeha clinicians. One parent said she felt superfluous, *like an appendage* and that *there was not enough consideration of the wider family context*. It was not until over two years into treatment that *the pain and hurt was acknowledged* when Maori therapists asked the family *what it had been like for (them*). Similarly, a caregiver commented that it would have been beneficial for a couple of boys to sit down with the Maori therapist at the outset.

> *I would have liked korero about tikanga right at the start to make them feel more comfortable, to settle them in, having someone to explain step by step.*

A few parents and caregivers said they also found it easier having a Maori worker with whom they could korero. One caregiver identified *the Maori side* of the programme as a real strength and he valued opportunities to korero with Maori staff. He could not do that with Pakeha therapists as they *talked about the clinical perspective, they did not talk about the cultural.* A parent whose child had recently been assigned a Maori therapist commented on the impact this had on her husband during family meetings: *they can relate … being matched culturally has made a huge difference.*

Allowing time during the onset of treatment to establish whanaungatanga: Many adolescents, parents and caregivers emphasised the importance of having time to build rapport, warm to therapists, and get used to premises, systems and ways of working. This was particularly relevant for Maori clients who felt whakama. In one situation, a young person and his caregivers would have preferred to *spend time chatting about things first over a cup of tea* to establish whanaungatanga, before talking about the offending. There were several references to slowing the pace for Maori clients and allowing them time and space to open up as this facilitated engagement and a positive response to treatment.

> *They could have taken time to build whanaungatanga (parent).*

It takes time – it's all new and different around here. Everything's familiar at home (adolescent).

At first the (Pakeha) staff member was intimidating and very blunt. The boy wasn't co-operating and didn't want to face offending. The therapist was too abrasive – it was difficult dealing with this. The therapist was too "in your face" and didn't take time to build a relationship (caregiver).

Communicating in culturally appropriate ways: According to most parents and caregivers, Maori therapists had the ability to engage the adolescents using tikanga and other methods that they knew the young people would respond to. There were references to aroha, wairua, te reo, karakia, mihi, waiata, haka, taonga at graduation, and kai for meetings. One adolescent commented:

I started seeing the Maori staff 5 or 6 months after commencing the programme. I would have like to see them earlier because they know Maori words.

Some therapists adapted their approaches to suit the adolescents and their situations. A therapist played guitar on the beach to calm a young person with an anger problem, another helped an adolescent by *looking at things more holistically.* One parent commented on the ability of a therapist to relate to her son by explaining things in *black and white.* She explained *he needs to have things in black and white, concrete concepts if he is to live in this culture.* A caregiver spoke at length about the ability of a therapist to calm a boy by *introducing the tikanga to him.* Overall he felt that cultural input had helped the boy to progress by enabling him to take criticism and deal with his anger problem.

Several Maori staff also talked about the way they incorporated elements of tikanga into therapy.

We Maori staff present taonga at the time of graduation. And pounamu are handed round at termination. We're also making hangi at camps for the Maori boys.

With this one boy who had aggressive behaviour we talked about being a warrior. He liked this terminology - what it meant for a Maori to be a warrior. He took pride and channelled his aggression into discipline. There were huge changes in him. We always had a karakia with him before every session. His posture was slouched. The karakia engendered respect - he sat up and took his hat off and bowed his head. Previously he'd been aggressive and defiant. There was an acknowledgement of his father's culture and an acknowledgement that he belonged to a marae and we didn't underestimate his knowledge of tikanga and Maori protocols.

Family Support is Crucial

For most adolescents, irrespective of ethnicity, the participation and support of family members made a significant contribution to their involvement in treatment. Parents and caregivers reported that they attended assessment meetings, education groups, family therapy sessions and system reviews. The involvement placed heavy demands on their time and required long-term commitment. For many, it disrupted home and work life as they transported the young people to and from sessions, most of which were during work hours. This was described as being particularly stressful for parents who lived some distance from the agency's premises and had to make arrangements for other dependent children. Some parents reported visiting their child's school to discuss safety plans and other issues with teachers. Caregivers at residential homes all talked about having to be available for team meetings involving programme staff and other residential workers. For the parents or caregivers of children under CYF care, there were additional meetings with social workers.

Most parents and caregivers felt that their input was valued and they appreciated the central role that they played in the adolescents' treatment. It was a reciprocal relationship involving mutual consultation and assistance.

> *I was made to feel part of it - I knew what was going on - it wasn't behind closed doors. It was helpful being involved in the process, finding out what was going on in the boy's head. There was a triangle - we all talked and gave feedback to each other.*

Family involvement was viewed by most participants as integral to successful engagement because it provided the adolescent with support while they were on the programme. Several parents acknowledged that it was not always easy to offer support when they felt angry with their children for what they had done. This was compounded when the abuse had been perpetrated against a sibling, or when the parent had been a victim of child sexual abuse. Initially, some parents were reluctant to be involved in treatment at all, but persevered once they became aware of how vital their support was and saw how much it benefited their child.

> *It helped my child most that I was there to support him. I listened to him. I didn't display anger or disgust or negative emotion, and gave him the opportunity to talk. I was supportive. He knew someone was sticking up for him.*

> *Even though I was pulling away from her, we still supported her, listened to her, told her we loved her, to make her feel more safe and secure. I encouraged her despite my other feelings of hating her for what she had done.*

Several parents and caregivers talked about how their support encouraged young people to open up during difficult moments and this was confirmed by adolescents.

> *He was in such a state - he wasn't forthcoming during much of the process, he wasn't prepared to speak. What helped was me being there, picking him up, and providing steadfast support (caregiver).*

> *They were encouraging me that it was alright and I could talk - there was nothing to be afraid of (adolescent).*

While adolescents talked about the practical ways their parents and caregivers helped them (e.g., driving them to sessions and bringing them *stuff* they needed) they also highlighted the importance of the emotional support they received. For one adolescent, his parents' participation demonstrated that they still loved him despite his offending. Another young person said his stepmother cuddled him when he began to talk about his abusing. Many said that although they were scared about going on the programme, they had been encouraged and supported by their families. One commented: *if it wasn't for my parents I wouldn't be doing it.*

Summary

While there has been increasing recognition of the importance of therapeutic engagement in producing positive treatment outcomes (Marshall et al., 2003; Rich, 2003), researchers have typically focused on the relationship between the quality of the client-therapist relationship and treatment outcome (Marshall et al., 2003). While support for the influence of the therapeutic alliance in enhancing engagement in treatment was evident in this study, family involvement in the therapeutic process was also reported to contribute to adolescents' engagement in treatment.

Findings suggested most staff appeared to possess the necessary skills and personal characteristics to actively engage clients and families. However, a few adolescents, parents and caregivers described negative experiences with programme staff. A need was therefore identified for therapists to be reminded of the importance of punctuality, appropriate language, and notifying parents and caregivers of any changes to appointment or session times.

While some researchers have identified therapist characteristics that facilitate change with adult sex offenders (Marshall et al., 2003), less is known about process issues in the treatment of adolescents. Although some of the positive therapist features identified in this study are consistent with descriptions in the general literature, others appear to be particularly relevant for this population group. These include being given time to work at an appropriate pace, being down-to-earth, communicating respectfully at an appropriate level, taking a personal interest, availability beyond session times, and avoiding expressions of anger. Interviews with Maori participants highlighted the importance of having a Maori therapist and communicating in culturally appropriate ways. While Pakeha youth talked about the need to have time to work at their own pace, it was even more crucial for Maori young people to be given time to establish whanaungatanga. It was suggested that wherever possible, Maori adolescents and whanau have access to a Maori therapist or key worker from the beginning of treatment.

There has been little evaluation on the use of a family focused approach with ASO's and many community based treatment programmes prioritise individual and group therapy at the expense of family involvement (Rich, 2003). However, the findings from this study indicated that parental involvement and support was vital to the adolescents' engagement in treatment and that parents and caregivers played an integral role in treatment.

Perspectives on Therapeutic Approaches

Adolescents, family members and caregivers were not asked specific questions about treatment approaches. However, in their responses to questions about what they had learned on the programme, what was helpful and unhelpful, and reasons for making changes, several therapeutic approaches were identified as being influential. Responses from participants were coded into three themes: the effectiveness of the Good Way model (Ayland & West, 2006), creative and physical activities, and the importance of involving the adolescents' wider network in treatment.

The Good Way Model is Effective

At the site where it was employed, the Good Way model had high recall with most young people and received positive comments from many parents and caregivers. Several young people described the Good Way concepts in considerable detail which

suggested they had understood and assimilated them. An example of this was provided by an adolescent with intellectual difficulties who referred to the safety plan as staying on the *good side*.

> *It was good learning about the Good Way and how it operates. The bad side is the guy who makes you go the bad way - it's like they come and take over your life and make you do bad things, go the bad way and this leads to reoffending. And the good side - they make sure you do positive things and have a good life and make sure you don't get into trouble and go to jail.*

The young people also applied the concepts to their own particular problems and behaviours. This facilitated insight and provided them with a framework for making changes.

> *It's important for me to manage anger. They've got these three people that they give to you - Mr Sneaky, My Bully and Mr Just Do It. It helped me a lot. I wrote their profiles and some of them sounded like the things I used to do a lot e.g., I used to bully my brother and sister and other kids at school. I used to do things that just popped into my head.*
>
> *I've learnt about myself. I do this exercise of me put in half - I have a good side and a bad side and I learned a lot about those two sides … reminded me of how much stuff I had in me.*
>
> *Learning my good side helped me a lot to deal with problems. If I get into a serious situation and think something's gonna happen, then I go the Good Way and sort it out.*

A few adolescents also used the concepts, vocabulary and characters to describe the behaviour of others in a range of situations. One adolescent described a social worker as *sneaky*, drawing on the character profile of *Mr Sneaky* from the *Gang*. Another adapted and personalised the concepts to suit his Christian background. He described having his good side and bad side as having the devil on one shoulder and the angel on the other.

Comments from some parents indicated that the model was a vehicle for their own education. One Maori parent of an adolescent with intellectual difficulties reported that the concepts of the Good Way model had helped her and her son.

> *They have three puppets - Mr Bully (that applies to me too, I need to make changes), Mr Just Do It and Mr Sneaky. They're teaching me those three things. It helps me to look at my child's behaviour and also change my own ways. I like being here even though I don't get chocolate fish.*

Creative and Physical Activities are Effective

Of the many adolescents who mentioned creative and physical activities, all made positive comments about these approaches. They appeared to enhance engagement in treatment and strengthen the client-therapist relationship. Some young people reported that they frequently felt shy and reluctant to speak when standard forms of therapy were used. A few said they had difficulties understanding the language that was used. However, participation in experiential and expressive therapies enabled them to talk more freely about difficult issues and feelings. Adolescents talked about music, games and play, active pursuits and sports, and camps.

Music: There were several positive reports about therapists who played the guitar during sessions. Maori adolescents in particular talked about how the music helped to calm them down and to talk during therapy. One Maori adolescent admired the fact that his two Pakeha therapists were both good on the guitar. This was followed by a comment that he particularly liked one of the therapists whom he described as a *good counsellor*.

Games and play: Most young people said that they found it easier to talk during sessions while playing games such as K'nex, dominoes, cards, backgammon, snakes and ladders, and chess: *it was good working in the sandpit and playing with K'nex … playing and talking without knowing what I'm saying. I'd have a few laughs and just spill.* A *resistant* adolescent (with a dual diagnosis of ADHD and conduct disorder) said that the most difficult thing for him during the assessment phase *was trying to figure out a way to talk to people.* He commented:

> *I was shy, I wasn't used to talking to people. I didn't know why I was here. They made it clearer. They explained it to me. At first we played games - I didn't talk much. We needed to warm up to talk about things.*

Several adolescents commented that playing games would have made it easier for them to talk to their therapists. One adolescent commented that playing games would have helped to alleviate boredom during meetings. While some adolescents responded positively to play being introduced later in their treatment, they would have preferred it to have been used earlier and more frequently.

Drawing and writing: A few adolescents talked about the value of drawing and writing stories to help them explore difficult issues. One therapist used a number of informal techniques to engage an 11-year-old who had been sexually abused. The adolescent talked about how writing stories and drawing on the computer about the abuser made it easier to *talk about stuff.*

Active pursuits and sports: Some adolescents said they played sports such as soccer, touch rugby and handball, and went hiking and tenpin bowling. They were generally played during group sessions and camps. Adolescents derived enjoyment from these activities and talked positively about therapists who joined in. One adolescent described it as *fun* going on a group outing: *they combine work, play (touch rugby) and socialising and we have lunch together.*

Irrespective of age and ethnicity, adolescents enjoyed these informal approaches and many thought more of them should be incorporated into the programme: *I'd have liked more activities like drawing, painting, doing something active like hikes and camps.*

Involving the Adolescent's Wider Network in Treatment is Beneficial

Comments from many adolescents, parents and caregivers suggested that the success of the programmes was largely attributable to family and caregiver involvement, and the adolescents' involvement in school, work, and community activities. Their comments indicated that this was actively encouraged by programme staff. However, there was concern regarding the lack of posttreatment support for clients and the inadequacy of input from CYF social workers.

Family and caregiver involvement: Comments from the vast majority of adolescents, parents and caregivers, suggested that support and participation of family members and caregivers played a vital part in helping to ensure an adolescent's engagement on the programme and often determined whether outcome was successful. Comments from several parents and caregivers suggested that programme staff were also adept at engaging and maintaining families in treatment and assisting them to develop strategies for improving communication and resolving conflicts. Several parents commented on the way therapists helped them with their own personal issues, such as relationship problems, parenting issues and prior sexual victimisation experiences. *Any time I*

needed help, especially through the breakdown, the therapist would break down the problem into steps and help me deal with it.

Several caregivers commented on the co-operation that existed between the programmes and placement caregivers. In some cases, the experience of being in a placement added another dimension to the programme. Several caregivers took on the role of *pseudoparents* by including the adolescents on outings and involving them in shared interests. This increased the adolescent's involvement in prosocial recreational activities and provided opportunities for meaningful interactions with others. One grandfather reported getting to know his grandson when he took him fishing. A grandmother said her grandchild had a paper run and she helped him as it gave them a chance to do something together. There was also comment about an adolescent who *shared similar interests as his caregiver - hunting, fishing and motorbikes. They had dinner and went fishing together. They spend the weekends together.* Maori house-parents from a foster home placement said the boy in their care now went to church and had formed better relationships with others. A few Maori caregivers from residential homes reported introducing the young person to various aspects of Maori culture and life: *in terms of being Maori it is useful working with the boys - I do things differently - I take them out eeling, teach them how to do a hangi and teach them respect.*

Involvement in school, work, and community activities: Many parents and caregivers spoke of the benefits that accrued to young people when they participated in school, work, sports teams, church youth groups, and other community activities. Some programme staff adopted an active role in facilitating this involvement. There were several descriptions of adolescents who had improved their performance at school, were involved in prosocial recreational activities and programme staff who assisted adolescents with work experience and finding jobs. Several schools participated in rehabilitation by supporting adolescents with their safety plans and providing a contained, safe environment for them to put into practice what they had learnt on the programme.

> *We wanted to be part of the school safety plan. He has set boundaries at school. We were included at a meeting at school and it was like "wow!" we could see that the programme's actually working and that is brilliant for us (caregiver).*

Inadequacy of CYF social worker input: When CYF social workers maintained regular contact with the adolescents during treatment it enhanced collaboration and co-operation among the key personnel involved in the adolescents' treatment: *(the CYF social worker) came to a few meetings. He was pretty cool. He helped me with placements and clothing grants. He keeps in touch with (the programme) and my parents.* Despite a few references to *cool* social workers who were attentive, efficient and took an interest in the young person, there were many more reports from adolescents and family members of social workers turning up late, not turning up for sessions, not returning phone calls, *not getting anything done on time,* high staff turnover *(like I change my shirts almost)* and not being notified of changes in personnel.

> *I haven't liked the fights. The social worker's hardly ever there, is often late and my father gets pissed off with this. My father fights with the social worker – there are always fights. I think the social worker's slack 'cause he should be there.*

A clear need was identified for CYF social workers to become more involved in the programmes.

Transition into the community posttreatment: The absence or inadequacy of posttreatment services for adolescents at programme completion was a concern for several parents and caregivers. There was also comment about the need for agencies to take more responsibility for ensuring a smooth transition back into the community. Some parents and caregivers wanted to know how the young people would be monitored and where they would live posttreatment and there was uncertainty about the role of the programmes during this transition period.

> *I'm concerned what happens to the boy posttreatment. Who's going to follow this up? He wants to live with his father who is a negative influence and this could undo all the work done. The boy thinks he will be going to his father's and he will be devastated if this doesn't happen. It will destroy his dreams. Given the attachment issues that he faces in his life, it's important that the transition posttreatment is managed carefully. He has conduct disorder, it's an added complication. Do they know how to deal with this?*

Summary

Given the positive comments about the Good Way model it was suggested that this be further developed and evaluated with a view to being used more extensively with different client groups and across other programmes. While it has been suggested that

the provision of expressive and experiential therapies in ASO treatment programmes is crucial (Rich, 2003), their efficacy for this population group has yet to be established. Findings from this study indicated that the exploration of difficult issues through creative and physical activities enhanced treatment. Moreover, taking into account developmental factors, differing learning styles and abilities, and the verbal skills required for most interventions, it makes sense for programmes to provide alternative avenues for self-expression. It was therefore recommended that the programmes review their current therapeutic practices with the aim of increasing the use of expressive and experiential interventions.

In the literature, MST with its focus on the interconnected systems of family, school, work, peers, and community, has been described as the most promising intervention for this population group (Prescott & Longo, 2006). The programmes incorporated aspects of this approach and participants' comments suggested this was a key component of successful treatment. However, findings suggested that more could be done by the programmes to ensure posttreatment support for adolescents and their families. Given indications that treatment gains can be maintained when parents, caregivers and significant others receive ongoing support (Flanagan & Hayman-White, 2000), it was recommended that the programmes review their provision of aftercare services. Follow-up treatment could be offered at set intervals for a 12 month period. Another option could include the provision of an 0800 number to enable families to contact a duty counsellor should they require advice or support. Findings also suggested a need for greater involvement of CYF social workers in the treatment of adolescents in their care. It was therefore recommended that systems be developed to ensure CYF social workers become more actively involved in supporting adolescents while they are on the programme. As a starting point, a fulltime CYF social worker could be seconded onto each programme.

Perspectives on Treatment Modalities

Adolescents were asked about their experiences of individual therapy, group therapy, family sessions, and system review meetings. Although parents and caregivers were not asked specific questions about treatment modalities, they frequently referred to them when talking about programme strengths and weaknesses, and what was responsible for bringing about change. Five themes were identified from participants' responses: mixed

experiences of education and parent groups, individual therapy is highly valued, group therapy is both helpful and potentially harmful, family therapy facilitates positive outcomes, and system reviews place treatment in context.

Mixed Experiences of Education and Parent Groups

Education and parent groups were a significant component of treatment for most parents and caregivers. They served as an induction for participants, providing them with information on sexual abuse and offending and *how it affects the whole community, not just the abuser*. Participation in these groups reduced isolation, guilt and self-blame, and fostered a sense of hope for change. However, listening to other people's stories could be difficult and a need for a parent support group was identified.

Sharing experiences reduces isolation, guilt and self-blame: Education and parent groups enabled parents to meet others who were going through the same thing in a *nonpressurised* environment. Many parents described how sharing their experiences reduced their feelings of isolation and guilt. They *valued the friendships* of others in the group and liked *getting to know other boys and being part of the wider community.*

> *I didn't feel so isolated as I could relate to what the others were working on ... before I felt guilty, felt shame about having a son who had sexually abused.*
>
> *It's helped me heaps … because I've got a clearer view of what's going on with my son and that the other parents have the same problems and suffer in the same way (Maori caregiver).*

Sharing experiences gives hope for change: Several parents talked about how listening to the stories of others who had been through the programme gave them and their child *hope for the future.* Others commented on how the group process helped their children.

> *He was able to learn about himself and find things deep within himself. He began realising the impact of what he'd done - he'd never taken this in before. He was given permission to shift his thinking. Other boys in the room helped. The clinicians involved the boys.*

Listening to other people's stories was difficult: However, for several parents, talking about their child's offending and having to listen to other people's stories was extremely difficult. Suggestibility was a major concern for some.

We came away really angry that he had to be there and listen to this. We felt like we didn't belong but that's a standard reaction. We certainly felt empathy towards some of the other kids - we learnt how much worse it can be.

A number of parents felt they did not fit in with the group. Reasons given were that they considered their child's offending was not as serious, or that people's backgrounds were too dissimilar: *we felt out of place - some kids were really bad and stroppy.* One parent commented that the language used was *deliberately simple* and another thought that *while the education groups worked well, some parts were a bit childish.*

Need for parent support group: Several parents and caregivers missed the opportunity to socialise and share experiences after they had completed the education group and would have liked the option of attending a parent support group.

We would have liked a parent support group. It's difficult to seek help around this stuff. I am a victim of sexual abuse – perhaps that makes it harder. It took me days to get over his disclosures in family meetings. But what support do we get after we've listened to this?

It would be good to have a counselling service or referral service for supporting parents. Groups can be devastating re disclosure issues. Parents have to deal with the children's abuse against other siblings…it's especially difficult when the boys are going through their sexual abuse histories…guilt sets in and parents blame themselves.

Individual Therapy is Highly Valued

Individual therapy was highly valued by all adolescents: *you learn heaps when you do individual work with counsellors.* It allowed for the development of a one-to-one relationship where personal issues could be discussed in confidence.

Individual therapy builds helpful interpersonal relationships: Adolescents, parents and caregivers made several references to the bond or friendship that developed between some therapists and adolescents.

My mate comes here and he's friends with his worker too. I think all staff here are mates with boys here and that's one of the best things they can do here. Kids trust them and they can talk to them.

I'm pretty close to (my therapist) – we've done some pretty personal stuff. (My therapist) helped me understand more and more and get through this stuff I'm doing.

For a few parents, individual therapy also provided opportunities for closer involvement with families: *I definitely like the way I can talk to the therapist along the way (at the end of individual sessions). She's someone I can talk to.*

Individual therapy allows work on personal issues: Many adolescents talked about how individual therapy provided them with opportunities to *talk privately* about topics they were struggling with, learn problem solving skills *(…talking and solving problems I get stuck with)* and do in-depth work on personal issues which was not possible in a group setting. Some adolescents talked about how they had worked with their therapist on a particular problem, such as anger management, and described in detail how their therapist had helped them manage their problem in real-life situations. Several adolescents also explained how individual therapy had helped them talk and overcome shyness: *I used to have communication difficulties. They got me talking in individual therapy.* A few adolescents, parents and caregivers commented that individual therapy allowed for the pace to be set at an appropriate level which made it easier to work on difficult issues: *I do work at my own pace instead of rushing it (adolescent);* and *they can work at the kids' pace … not having to rush* which enabled young people *to talk about the hard stuff (parent).*

Group Therapy is Both Helpful and Potentially Harmful

Most adolescents, parents and caregivers shared similar views about group therapy. Their views suggested it was both helpful and difficult, and the potential for negative influence of other group members was highlighted.

Group therapy is the most helpful and most difficult process: Many adolescents expressed the view that group therapy was the most difficult and the most helpful form of therapy for them. It was difficult because they were asked to talk about their sexual abusing and personal problems in front of others. At the same time, being in groups was destigmatising and reduced their sense of isolation. As one adolescent commented: *some people go through a lot more than what I've been through. That helped. I used to think that I was the only person that stuff had happened to - you don't feel so alone.* Some adolescents talked about sharing distressing experiences, such as overcoming sadness about not being able to live at home. An older adolescent with intellectual

difficulties described how important it was for him to talk about this, let his feelings go, and start crying.

Many adolescents also valued the support of group members and learnt from being challenged: *the other people in the group are supportive and quick to challenge me. It helps me to be honest.* Most said they felt shy and awkward when talking about their offending but the discomfort eased with time as they got to know each other and began supporting and co-operating with one another: *in the group sessions I can help others while I'm helping myself.* Comments suggested the group process enabled most young people, many of whom may have had few positive experiences of family life and struggled with peer relationships, to learn how to share, support and encourage each other.

Many parents and caregivers valued the way groups provided opportunities for adolescents to challenge and support each other and some caregivers identified group work as a key strength of the programmes. They were impressed by the ability of adolescents to be brutally honest yet supportive of one another.

> *For these kids to call each other liars is incredible. They do challenge each other.*
>
> *Group therapy has helped our child learn and understand the material about sexual abusing. It's the way they run their groups. He has other people pushing him to be honest and face up. They support each other.*

With regard to camps, young people described them as *fun*, *helpful* and *difficult* as they were encouraged to talk about their offending in this setting. However, for a few adolescents, being in an informal less structured environment seemed to facilitate disclosure: *the reason I've made changes since being on the programme is that I now realise what I've done is wrong - I've learnt this mostly at camps in disclosure.* Conceivably, the games, sports and hikes that young people enjoyed may have enhanced their self-esteem and reduced social alienation thereby making self-revelation easier.

Group therapy can be negative because of individuals in the group: There were some negative responses to the group process. Several adolescents expressed concern about the disruption and negative influence of having antisocial youth in group

interventions. Some complained that bad behaviour had distracted them from their work.

> *In the group I'm thinking stop the bullshit and get on with things, stop making arsey comments. It pisses people off.*
>
> *I haven't liked the smartness in the group - people muck around too much and don't do their work and don't support others.*

A few adolescents thought some therapists could have been firmer with the disruptive ones who were *ignorant* and did not *give a shit about anyone else*.

Several parents and caregivers expressed concern about their children being exposed to harmful information: *I didn't like the thought of him hearing about boys who'd done worse stuff. I didn't think my son was as bad as theirs. I asked that he be removed from the group as I thought he'd pick up bad habits.* One Maori family had serious concerns about the group process. Their son, who was developmentally delayed and had experienced a *shattered upbringing*, was thought to be particularly susceptible to the negative influences of others. Another family thought the power of the group exerted too much influence: *we were concerned about the power of the group – like they made decisions that overrode parents.*

Family Therapy Facilitates Positive Outcomes

Client responses to family work were overwhelmingly positive. Adolescents and their families viewed it as an opportunity to work on family communication and functioning, review progress and manage safety plans. There were suggestions that family work with Maori whanau could be further expanded by the programmes.

Family therapy helps family communication and functioning: Discovering and acknowledging that a child has sexually offended put families under considerable strain, especially families that were already struggling. Comments from several adolescents and most parents suggested family therapy helped to undermine the denial and secrecy that frequently accompanies sexual abuse. Several adolescents referred to hiding feelings, *putting up brick walls,* and being *shut down* before treatment began. Family therapy facilitated communication among family members. It enabled one young person to *talk about his sexual offending against his siblings.* His parents thought he was

prepared to be honest about what had happened when he saw how much his family backed him during family sessions.

Many adolescents and parents talked at length about issues within their families and how they had worked on them in family therapy. The input of parents and caregivers helped the therapist gain insight into the young person's family situation: *it's been helpful being involved because it allows me to see what's going on and they have my input and I can tell them some home truths.* It enabled the therapist to build up a 360-degree picture of the young person across different settings and to address problematic behaviours that occurred between sessions. One adolescent described how his father's anger problem had affected other family members and led to fights between them. Family therapy provided him with strategies to cope with his father's outbursts. He learnt how to *read* his father and to walk away rather than get into fights.

Family therapy not only helped many adolescents understand and talk about their feelings more, but also had an impact on their parents' attitudes and behaviour. One adolescent described changes in his behaviour and in his mother's attitude towards him. His family *never used to talk about feelings* and as they opened up during therapy, his mother began trusting him and seemed more caring towards him. Similarly, another adolescent described how family therapy had brought about a communication *breakthrough* in his relationship with his mother. Another adolescent developed a better understanding of what *his parents felt and what their opinions were - it's stuff I needed to know. It helps me to relate to my parents better.*

Family therapy provides opportunities for review of progress: Several young people reported with pride that family sessions enabled their parents to learn how they were progressing on the programme. As one adolescent commented: *my family, who came up from Hamilton can see how good I'm going and how long I've got to go.*

Family therapy helps to manage safety: Family therapy also provided adolescents and their families with opportunities to talk about how they would manage safety during weekend home visits: *we talked about how to keep safe and the offending cycle – how the family can tell if I'm in danger.* Several adolescents talked about the process of discussing and reviewing their safety plans with parents prior to their return home.

We talk about what's going to happen when I come home – how I can prepare for the rules like taking responsibility for my car, the warrant etc. I also talk about my safety plans and getting more freedom when I get back home. I used to have a security person with me to make sure I wouldn't take off.

There is a need to expand family work with Maori whanau: Although there were no negative comments about family therapy, one Maori adolescent who thought family sessions *were really good* would have liked his whole whanau present, particularly his brothers and sisters, not just his mother. A few Maori parents and caregivers thought too much emphasis was placed on the individual child and *there wasn't enough consideration of the wider family context.*

In the family sessions there needs to be a focus on the family. There needs to be stuff in place for supporting families. This will help the whanau to become more confident, honest and decrease risks.

The sole focus was on (the child) – how he was doing. I would have liked to hear things like how is it meeting your family needs – not just (the child) and programme content.

There wasn't enough work with the whanau – nil to slow. I think they should have seen his family more regularly – they should establish more whanau hui (residential caregiver).

System Reviews Place Treatment in Context

When young people talked about the system review process, they valued being kept informed about their personal progress and future direction; receiving support from family and caregivers, therapists and other key workers such as social workers; being challenged by the group; and resolving issues that arise in other settings.

Information on personal progress and future direction is important: System reviews provided clients with opportunities for detailed feedback on the progress of the adolescents. This aspect was recalled by many adolescents, parents and caregivers as being helpful.

I get feedback from the group. It's read to me. It helps me get different views from different sides of the square. Everybody sees different things - everybody's challenging me - I get a whole picture of myself (adolescent).

We get an overview of how others are feeling, we get to know more about our boy, we see the big picture, we see how things are progressing, we listen to the changes. It's encouraging. Also he might be doing something we're unaware of (caregiver).

System reviews, with everyone providing feedback and input, also helped many adolescents develop a sense of achievement and get a clearer view of what might happen once they finished the programme: *Mum and my therapists talked about what I've done, my achievements and future goals. I talked to Mum about what I'd done.*

Review meetings provide care and support: For some adolescents and their families, review meetings fostered an awareness of the wider social support network involved in the care and treatment of the young people. Comments included: *it was helpful seeing how much support I have; good seeing everyone that's involved with me; if there's something I need, I know someone's going to do something about it or try;* and *having my aunties and nana there was the best thing.* There were several references to teachers who became involved in safety plans and a few references to CYF social workers who maintained regular contact and support: *I've got a cool social worker who comes to visit me most meetings. He helps – he takes me out, we have lunch, he sees me every week.*

Review meetings provide challenge: System reviews also provided a forum for discussion about aspects of the programme that were not working so well for adolescents and their families. Some young people referred to being challenged about negative behaviour that sometimes served as a wake-up call: *I was feeling a bit scared, worried that I might get kicked off the programme … it's hard being challenged.*

Review meetings resolve issues that arise in other settings: Review meetings also provided opportunities to talk about problems occurring in other settings, such as at school or in a residential facility. One adolescent commented: *if I've been violent, punched someone over at school, not abided by the house rules I get pulled up. We just stay in the same place until we get our act together.* Another adolescent reported that there had been long discussions about house rules in the residential home where he was staying. While it annoyed him and he described the system review meetings as *pissing him off*, the problems were eventually resolved satisfactorily. A caregiver described how staff from the residential facility where she worked applied programme content to the everyday lives of the young people in their care.

> *The programme and home are interlinked. For example, we do the "New Me" in the home – to replace behaviour that's not appropriate with behaviour that is.*

We live by this in the home. We identify what they've done in the course of the day and apply it to their lives – there's a roll on effect. We work side by side.

Summary

While multimodal interventions (individual, group, and family) were highlighted as instrumental in facilitating change, concerns about group interventions were raised. Although group therapies have traditionally been the mainstay of ASO treatment programmes, there is little empirical support for this practice (Hunter, 2006). Furthermore, research on iatrogenic treatment effects (Dishion, McCord, & Poulin, 1999) raises the possibility that uninformed mixing of disturbed youth with less impaired youth in therapy groups for sexual offending may be harmful (Hunter, 2006). While this study indicated support for group interventions it also highlighted the need for clinicians to give greater consideration to the possible iatrogenic effect of combining youth who differ in their demographic profile, psychological and emotional adjustment, risk level, and offending behaviour. The only other identified need related to broadening the model of family treatment, particularly for Maori whanau. It was therefore suggested that the programmes review their provision of family therapy with a particular focus on session frequency and duration, the number and nature of participating family members, family treatment goals, and increasing support for parents.

Treatment Components that Facilitated Change

These were identified from responses given by adolescents, parents and caregivers, to questions about what had been learned from the programme and the ways in which the programme had helped them. There were no direct questions about particular treatment components. Responses revealed that adolescents and caregivers attributed significance to the same components which were coded into five themes: impact of victim empathy, breaking the cycle of offending, enhancing safety through relapse prevention, managing anger, and learning communication and social skills. The introductory description of each component was sourced from the agencies' clinical and treatment manuals.

Treatment Produces Victim Empathy

In this process, offenders learn about the impact of their sexual offending behaviours and are helped to understand their victim's perspective.

Victim empathy was the most frequently mentioned therapeutic component by adolescents at all sites. Many of the comments suggested that adolescents had gained an understanding of their role in the offending and the effects of this on victims.

> *Empathy - it's really hard to do … opening up … saying "I'm sorry". It was really in-depth shit - like "boom!" I've learnt that there is another face to the coin ... like you feel like the victim felt. You get hurt, so you hurt her sort of thing - but you feel like she felt, or the person you abused - like you really* ***feel*** *it in your head.*

> *Empathy is the big one. When I first started the programme I used to think my victim enjoyed some of my actions. I know it was hated. Now I feel sorry for the victim. I am no longer angry that I was caught and had to be here at (the programme).*

Empathy was described as *learning to put myself in someone else's shoes,* and *knowing how others feel.* Most parents and caregivers reported that the adolescents were much more aware of the impact of their offending on their victims, family members and others they may have *hurt* by their actions. Some adolescents applied what they had learnt about empathy to people and situations beyond the programmes. For example, a caregiver described how a boy had decided not to go home one weekend as she had just come out of hospital and he wanted to help her husband look after her. When young people recalled what they learnt about victim empathy they mentioned:

- putting themselves in the victim's shoes, realising the impact of offending on others: *I've learnt how everyone feels, parents of offenders and victims.*
- apologising and showing remorse to victims - writing victim empathy letters. Several parents and caregivers also referred to empathy letters: *when he read it he was tearful. He's now much happier - he's no longer got that screwed up, strained look on his face. Tears showed how real it was for him.*
- thinking errors: *lying to yourself to make something seem OK.*
- minimising: *telling yourself that it's not as bad as it really is.*
- exerting power over the victim: *if you have power over someone - like you're stronger or older than they are – they might be scared to tell you if they don't want to do something.*

Therapy Helps Break the Cycle of Offending

The cycle of offending is used to help adolescents identify their offending pattern and to identify strategies for breaking the cycle. They are helped to understand how their own

situations, thoughts, feelings and behaviours contribute to this cycle and are taught to take responsibility for their behaviour.

Many young people talked about what they had learned about the cycle of offending. Comments suggested they realised and feared that unless they broke the cycle they would end up in jail. There were several accounts that suggested the young people knew what they needed to do to break the pattern. One adolescent's insight about his tendency to minimise and deny facilitated change.

> *It's important for me to accept what I've done because when I do things I never own up. My therapist helped me with this. I lie, pretend it's a small thing, I refuse to believe I've done it. I've learnt to move on, change my pattern, break the pattern. I'm trying to live a normal life.*

Several parents also described what their children had learned about the cycle of offending and how they had learned to accept responsibility for their offending. Some parents commented on how the young people had become less impulsive and thought more about the consequences of their actions.

> *It's not so much "poor, poor me", he's less of a victim. He used to attract trouble – he's now starting to take responsibility for his actions. He's most definitely starting to take responsibility for his abusing. Instead of passing blame onto others, he's starting to make "I" statements.*

Some parents said they had benefited from learning about the cycle of offending. One no longer blamed herself for what had happened: *we needn't take responsibility for the boys' actions*.

Relapse Prevention Enhances Safety

Relapse prevention work, which follows on from teaching the cycle of offending, includes safety plans and boundaries. It involves education about how relapse occurs, developing awareness of high risk situations and identifying strategies for dealing with them. Ongoing behavioural and lifestyle problems are addressed while positive changes are monitored and reinforced.

Adolescents at all sites talked at length and in detail about safety plans and the rules they needed to abide by to prevent reoffending. Their comments suggested a clear understanding of the material. Many identified their triggers and high risk situations and

described how they kept themselves safe by using *thought stoppers*, *escapes* and distraction techniques.

> *When I was growing up I had virtually no rules and now I've got boundaries, rules to stick to or else I'd get into really big trouble.*
>
> *I've learnt to keep myself busy and occupied. I go out to see my mates. I've also learnt to look after myself in risky situations.*

Some adolescents explained strategies they used to cope in high risk situations. For one young person it was remembering the three R's; respect for self, respect for others, and taking responsibility for actions. He said that if he thought he might get into trouble, he thought of the three R's and this gave him the time to reflect and walk away. Another adolescent described his high risk situations as being alone with younger children and *sneaking porn and cigarettes* into the house. He described in detail, the safety plan, escapes and distraction techniques he employed to keep himself safe.

Many parents and caregivers also talked about what triggered offending and the part they played in helping to keep them safe. A residential caregiver was acutely aware of the need to monitor adolescents on outings as their *lines of sight would be drawn to children*. She described how therapy had been so effective that the youths spoke up if they felt at risk. A mother described how her child would remove herself from high risk situations in their home if young children were present. She now played in *public areas* such as the lounge. Another parent said that the safety plans had become so much a part of her son's life that he *automatically clicked into his safety plan.* She described an occasion when he had been at a wedding where many young girls were present and he sat with his parents all night to keep himself safe.

Treatment Helps Manage Anger

Anger is a common feeling experienced by adolescents on the programme and can impede programme progress if not dealt with effectively.

Anger and violence usually directed at parents, siblings and peers were problems that many of the young people referred to. The programmes provided them with the concepts and skills to understand and develop prosocial attitudes and behaviours.

> *I've changed a lot with my violence and anger. I've got ways of controlling it. I don't want to get into more trouble.*

> *I've learnt to handle emotions. I didn't have control over myself previously. If I got angry, I'd pack a mental. I don't get like that any more. I'm no longer emotionally like a 4 or 5-year-old, more like 12 or 13.*

One young person recalled learning what happens when you use aggression to get your own way and the impact of staying calm: *if you walk into a shop and the shopkeeper mucks something up, it is better to stay calm rather than get aggressive. The shopkeeper is more likely to sort the problem out for you.* All adolescents who mentioned they had an anger problem had made some headway and several who had been physically violent said they no longer hit people: *I used to lash out, hit and swear at people that annoyed me. I now yell and ignore them rather than getting violent.*

Several parents and caregivers also recognised that their children were being taught to control and express their anger in appropriate ways. They were better at avoiding confrontations and could *tone down* their anger or get over angry feelings more quickly. Instead of *having tantrums* one adolescent would stay in his room. Another would go outside and take his anger out on a punch bag. One adolescent with intellectual difficulties reported that the three characters, *Mr Sneaky, Mr Bully* and *Mr Just Do It*, had helped him *a lot*. He said he was a bully and used to do things that *just popped into (his) head.* Learning about *Mr Bully* had helped him *control his anger* and *stay out of trouble (also with the Police).* He commented that his mother had *learnt the stuff as well* and that he had *got the anger problem from her.* Although he acknowledged that they both still got angry sometimes, they had developed *ways of dealing with it.*

Learning Communication and Social Skills is Helpful

Effective communication skills can enhance outcomes by helping young people relate to others, assert themselves and express feelings appropriately, improve their self-esteem, and ask for help when they need it. Effective communication can provide offenders with the necessary social skills to replace behaviours that previously led to offending.

Most adolescents described learning how to communicate more effectively whilst attending the programmes and many parents and caregivers noticed striking improvements in this area. Young people reported they had learnt how to:

- talk to others openly and honestly about their feelings: *it's important for me to speak up about problems and talk about stuff - it gets problems out of your head; It's easier to tell the truth than lie - it ends up in more lies to cover previous lies.*

- resolve conflict by talking rather than using their fists, becoming aggressive or resentful: *Mum and I had an argument and rather than me stewing about it for days, within half an hour I apologised; I used to tell my mother to shut up and swear at her. Now I don't. I've learnt all this here at (the programme).*

- express themselves using language more effectively instead of swearing or being monosyllabic: *I used to say "yep, yep" or "whatever". Now I use proper English; I've learnt to respect my parents and not swear and backchat them.*

Parents and caregivers were impressed by the young people's willingness to engage in more mature conversation.

> *He listens carefully now, there's better communication. We can sit down and have a coffee, have a conversation - it's more adult to adult, not adult to child.*
>
> *We have good quality conversations.*
>
> *He engages more in everyday conversation.*

Summary

Adolescents, parents and caregivers demonstrated good recall of particular treatment components. Their comments suggested that adolescents had understood programme material and incorporated it into their behavioural repertoire across a number of settings. While the aforementioned salient treatment components are typically included in most treatment programmes for adult and adolescent sexual offenders, their appropriateness and effectiveness in relation to adolescents has been questioned (Longo & Prescott, 2006). For example, despite concerns about the applicability of the relapse prevention model for adolescents (Hunter & Longo, 2004), the findings from this study suggested that relapse prevention can be used effectively with adolescents as one aspect of a holistic approach. Its apparent usefulness may be related to the way it was introduced by therapists, particularly the use of appropriate language that not only invited engagement with the material but also took into account developmental and contextual issues. Another aspect of treatment that has received attention in the literature relates to empathy training (Longo & Prescott, 2006). Longo and Prescott point out that a nationwide survey of North American treatment programmes and models conducted by the Safer Society Foundation in 2000 found that less than 7% of

adolescent programmes incorporated empathy training. Taking into account the breadth and depth of comments from clients and their families in this evaluation, empathy enhancement appeared to be a particularly valuable treatment component and as such may warrant inclusion in treatment programmes at wider levels.

Treatment Outcomes

Adolescents, parents and caregivers were asked questions about what had changed since starting the programme (positive and negative changes), whether or not the programme was having an impact on sexually abusive behaviours, the reasons for making changes (whether the programme was responsible or other influences) and any impediments to change. This part of the interview drew the most animated responses from adolescents and parents. There were no reports of negative outcomes or no change, despite prompts to do so. Eight themes were identified which are as follows: the programme was life-changing, there is reduced risk of reoffending, family relationships have improved, there is greater engagement in prosocial behaviours, there is improvement in peer relationships, more positive attitudes to school and work, increased confidence and self-esteem, and parents and caregivers have acquired knowledge and skills.

The Programme was Life-Changing

Many adolescents and several parents and caregivers referred to changes in a global sense. Their comments suggested that where there had been despondency and hopelessness pretreatment, the programme had instilled a sense of hope and expectancy in many adolescents.

> *There's overall growth in the boys. They can talk about a future, their dreams and goals.*
>
> *My whole view of life has changed. I used to think fuck the world. Now I think life is what you make of it. I've got a chance to get a job, I'm getting an education through the course, I'm closer to my parents, I've matured. I'm starting to become a gentleman, trying to be kind to people, be more honest. I'm more confident, I've got better self-esteem, I've made friends.*
>
> *My life has changed, everybody's lives have changed. I used to be a crazy nutter – I used to be an arsonist, a bully, break windows. Now I have a secure life, a good one.*

Some parents said they barely recognised their children, so great were the changes in their behaviour, attitude and outward demeanour: *he's just completely changed, he's not even the same kid.*

> *He no longer looks so stressed and withdrawn. He was incredibly uptight. Now he looks different. He used to look gaunt, white, tense and was tearful at times. His skin was really bad. He was under huge pressure. Now he's more relaxed, seems to be getting on with life, he has settled into school, has better friends and more confidence. He's more mature.*

There is Reduced Risk of Reoffending

Several experienced residential placement caregivers commented that to the best of their knowledge, there had been no sexual reoffending posttreatment amongst adolescents they were involved with: *these kids I've known have not gone on to reoffend... they've healed*; and *all our kids have made positive changes – none have reoffended.* Adolescents also commented on their behavioural changes with regard to offending.

> *Since I started the programme everything's changed (where my abusing is concerned). My behaviour has changed. I'm mature enough to make clear decisions about what is wrong and right.*
>
> *The reasons I've made the changes and don't sexually abuse is I don't want to be in jail, I don't want to lose my kids. I want to be at home.*

Many young people talked about how what they had learnt on the programme had stopped them abusing or *bad touching*. When talking about their resolve not to reoffend, they talked about the safety plans they had put in place, the fear of being sent to jail, the empathy they felt for their victims and the impact that their offending could have on others: *I've learnt who is affected by offending in the community and at school … friends, family, the victim's family, your youth worker. You learn how your actions have affected everyone else and not just you*. Several reported that they had learnt to distinguish between safe and risky situations, good and bad touching, and were aware they should socialise with same age peers rather than younger children.

Many parents and caregivers described how the adolescents had learnt to adhere to safety plans. They felt they could now trust them around younger children. One parent said she could now go to the toilet and leave her boy in the company of young children, knowing he would not touch them. Another said her son was *not leering as much at young girls*. Some caregivers reported that the adolescents could recognise triggers and

walk away from high risk situations: *divert their eyes when they see a TV commercial for nappies*; and *avoid the company of young children.* Whether the adolescent was part way through the programme or had nearly completed it, the majority of parents and caregivers expressed confidence that programme input had led to a reduced risk of reoffending: *I've seen him growing and developing everyday. He doesn't concern me any more. He's had education and treatment. It's unlikely he'll reoffend now.*

Family Relationships have Improved

Comments from many adolescents and parents suggested that improved family relationships were a result of the programmes' emphasis on healing damage within families and helping young people become functioning members of the family unit. Many adolescents, parents and caregivers described transformed households and a few parents became visibly emotional when describing these changes. There were descriptions of chaotic family environments before adolescents began treatment involving violence and arguments among family members, lack of communication and negligible trust. Comments suggested that family functioning improved when families became involved in treatment, which many parents and caregivers attributed to skills they acquired while accompanying the adolescents to therapy. They reported learning how to manage their anger, communicate more effectively with their children and resolve conflict before it escalated. The outcomes of improved family relationships were reflected in more harmonious relationships among family members and emotional closeness.

Relationships are more harmonious: For many adolescents and parents, family therapy facilitated change across the family system and there were many references to improvements in family communication and interactions, and reduced levels of conflict. One parent commented: *it's still tough but we're a normal family now with normal problems. We're a lot happier, we don't argue as much.* An adolescent commented:

> *Within our family we're less anti to one another now. I used to have fights with my stepdad every night. Once I broke his nose with a head butt when he held me down. He doesn't get so angry with me now - I'm better towards him.*

One caregiver described the changes a mother of a boy in his care had noticed after spending a week with him in the school holidays. She was *nearly crying* and said it was

the best week she had ever had with the boy. The caregiver said that was a *huge statement for (them) to hear because he'd been uncontrollable before*.

Adolescents also commented on changes they had witnessed between their parents. One adolescent said that his parents had separated prior to his attending the programme, and that *they were always fighting* and did not want to *go near each other or even live in the same country*. Although they remained separated, they could now live in the same town and the family regularly drove to sessions in the same car. His relationships with his brothers had also improved as they no longer fought. His mother commented: *it's opened the world to our family in coping with everyday things.* Some caregivers also noted improved relationships between the adolescent and siblings. One commented that the boy in his care was treating his brother and sister quite differently. This was evident in the way he spoke to and behaved towards them. Another commented: *there have been positive changes in his relationship with his brothers. He gets on well with them - tries to resolve difficulties with them. There's a very different pattern of behaviour.*

Emotional closeness has developed: There were several references to the development of emotional closeness in family relationships. One parent commented: *(the programme) has brought our family back together – closer together. We've grown in strength.* Another said that her son had become more tolerant and was spending more time with his grandparents. Adolescents commented:

> *Before the course started my relationship with my parents was distant. When they became involved in the family meetings and we talked about our feelings, we became closer.*
>
> *We've got closer. There's more love between us. There wasn't ever much conflict between us but now I feel more emotional closeness.*

A few adolescents talked about how their families were now doing more things together, working as a team, whether performing household chores or socialising: *my father and I didn't used to talk to each other. Now he's including me in things;* and *we have more fun – we quite often go out to tea, we work together round the house, doing domestics*.

There is Greater Engagement in Prosocial Behaviours

It was evident that the programmes targeted a range of problematic behaviours. Many adolescents recalled their antisocial behaviours prior to commencing treatment. These included swearing, stealing, lying, fighting, bullying and arson. When talking about treatment outcomes, many said they had learnt about the origins and consequences of such behaviour and learnt how to behave more appropriately. The prosocial behaviours they said they were engaged in included managing anger, acting responsibly, communicating effectively, and being honest.

Anger is better managed: Many adolescents pretreatment were described by parents and caregivers as physically violent *(there always used to be conflict and fist fighting – it was terrible)*, verbally abusive *(he used to be very, very angry – verbally abusive)*, and argumentative *(he used to wind up and argue about everything)*. Comments from adolescents, parents and caregivers suggested many adolescents had learnt strategies for managing anger and how to express themselves appropriately. There was reference to an adolescent who used to be *angry, destructive – smash holes in walls* but was now *like a normal teenager* and *thinking about a building apprenticeship.* Another adolescent who used to *hurt things and people* could now move away when his younger sister punched him in the face. A stepmother commented that an adolescent who became *angry over small things about his siblings' behaviour* now allowed her to intervene and deal with conflicts. She stated, *I've only had to send him to time out once - now I just give him a look - that's a great change.*

Some adolescents talked about using anger management strategies during their altercations with others on the programme. One adolescent in a residential home talked about how he had resisted getting into fights with the other boys by going to his room if they annoyed him and telling himself it was not worth it. Another explained how he used to *lash out, hit and swear at people* who ignored him but he no longer responded violently as he had learnt to ignore them too. Another adolescent described an incident where he and a friend were talking about cars.

> *Last night a boy at (the residential home) got me worked up – we had different opinions about cars. I'm into Ford cars – he said Holdens were better. I told him to respect my opinion and preference and just to leave it at that. Before I would have exploded and used a string of expletives.*

Ability to act responsibly has increased: Adolescents made frequent references to their increased maturity and ability to act responsibly. One adolescent who was reportedly violent prior to treatment talked about the transformation in his behaviour in the residential facility where he lived.

> *I'm a caring person, I look after the new guys that come in. I'm polite. I'm living away from home now - I'm having to live with others. I'm more responsible and mature. I do what I'm asked to do. I talk appropriately. I'm respectful of others.*

Another adolescent talked about respecting boundaries and taking into account the needs of other family members.

> *Before I came here I was a little brat – it was either my way or no way. It's not just me that can get everything – it's everyone – thinking of others. I've changed from a brat to a lovely young (person). I used to make my Dad buy heaps of stuff like $100 and $200 on toys but now I've changed. It's not just me that can get everything, it's everyone. When Dad used to ask me to do stuff I used to say "no". But now it's not just my way and I can't tell my Dad what to do…that's what I've learnt.*

Some adolescents talked about the privileges they had gained by acting responsibly. One adolescent with conduct disorder said his foster parents considered him responsible enough to be given a key to the house and be in the house on his own. Another adolescent was talking to his parents about having his own car once he finished the programme.

When parents and caregivers talked about how their children were beginning to act more responsibly, they referred mostly to their interactions with others. There were descriptions of adolescents who were more mature, more honest, and more aware of how others were feeling. One parent commented on how her son had learnt to respect his belongings: *he went through two bikes really quickly, now he's more careful.*

Communicating more effectively: Most adolescents described improvements in their ability to communicate *(when I came here I could hardly talk – now they can hardly shut me up)* and this was commented on by many parents and caregivers. A young person described what he had learnt on the programme about communication.

> *I've learnt the main steps to communicate - making "I" statements, learning good communications skills. I've worked on this. I never used to be able to*

> *communicate very well … knowing the difference between fact and opinion. My stepmother has noticed a real difference.*

Many adolescents talked about having been *shut down* prior to treatment and lacking the social skills to have positive relationships with others. They talked about the value of opening up, talking about their feelings and the difference this made to their lives.

> *In a family session I got heavily challenged about the way I shut down and don't talk. Our family doesn't show feelings so it was hard to do that. Now I can open up.*

> *I've learnt to be more straight up. When I first started I was noncommunicative. Now I put it out there. I no longer shut down.*

Participants also made references to the use of proper English and the more sophisticated use of language: *he can now speak in whole sentences, no longer gives just yes or no answers; they're more eloquent;* and *they learn to use words that are not normally used by teenagers in everyday conversation*. One caregiver commented on the significance of just being able to have a conversation with the boy in his care.

> *He was an arsehole – an awful boy. He's done a 100% turnaround. He listens carefully now, there's better communication. We can sit down and have a coffee, have a conversation – it's more adult to adult, not adult to child.*

Being more honest: An outcome mentioned by many adolescents was that they had become more honest. While many referred to being *upfront* and being able to identify and reveal their feelings, some adolescents said they no longer stole *(instead of stealing I ask Mum for money or I earn it by doing a job)* and or lied about their offending *(I told lies about what I'd done but this got sorted out at the programme).* Several parents and caregivers also said that the adolescents had become more honest and there were references to adolescents who self-initiated disclosures (*he's opened up about his previous life*), had reduced their level of criminal activity (*not stealing like he used to),* and who were beginning to acknowledge personal responsibility *(he's beginning to take responsibility for his actions).* One stepmother said her child used to be manipulative and lie prior to treatment but this had changed: *she's become a beautiful young lady … she's someone I want to be around and love.* Another parent talked about her son's willingness to open up about other problematic behaviours.

> *He's more honest – more respectful. He thinks about how his actions and words affect others. He said today he's going to cut down on alcohol – it was unprompted. We didn't know he'd been drinking. He's opening up.*

There is Improvement in Peer Relationships

Several adolescents talked about the importance of being able to foster and maintain peer friendships. Their comments suggested that the programme had assisted them to form positive friendships for the first time through the acquisition of social skills.

Forming positive friendships for the first time: Some young people reported that the programme had assisted them to form friendships for the first time which had led to dramatic improvements in their quality of life: *I've got heaps of friends, 4 or 5. I didn't used to have friends, I used to be a "dick", desperate for friends. I used to think of committing suicide*. Comments regarding peer relationships suggested that some young people had learnt what constituted a good friendship *(I told them I was coming here and they backed me up)*, the importance of having friends of the same age *(I've learned to make friends with people my own age)*, how to be a good friend *(I'm caring and respectful)* and to be more selective when choosing who to spend time with *(I have new and better friends – I won't get into trouble with them).* One adolescent commented: *if I do stupid things or do something wrong my new friends come and back me up. Before my old friends didn't care.*

Increased skills to form friendships: Comments suggested that many adolescents found it easier to make friends because they had gained new social skills. Parents of an adolescent who had been on the programme for 2½ years described how he used to be standoffish, but had grown more confident which enabled him to form peer friendships. An adolescent from a small town said he had learnt to be more sociable and to be himself in company. An older adolescent who had been flatting for 6 months said he had learnt to *talk to (his) flatmates about everyday flatting things.* A Maori caregiver noted a big change in the way a young person related to his peers and others. The adolescent had previously tended to destroy his relationships with abusive behaviour: *he was always fighting – it was awful. His manners are much better now - in the last 18 months it's been bliss. He's an awesome guy - he gets on with anyone*. When talking about the future, one adolescent commented that he did not think about his abusing any more, but focused on positive things like having a girlfriend his own age.

More Positive Attitudes to School or Work

Several adolescents reported that the programme helped them focus on their school work and if they had left school, helped them make decisions about work and study. There were several references from parents and caregivers to adolescents who were praised by teachers for their improved attitude and application to schoolwork. A few adolescents were no longer getting detentions or being withdrawn from classes for disruptive behaviour. The following comment from a caregiver at a residential facility illustrates the impact that therapy can have on school performance.

> *We get all the school reports and you can see that they got better and better over the course of the year. As they got through therapy, they were able to achieve more and more at school. That's a really good indication of how they're being helped to function normally.*

With regard to work, several adolescents talked about the value of work experience, the sorts of jobs they wanted, their increased levels of confidence about getting work and their determination to be independent. There were references to forestry, building and plumbing apprenticeships, automotive courses, computer courses, physical labouring work, getting a driver's license, training to become a chef, and being a retail assistant.

Increased Confidence and Self-Esteem

Nearly all parents and caregivers mentioned the growth in the adolescents' confidence and self-esteem and many adolescents made reference to this also: *I'm more confident, I've got better self-esteem*. One adolescent commented:

> *What's changed for me? The way I look at myself now. I used to think I was a weirdo, I wouldn't communicate. Now I'm a new person – others reckon I've changed heaps compared to what I used to be like.*

Increased confidence and self-esteem was viewed by several parents and caregivers as the means to achieve outcomes that were previously considered to be unattainable. For example, a caregiver from a specialist home reported that a Maori boy who was extremely shy with significant developmental delay due to early trauma, had succeeded in moving to the front row of the programme's kapa haka group. She described this achievement as *massive.* Similarly, a Maori caregiver from a foster home said that the programme had helped a boy muster enough confidence to give a mihi and introduce everyone at a family meeting. There were several references to shy and withdrawn

adolescents whose newfound confidence helped them to hold conversations and form relationships with others: *he can go and talk to others. He used to be quiet and solitary. He's still quiet but you can have a conversation with him.*

Parents and Caregivers have Acquired Knowledge and Skills

Many parents and caregivers reported that they benefited from supporting adolescents through the programme: *I've grown as a person – it's a real challenge*. Their comments suggested that the programmes had facilitated their understanding of the dynamics of sexual abuse and imparted life and parenting skills.

Better understanding of the dynamics of sexual abuse: Most parents and caregivers were familiar with course content and had learnt much the same material as the young people. Comments suggested they had a good understanding of the offence chain and the factors that may have contributed to the sexual abuse: *understanding why perpetrators do what they do – for me that was a big thing*. Many said they were aware of the role they could play in the adolescent's rehabilitation and protecting victims. Some parents used this knowledge to keep others safe.

> *I've got a better understanding of what sexual abuse is about now, and the factors that contribute towards it. I'm more aware of what good and bad sexual behaviour is in relation to my younger son. It's been educative.*

> *I've gained a lot of knowledge. I understand how others feel, I know the signs of sexual abuse and about helping others. It's been a learning experience. I can take it with me. I've learnt strategies, different tools.*

Improved life and parenting skills: Comments from some parents suggested that they had gained life skills: *I can now deal with the daily grind, cope with the everyday things*; and *parenting skills*.

> *Instead of yelling and screaming I tell the children quietly. I've got better parenting skills. I've learnt how to deal with different situations. Things get done a bit quicker when I talk quietly. I've also learnt to ignore them.*

> *One of the things I've really liked about the programme is the knowledge and skills I've gained – being able to communicate better with my children – managing anger, emotions, being a better parent, seeing changes in children, being more aware of the changes they go through. For example (my son) used to be a bubbly kid but when he started to change, I didn't notice but I've now taken note of my daughter and she's now changing…I'm taking more note now.*

Summary

These findings showed parents, caregivers and adolescents themselves consider that the ASO treatment programmes produce positive outcomes for young people and their families. Treatment outcomes tend to be gauged in terms of recidivism, and indeed the elimination of further offending is the ultimate goal of any treatment programme. However, taking into account the many factors that contribute to sexual offending, multiple domains of functioning are targeted in order for treatment to be successful. The focus of treatment therefore extends beyond sexually abusive behaviour and the outcomes as described by interviewees reflected this.

Most adolescents, parents and caregivers considered that participation in the programmes led to a reduced risk of reoffending. However, their comments also suggested that for many adolescents, the programmes were successful in promoting systemic change across family, school, peer and community. The programmes appeared to have achieved this through addressing sexual issues as well as other high risk and problematic behaviours, actively involving families, carers, and schools, fostering participation in work experience, and imparting new social skills and competencies to adolescents and their families. While there were no negative reports about treatment outcomes, the possibility that interview data was distorted by reporting biases cannot be ruled out. This is discussed further in the final chapter.

Chapter Five: Staff Perspectives

This chapter examines the programmes' delivery of service primarily from the perspectives of programme staff and external agency staff. While participants were asked specific questions about programme operations they were also asked a broad range of questions designed to elicit their views about programme strengths and weaknesses, successes and failures, likes and dislikes, what worked well and what could be improved. Participants' responses were organised into five main categories (a) review of referral and assessment procedures, (b) perspectives on therapeutic approaches, (c) interagency networking and collaboration, (d) organisational support for staff, and (e) funding and resource issues.

Review of Referral and Assessment Procedures

Managers, programme staff and external agency staff were asked questions about liaison and consultation arrangements and the feedback process during the referral and assessment phases. They were asked to comment on the adequacy of procedures and processes and to identify areas for improvement. Four themes were identified from participants' responses: referral and assessment processes generally work well, there is room for improving referral procedures, there is room for improving assessment procedures, and placement problems impede access to treatment.

Referral and Assessment Processes Generally Work Well

When external agency staff talked about their overall satisfaction with referral and assessment processes they made reference to the standard referral procedures, assessment reports and reasons given for nonacceptance on to the programme.

Satisfaction with referral procedures: Many external agency staff thought that referral procedures were straightforward and worked well. There were references to: being *comfortable with the referral process; the whole process was just great;* and having *particular links with two staff members makes it so much easier.* The following comment was identified as representative of many views.

We have to get financial approval first from the CYF manager. We fill out referral forms and then fax them to (the programme's) clinical team leader. Usually we have a discussion beforehand to ensure it is appropriate, then I'm contacted re the appointment or waitlisted. It's a standard process that's working well. If I'm not sure about something I speak to the clinical team leader – there's good communication.

Satisfaction with assessment reports: Many external agency staff reported that they appreciated reports that were professional, prompt, and offered recommendations that were possible and well researched. Their comments suggested high levels of satisfaction.

The feedback we get in assessment is absolutely invaluable. Very useful. Very skilled. They're able to pull together disparate bits of information about a person's history – they provide a comprehensive history of the person – the behaviour is seen in context. It elevates the behavioural context and puts sexualised behaviour in a helpful clinical context.

They always send a report and I'm very impressed with them. They give me social worker recommendations and it helps me a lot e.g., if a boy needs a neuropsych report, they tell me. They give me options for treatment and recommendations. They also make placement recommendations.

One CYF social worker said that sometimes they received more information in the assessment report than they had knowledge of and remarked that people often *felt more comfortable sharing knowledge with the programme than with us.*

Satisfaction with reasons given for nonacceptance on to the programme: External agency staff gave a variety of reasons as to why their clients were not accepted on to the programmes. This included severe cognitive impairment, the offending was considered too serious and adolescents went to prison, the family were not prepared to travel the distance and bring the adolescent to treatment, the client *wasn't considered high risk – he needed help in other areas,* and lack of suitable placement. Their comments suggested they understood the reasons why the programmes did not accept clients and most were satisfied with the reasons given and appreciated the recommendations made by the programmes for alternative treatment: *we got good feedback from (the programme) – we were given alternatives. He's now going to individual counselling where he's getting sexual offending counselling.*

There is Room for Improving Referral Procedures

Notwithstanding the overall satisfaction with referral procedures, comments from some external agency staff suggested there was room for improvement. Suggestions included modification of the referral form, clarification of criteria for acceptance on to the programmes, and Maori stakeholders' preference for personal contact with staff.

Need to modify referral form: Several external agency staff thought the referral forms could be abbreviated and include explanations for some questions: *when I fill out the form sometimes I'm not sure what they're asking for – perhaps something in brackets would assist*. There were references to the programmes' need for *a lot of information* which *sometimes gets onerous,* and preference for a *single page referral* which would *simplify things.*

Need for programmes to provide clarification about their acceptance criteria: Several external agency staff wanted clarification of criteria for acceptance on to the programmes; *sometimes it's hard to determine at what point of level of offending we need to refer a client to (the programme).* One CYF social worker said (the programme) was very specific about who they accepted and implied this may not always be obvious to a referrer: *they will take boys who are at "high risk" of offending even if no obvious offending has taken place.* Several programme staff also made reference to occasions when they had received inappropriate referrals from CYF. There was comment: *CYF workers need a clearer understanding of our role as therapy providers and our programme criteria.*

Maori stakeholders' preference for personal contact with staff: Some Maori external agency staff would have preferred more personal contact with staff during the referral process. One commented that while the referral process was *adequate,* it would have been better *to get a real person on the end of the phone instead of an automated voice* every time she phoned the programme. She would have preferred immediate personal contact and was frustrated by having to deal with automated options when she was uncertain as to which option to choose. Another said that face-to-face contact would have been preferable to phone contact, and would have helped whanau also.

> *It would be good to have someone from (the programme) physically here at CYF at the beginning of the referral process, at the initial meeting to make things clearer for whanau.*

There was further comment that the provision of some information verbally would have been preferable to written communication.

> *Having to fax through and type up lots of additional information is very time-consuming. It would be good to give the main information to (the programme) and then provide verbal information.*

There is Room for Improving Assessment Processes

Some programme staff and external agency staff thought assessment processes could be improved. Their comments suggested there was a need to standardise the use of psychometric tests across the programmes, to incorporate a cultural perspective when assessing Maori clients, to improve the delivery of information to families, and for further collaborative involvement with other agencies.

Need to standardise use of psychometric tests across the programmes: A few staff commented that gains could be made if the use of assessment measures was standardised across the programmes.

> *I would like to see standardised assessment measures with other agencies as we have kids that go to (other programmes). We're a small sector – it would create broader understanding. We don't want to lose our ability to share information and look at other issues.*

Need for cultural perspective when assessing Maori clients: Comments from all Maori staff suggested the need to approach assessments involving Maori clients from a different perspective. One Maori staff member said she could often sense what the young person was feeling and described it as *feeling the rub of wairua*. It was not always *an explainable science* and *a Pakeha doesn't feel it.* The standard agency assessment forms were considered by some Maori staff to be culturally insensitive as the questions were too sexually explicit for Maori clients. Similarly, some of the questions asked by psychologists were considered too intimate for Maori adolescents and whanau who felt whakama and reluctant to talk about sex openly. A whanau worker said she did not like taking pen and paper into assessment meetings as this *shut people down*. She recorded information by entering it into the computer immediately after sessions. A few Maori staff also commented on the importance of assessing Maori clients in their cultural context.

> *The programme could be improved for Maori if the assessments were done on the marae with Kuia or Kaumatua present (this would be screened for safety). It would also be good to look at going to people's homes. We could do with a different environment for some of the work. We could make Maori feel more comfortable.*

Although Maori staff incorporated Maori health models which provide concepts and guidelines for working with Maori (Durie, 1994), it was pointed out that *there are no risk assessment tools for the cultural aspect.* Furthermore, formal assessment tools were not always considered appropriate for Maori: *I use the powhiri process to help determine the level of risk of clients.* In some cases it was not possible to complete psychometric assessments on Maori clients, as questions remained unanswered. It was suggested by one Maori staff member that questions could be reworked to make them more culturally acceptable with multichoice answer options such as *sometimes, maybe, never.* This would also help clients who had problems with the language and literacy. Another staff member commented:

> *…(it would be helpful to have) Maori staff alongside when they answer questions so that things can be explained as they go. Filling out forms is a reminder of school failure.*

Need to improve delivery of information to families: A few programme staff and external agency staff talked about the need to improve the feedback process for families. One programme staff member said that one of the most difficult things staff had to do was explain the assessment to families: *it's like trying to piece a jigsaw together from multiple sources. It's difficult, hard information.* She suggested that while the agency did its best to prepare parents, staff could explore more friendly ways of delivering the report to families, rather than reading it out word for word. A CYF social worker made reference to a parent who had been dissatisfied with the feedback at assessment as *she disliked criticism of the family system.* It was suggested that that this could have been dealt with differently if she had been given the opportunity to go back and discuss it with them. For a Maori CYF social worker the feedback process could have been improved by *giving more feedback to Maori families – often we just get the basics. We need better plans for Maori boys, involving the family - it's not just the boy, it's the family. There's no feedback from a Maori perspective.*

Need for collaborative involvement with other agencies: Some programme staff and external agency staff thought that the assessment feedback process could be improved if

there were more interagency meetings and collaboration with other agencies involved in the care of the young person.

> *We could improve assessment feedback by widening the net and having more interagency meetings – where it happens it works really well. It's a question of time. Sometimes the interagency communicating is done by phone or email. (programme manager).*
>
> *It would be better if at the end of our assessment when we've pulled together all the data from all the areas, a case conference of all the professionals involved could be held. It would be good if (programme) responsibilities could be delineated and if we could have a clarification of roles – if this could be formalised as part of the assessment. It would be helpful for parents so they know who's doing what, where they need to go (programme manager).*
>
> *Communication at assessment could be improved if the professionals sorted out business first and then involved the family. Communication could be improved if systems were strengthened and there was more consistency across professionals. It gets mucky if (the programme) feed back to the family and they talk to professionals etc. It should be professionals only meeting first (CYF practice manager).*

Placement Problems Impede Access to Treatment

Managers, programme staff and external agency staff all talked about the difficulties associated with finding suitable placements for young people after they had been referred to the programmes and while they were being assessed. There were references to a shortage of options, and waiting lists which exacerbated the problem.

Shortage of placement options: All programme staff talked about the chronic shortage of good community containment for young people waiting to be accepted on to the programme. Finding suitable placements was even more difficult when clients were high risk, had intellectual difficulties or were 17 years of age and over when CYF was no longer responsible for their care and protection. It was reported that finding caregivers without young children was extremely difficult and some residential facilities had strict acceptance criteria that excluded particular clients. For example, boys with conduct disorder were not accepted at the only residential facility for high risk ASO's in New Zealand. Age could also be a barrier as CYF residential homes would not accept young people once they turned 17. One manager pointed out the dilemma for youth with intellectual difficulties who might be 17 chronologically but only 10-years-old developmentally when care options for them ran out. Furthermore, at several CYF

funded residential homes, boys were only accepted once they had begun treatment. A few staff described the situation as *a national issue; a disaster* that necessitated *forward thinking about placements.*

Waiting lists exacerbate problem: CYF staff at all sites were also vocal about placements as it was usually their responsibility to find suitable containment for their clients. They talked about the difficulties experienced when clients had to be placed on waiting lists. There were references to 3 and 4 month waiting lists at two sites.

> *The length of time it takes between the referral being made and the acceptance and assessment taking place is not adequate. There are considerable delays. It's difficult as the young people aren't safe in their current environment if we don't have placements for them. (Residential homes) won't accept until assessments are completed. It's difficult to hold on to people in difficult environments.*
>
> *We can't always place people in safe environments while they are waiting. Even 3 weeks is too long for us … the school won't let a person back to school until he's accepted.*
>
> *We have a boy at the moment who needs urgent assessment. The time factor is crucial. He's in a really quite inappropriate environment and he's on the waiting list. It's 12 weeks. We're trying to keep him safe, keep the victims safe and keep the family informed.*

Several external agency staff suggested that placement problems could be alleviated if high risk adolescents (for whom it was difficult to find interim placements) could be given priority and *assessed ahead of others.* One CYF social worker commented that more could be done by the programmes to support families during the waiting period to *keep the client engaged* and assist them with interim safety plans.

Summary

It has been suggested that interagency working arrangements involving initial decision making, assessments, and placements, need to be informed by procedures and practice guidance (Morrison, 2006). This would facilitate a co-ordinated approach to the exchange of information between agencies and help clarify individual roles and responsibilities (Calder, 2001).

In this study, external agency staff appeared to have an understanding of the formal arrangements that were in place with regard to initiating referrals and were generally satisfied with them. However, some external staff thought the referral form was

unnecessarily complicated, and there were indications that greater interagency clarity was needed with regard to the thresholds that were required for referral to the programmes. Personalised contact with programme staff was important for Maori stakeholders and findings suggested that the programmes could give greater consideration to this issue by creating opportunities for verbal exchange of information and for this to be conducted in community settings. Similarly, a need was identified in relation to giving Maori clients the option of being assessed in their cultural context away from office settings.

With regard to the assessment process, findings suggested a need for the programmes to review their use of psychometric measures with a view to developing a minimum set of measures that are standardised across sites. In relation to the feedback process following assessment, there was general consensus among referrers that the reports and recommendations provided by the programmes were relevant and credible. However, a need was identified to improve the feedback process for families by engaging in a dialogue using straightforward language, presenting information in therapeutic ways so that a positive slant is given, and taking into account cultural differences. Furthermore, the appropriateness of adopting mainstream, clinical approaches from the outset with Maori clients was queried. There were concerns that this can induce feelings of anxiety, powerlessness and self-doubt. Conceivably, these practice delivery issues could be addressed internally during training and supervision of staff.

A need was also identified for the programmes to give greater attention to collaborative involvement with other agencies at the conclusion of assessment. Findings indicated that a multidisciplinary assessment framework would assist in the development of effective working relationships among workers of all relevant agencies. It was therefore suggested that the programmes develop an interagency set of procedures for assessments to ensure collaboration with other agencies involved in the care of the young person and their involvement in subsequent treatment. Working together on a partnership document would also present opportunities to review the referral form, gain clarity about thresholds for referral and address the needs of Maori clients and stakeholders.

The difficulties and constraints associated with finding appropriate community and residential placements for young people who sexually offend are well known (Calder,

2001). All too often, there are few choices available with no guarantee that young people will be placed in an environment that meets their needs. In this study, placement and safety issues posed particular challenges for the programmes and CYF during the referral and assessment phase. In many instances, adolescents needed to live outside the home while they were being assessed and prior to being accepted for treatment. However, the shortage of options and strict acceptance criteria of some CYF funded residential facilities was highlighted as a serious impediment, particularly when there were lengthy waiting lists. While the dilemmas of placement availability are not easily resolved, findings suggested more could be done to reduce the inflexible stance of some placement facilities and to ease waiting lists. It was therefore recommended that the programmes and local CYF offices make greater efforts to develop partnerships so that tensions and difficulties around referrals and placements can be resolved. The programmes may also wish to examine strategies to reduce waiting lists and give consideration to developing a set of criteria for prioritising clients on the assessment waiting list so that high risk clients take precedence when deemed appropriate.

Perspectives on Therapeutic Approaches

Programme staff were asked to describe and give their opinions on treatment models used on the programmes. In addition, managers, all of whom had been with their agencies since the adolescent programmes' inception, were asked to describe any changes to therapeutic approaches that had occurred over the years. Programme staff and external agency staff were also asked to describe occasions when treatment had been successful and unsuccessful. They were then asked to identify what contributed to these outcomes and to comment on the extent to which this could be attributed to the programmes. Seven themes were identified which are as follows: therapeutic approaches have changed over time, integration of holistic approaches works well, involving families in treatment leads to successful outcomes, the Good Way model is effective, client-therapist relationship is of central importance, client factors influence the therapeutic alliance, and there is a need to review treatment interventions.

Therapeutic Approaches have Changed over Time

Managers reported that treatment approaches with adolescents were based on those found to be effective with adult sex offenders. In the early days, adolescent offenders

were treated as little adults and there was a focus on sex offence-specific behaviours. However, over time the programmes responded to research suggesting that programmes for ASO's need to address developmental and contextual issues (Ryan, 1997a) and other problematic behaviours. There were references to: being *more systemically aware; moving away from the shame focus; assisting kids heal from trauma; looking at the use of language … trying to present information in ways that adolescents and their families can understand;* and *adventure activities and creative ways of working with boys and families as adolescents don't always hear the talk and need to get the message in different ways*.

Managers reported that CBT was no longer the dominant therapeutic approach and that staff with specialist skills had introduced psychodynamic models, narrative approaches, creative ways of working with children and adolescents (particularly those with intellectual difficulties) and cultural components for Maori clients. They said that staff had also adapted standard therapeutic approaches, such as CBT, to suit the cultural and developmental needs of clients and make the material more accessible for adolescents by taking into account their different learning styles. One manager talked about therapy as a *continually evolving process* and about staff who worked creatively to find new ways of engaging and communicating with young people. There was reference to the development of the Good Way model (described in Chapter 3) by two clinicians at Site 2 (Ayland & West, 2006) and another manager talked about the increased focus on working systemically and holistically.

> *If systems aren't in place, the therapy won't have impact ... You can do all the therapy in the world with a kid in a room but if they haven't got a good place to live and aren't plugged into the community, in the sense of going to school, getting a job, if they've got no friends, if they've got no sense of themselves or the world, you're sort of whistling into the wind.*

Integration of Holistic Approaches Works Well

When programme staff and external agency staff were asked to identify factors that contributed to treatment success their comments suggested that the integration of holistic approaches was a key influence. There were references to the breadth and depth of the programmes and programme staff talked about the freedom they had to work creatively and use a range of treatment models.

Breadth and depth of programmes: Many programme staff and several external agency staff made reference to the broad scope of the programmes in their assessment, treatment and management of offenders. Their comments suggested they viewed this as a key component of successful treatment.

> *One of the strengths of the programme is its depth. It deals with the wider issues, not just sexual abuse. It's a totally different way of looking at life, bringing kids around to think empathetically about themselves, others and their families (caregiver).*
>
> *The programme is successful because there is really good assessment and a well targeted comprehensive plan involving the adolescent sexual offenders, caregivers and other agencies (manager).*
>
> *The primary focus is of course to stop them reoffending but it's also that they can function as whole human beings and have a life (CYF social worker).*
>
> *There have been no renotifications. I've noticed changes in their behaviour. They stand tall, can talk to you and they always have something good to say. Their self-esteem and demeanour improves. When I meet them they want to tell me what they've achieved. They feel safe in themselves (CYF practice manager).*

One CYF social worker described the programme *as highly structured, client-focused, it takes into account families, client needs, education.* Another external agency staff member talked about how the programme had worked for a Maori client, focusing on all aspects of his life.

> *He had support from a male Maori teacher, his mother, the RTLB (resource teacher of learning and behaviour) at school and he's living in a family where relationships are being built and he has a caring stepfather who's set rules and boundaries. There's a good relationship at (the programme), supportive yet challenging. He has a good safety plan and is thinking about things before acting. He has an extended support network.*

Many programme staff and some external agency staff nominated programme content as influencing treatment success. Programme material was described as: *thorough and comprehensive and based on research-based models and practices; hard; challenging and stimulating; engaging;* and having a logical structure that was easily understood by clients. Particular treatment components were also thought to be particularly influential, particularly the work on empathy, taking responsibility for actions and safety plans: *the programme is very good at providing the young person with boundaries and limitations and reinforcing them when the young person oversteps them (Maori residential worker).* The *length and intensity of treatment* and having a range of modalities

(individual, group and family) were also considered by a few to contribute to positive outcomes.

The freedom to work creatively using a mix of models: Staff had preferences for certain models depending on their training, their experience of what worked best and the particular attributes of the client. Many valued the freedom they had to work with a variety of models and adapt models to meet the needs of individual clients: *as a therapist I can be creative – in therapy, working out what needs to be done. Working with adolescents in a new area. There's no laid-down formula.* They thought their agencies gave them the latitude to work creatively and *eclectically*. *The treatment models are pretty dynamic, constantly evolving. There's a balanced, eclectic mix.* Several staff gave examples of different models they used to reach clients: *I use a lot of transactional analysis and motivational interviewing. I use elements of both of these. I have choices in the models I use;* and *with narrative therapy we apply it to retelling the life story from the youth's perspective – then present it to the family using different modalities e.g., using masks and props.* Some Maori staff members said that working with different therapists was helpful as it exposed them to different approaches.

Involving Families in Treatment Leads to Successful Outcomes

As one staff member commented, family can represent *the strongest relationships in a person's life* and when family were involved in treatment, it enhanced successful treatment outcomes. *When parents back up their kids, they make it through to the end (CYF social worker).* When staff talked about the importance of involving families in treatment, they made reference to the broad impact of family involvement, the ability of staff to engage families, and the negative impact of disengaged families.

Broad impact of family involvement: Family engagement in treatment was viewed as providing *a sense of belonging to people*, and *a sense that they will be there for (their child) beyond treatment.* Similarly, family support was described as providing young people with *someone external to back them up* and opportunities to practice what was being taught on the programme. This was mentioned many times by programme staff in relation to conflict management, safety plans, open communication and social skills.

For some families, involvement in treatment provided opportunities for parents to work on their own issues. Several external agency staff made references to *dysfunctional*

families who had worked on repairing relationships and parents who had achieved significant personal growth.

> *I see the whole change in the family, in the whanau. I can see the aroha of the young person – there's so much healing for the whole family.*
>
> *The boy is achieving his goals. His mother enjoyed the parent group so much she said, "I can help others". It made her feel worthwhile. It was almost a social outing for her. She looked forward to participating.*

Ability of staff to engage families: Many external agency staff described occasions when programme staff had worked hard to engage family members. If parents were not able or willing to participate, then extended family members (such as grandparents, uncles, aunts or step-parents) were encouraged to attend. Despite references to the significant barriers to participation in treatment for many families, the persistence of staff to involve these families was recognised by several external agency staff.

> *It took some time for his family to come on board - the way the staff worked hard to make this happen and formed relationships - that made a real difference. This was in stark contrast to his attachment deficit disorder.*

Negative impact of disengaged families: Lack of family involvement was viewed by many participants as a strong indicator that a client would not successfully complete the programme. When programme staff were asked to recall cases where clients had not done well, the majority had had erratic, or nonexistent input from family members. Sometimes parental shame and guilt, and perceptions of blame prevented participation. In one case, a parent was not willing to become involved because she could not accept that her son had abused other siblings. While some participants reported that geographical distance from the programmes could be a restraint to participation, many commented that the majority of parents who did not become involved in their child's treatment appeared to be overwhelmed by their own problems. Families that did not engage were typically described as *chaotic*, *unsupportive*, *negative,* and having high levels of conflict and stress *(the family were divided, in battle basically).* However, even when families did attend treatment, it did not always work: *the family were hugely obstructive and there were lots of victims within the family – they withheld critical information.* The following comments from external agency staff illustrate the impact on young people when their families do not get involved in their treatment:

> *If no family turn up, the child can't be bothered - no one cares.*

He walked into the (residential) home sad and resentful and walked out sad and resentful. He's had no contact with his family. There's no integration.

The Good Way Model is Effective

Many staff at one site commented on the apparent effectiveness of the Good Way model with young people with intellectual difficulties, children and young adolescents. It had been observed that *children got bored with workbooks which are CBT focused* whereas the Good Way concepts appealed to and were readily grasped by young people as it drew on their language and concepts.

The Good Way model works well. Kids can understand it and it places us on their side. We can use their own metaphors - it's a lot more engaging - we have computers - they love it - making stories, using clip art.

I'm excited by the Good Way model. I can see kids buying into it. A boy did a picture of himself showing his good side and bad side - it illustrated it clearly. This sort of thing happens all the time.

A few external agency staff also reported that adolescents and their families understood and related to the model's concepts. One social worker commented: *he knows his Good Way, understands the right and wrong way*. Another reported: *he loved the Good Way model. The family did as well.*

Client-Therapist Relationship is of Central Importance

In the previous chapter, the client-therapist relationship was identified by clients and their families as a critical component of engagement in treatment. Many staff from the programmes and external agencies shared the same view. Some programme staff members referred to the client-therapist relationship as the *dominant therapeutic approach* in their agencies. One commented:

As I see it, a therapeutic model accounts for 15% of change, same as placebo. The client-therapist relationship is more important. It's my connection with the kids that makes a difference. I use models as a way of relating to the client, not the other way round.

When programme staff and external agency staff talked about the importance of the client-therapist relationship there were references to therapist characteristics that enhance engagement, skilled programme staff, and the negative impact of changes in therapist.

Therapist characteristics that enhance engagement: Most staff gave considerable emphasis to the importance of building trust, *attachment, engagement, connection* and *rapport:*

> *For guys to make significant change they have to form attachments with the people who work with them … If they trust you and have a sense that you're not going to walk out and leave them, then I think it's hugely successful.*
>
> *A factor that contributes to positive outcomes is having a therapist they connect with who likes them, and this is communicated to them. Boys don't connect if therapists don't hear kids, make judgements, interrupt, aren't respectful and rush through things.*
>
> *You're not going to get the programme stuff unless you can connect. We're working on two levels – the programme goals and the distressed person.*
>
> *The boy was 14 at the time. The manager was his worker. We had a hui for the boy and the Maori victim was there - it was like a tangi experience with the victim - it was amazing to be there. The manager worked with him and consulted a Kuia - they worked with the whole whanau. There was a building up of trust between the manager and the boy.*

In addition, there were frequent references to the importance of therapists being able to inspire trust in the early stages of therapy. This provided clients *with a safe place to express their feelings and their offending, their history of abuse and being abused.* A few programme staff also recognised the importance of keeping clients informed from the outset about what was expected of them on the programme: *it provides a sense of some control and predictability in his life.*

Managers described some of the attributes they thought therapists should have in order to form good therapeutic relationships. One commented:

> *The therapeutic relationship between the primary clinician and the boy cannot be understated - it has an impact on healing. These kids need to know we care about them, their futures and their safety. If that doesn't come through it won't work. That message is conveyed top down - from saying hullo to the boys in the waiting room … the human interface, respectful interaction - a genuine sense of caring.*

Others referred to the importance of persistence, and supporting and challenging clients whilst motivating them to make positive changes.

> *The ability to hold a child through a crisis, a therapist who stays with them when they want to give up and motivate them, is caring but can also confront …*

> *a therapist who is able to "walk the tightrope", is warm but challenging about issues. The key skill is holding people through change.*

Skilled programme staff: Most external agency staff thought very highly of programme staff: *they know their stuff – they can put it across;* and *staff are passionate and committed – they're good people dedicated to their cause*. They talked about their expertise, professionalism, experience and frequently used superlatives to describe them: *special people, high quality person, marvellous*, and *really incredible*. Some talked about the extra steps therapists took to engage clients, relate to them on a personal level and make them feel comfortable. There was reference to a situation where a lovely relationship had developed between the therapist and her client. The adolescent had been made to feel so comfortable, he sought help from the therapist in the early stages of a relationship with a girl.

Several staff members described the informal efforts they made to develop good therapeutic relationships:

> *It's about getting to know what their interests are, getting to know them, forging a therapeutic alliance. It might involve doing other things together, establishing a relationship - walking down to the car yard if a boy likes cars, looking at motorbikes, playing video games. It helps establish a rapport – you talk about low key stuff to get them onside.*

Negative impact of changes in therapist: A few staff talked about the negative impact of changes in therapist. One commented that if clients experienced several changes of therapist, *this can reduce the programme's effectiveness – it compromises the development of trust and the relationship – the therapist leaves them like everyone else has – it's a loss.* Another thought that any change of key worker, therapist or social worker, could *upset the continuity of standards that the client becomes familiar with* and have a detrimental effect on treatment outcome. At one site, where there had been high levels of staff turnover, the manager was aware of the need to work hard to address the situation because of the disruptive influence it had on treatment.

Client Factors Influence the Therapeutic Alliance

Many programme staff referred to client factors that could influence the development of a therapeutic alliance and positive outcomes. They talked about resilient qualities, difficult behaviours and apparent intractability, and clients with unresolved trauma issues.

Resilient qualities: Although the personal characteristics of clients that were identified as contributing most to positive outcomes were varied, motivation to change and the ability to form attachments were mentioned most frequently: *motivation came from within; he had an ability to create relationships that matter;* and *he had the ability to attach with his individual worker and staff at (the programme).* Other characteristics noted were *inner resilience, good self-esteem,* intelligence, having an easy temperament, and having a sense of personal responsibility that facilitated insight.

Difficult behaviours and apparent intractability: Many staff identified client factors that could prevent an adolescent from doing well on the programme. For example, *the boy was in aggressive denial. He was surly and belligerent in the group. He was doing things on his own terms.* Other examples included: lack of motivation to change, comorbidity, impaired cognitive ability, drug and alcohol problems, attitudinal and behavioural problems, and to a lesser extent, aspects of their physical appearance and demeanour: *there was a lack of insight - passivity was his toxin; dishonest; very angry; unfixable aspects – he was dangerous, top end;* and *everyone found him difficult – he was physically unattractive, whiny, overweight, moany.*

There were also reports of adolescents who seemed unable to develop a sense of personal responsibility.

> *He has a volatile nature, ingrained cognitive distortions around responsibility taking. He blames others and is scared of taking responsibility - that's particularly strong.*
>
> *He didn't see that what he'd done was wrong - voyeurism, the theft of clothing etc. He was minimising his involvement in the offending.*

Unresolved trauma issues: Some adolescents were viewed as *too damaged* from their experiences of loss, trauma and attachment disruption. In these cases, staff said they found it difficult to establish a workable therapeutic alliance (*inability to make connections).* Several programme staff commented that adolescents who were victims of sexual abuse sometimes struggled to make progress on the programme: *some of the boys are victims of sexual abuse. We don't work with this. It can be used to excuse offending – there's unfinished business – there's anger and grief that gets in the way.* They thought the programme had failed these adolescents because it had not addressed their sexual victimisation issues satisfactorily.

There is a Need to Review Treatment Interventions

Despite many references to treatment approaches that worked well on the programmes, programme staff and external agency staff also identified areas for improvement; specifically, a need to expand family work, inclusion of a positive sexuality curriculum, greater inclusion of experiential and expressive interventions, a need to review group interventions, and a need to develop Maori models of practice and culturally appropriate services for Pacific Islands clients.

Need to expand family work: While all programme staff talked about the role of family therapy in influencing successful outcomes, several programme staff and a few external agency staff considered that more emphasis should be given to family work on the programmes.

> *I'd like to see more family work - a greater consideration of the family context. Historically there's been an emphasis on individuals – repairing of trauma and attachment is facilitated through familial-like relationships (programme staff member).*

> *We could reduce dropout rates by working harder and better with the wider family – meeting the needs of siblings and victims (programme staff member).*

Several staff were also of the opinion that more could be done to build functional family relationships by providing more education for families and opportunities for them to network with each other.

> *It would be good to have broader family connections, networking for families. Education group is the only time parents or caregivers can get together with one another and know that they're not alone. It would be good to have sexual health education about sexual behaviour – to normalise what is healthy and good. There needs to be more focus on family education so we support the family to support the boy (programme staff member).*

Need to include positive sexuality curriculum: Several programme staff thought that the treatment focus could be broadened to include more of an emphasis *on positive sexuality and developing positive relationships.* A social worker from a residential home also talked about the need for such input: *he needs to know how to have relationships – he's got girlfriends but is all over them – too needy – cuddles them all the time – smothers them – pushes them away. Another programme should be put in place to teach them how to have relationships.*

Greater inclusion of experiential and expressive approaches: Several staff also thought there should be more use of play, music, art and adventure activities with all clients, irrespective of age. As one staff member commented: *these creative approaches access a different part of clients - it plays to their strengths - play facilitates a different way of seeing things. It helps clients catch up and play things out*. Another suggested: *we could see boys in different settings, for example, at the beach, in the bush - it is more interactive, outdoorsy.*

Need to review group interventions: Several programme staff identified similar benefits and concerns regarding the group process as adolescents, parents and caregivers (outlined in the previous chapter). Moreover, some staff were uneasy about the age differential between some group members and at one site there was concern that a young female offender (also a victim of sexual abuse) had attended the same education group as male sexual offenders.

Need to develop Maori models of practice: All Maori programme staff and external agency staff highlighted the need to develop and implement culturally appropriate treatment models and ways of working with Maori. Current treatment models were considered *inadequate*, *ineffective, too western*, or *too clinical.*. *We need to improve cultural sensitivity, protocol … approach the heart stuff … a way of being that affirms Maori.* A few Maori external agency staff thought that some Maori clients were not responding to the *clinical models* used in therapy. One programme was described as *a clinical organisation not a cultural organisation - that's the feedback we've had.* At another site, a manager from a specialist home asked rhetorically: *how well does their model of therapy link with cultural models? Do they employ a cultural model?* Comments from a few Maori CYF social workers suggested that the programmes needed to make further provisions for cultural input when working with Maori clients.

> *When we have a review meeting with Pakeha therapists, there's no Kaumatua to open up with a karakia. A lot of Maori agencies have a Maori component. We at CYF do. I felt uncomfortable when there was no Kaumatua and no karakia at (the programme) – it sets the scene and this was missing. They need more Maori therapists to work with the tamariki.*
>
> *I'm not sure whether Maori staff are directly involved or whether they are just latched on. Cultural input would benefit the client. Having a Maori counsellor, a Kaumatua and more cultural people involved would be of huge benefit to Maori.*

Although Maori staff at all sites said they included cultural components into therapy, many thought more could be done to ensure that programme material was presented in culturally appropriate ways. Examples included: *the cycle of offending could be conveyed visually rather than in letters of responsibility*; and *if boys want to do the cycle of offending in rap form, using waiata or haka - maybe that would provide a better avenue for expression*. However, there was comment that many young Maori people have limited association with Maori society and do not necessarily relate to Maori ways of doing things (exclusively). Therefore partnership and collaboration was required so that Western models and Maori models of practice could be combined to *provide complete coverage.*

Need to develop culturally appropriate services for Pacific Islands clients: Staff at all sites reported that the programmes had not provided services that attended to the cultural context for Pacific Islands clients. Several staff and external agency staff identified this as an area of need.

Summary

All sites reported changing their therapeutic approaches over time in response to international research and influences of clinicians with specialist skills. In recognition of the need to adopt holistic approaches to the assessment, management and treatment of adolescents who sexually offend (Longo, 2002; Morrison, 2006; O'Callaghan, 2002), the programmes worked systemically and holistically. They incorporated interventions aimed at promoting competence, coping skills, esteem, self-management and positive life goals; working with families and carers; facilitating collaboration between agencies; and assisting young people to engage in their community. Moreover, the client-therapist relationship was viewed as the foundation of good treatment. Although the programmes had responded to research that demonstrates that for treatment to be successful there is a need to address factors relating to other forms of problematic behaviours as well as sex offence-specific behaviours (O'Callaghan, 2002), a need was identified for treatment to include a focus on positive sexuality. The programmes may therefore wish to incorporate a positive sexuality and healthy relationships curriculum into programme content.

While the treatment models and modalities used in the New Zealand programmes were similar to those used in programmes in other countries, a number of treatment approaches were given special mention. These included family involvement in treatment, the Good Way model (Ayland & West, 2006), experiential and expressive approaches, and cultural services for ethnic minorities. While findings suggested programme staff worked hard and possessed the necessary skills to engage families and individuals in treatment, a need was identified for family work to be given greater emphasis on the programmes. An important component of a holistic programme involves attending to the cultural needs of ethnic minorities (Morrison, 2006). Despite the reliance on mainstream psychological models, Maori staff incorporated cultural components into treatment. However, findings suggested that cultural services for Maori appeared to be adjunctive rather than an integral part of the programmes. A need to develop and integrate Maori models of practice in this field of treatment was identified. Moreover, given the lack of cultural input for Pacific Islands clients, it was suggested that the programmes be resourced to develop culturally appropriate services for this ethnic group.

Although programme staff and external agency staff identified family characteristics and client factors that impeded therapeutic progress and that were not easily remedied by the programmes, more could have been done to offset these difficulties. First, despite the reports from many external agency staff regarding the ability of programme staff to engage chaotic families, they were not always successful, despite their best efforts. Taking into account the finding in the previous chapter regarding the need to increase family support for some parents, the programmes may wish to review their current practice and procedures with regard to promoting the involvement and engagement of *resistant* families. Second, in some cases treatment failed to address prior childhood victimisation issues satisfactorily. Given that this treatment need is a recommended treatment target for ASO treatment programmes (refer Chapter 1), it was suggested that the programmes review their treatment goals with a view to providing treatment in this area. Finally, the programmes may wish to review their current assessment and screening processes regarding adolescents' suitability for peer group therapy interventions.

Interagency Networking and Collaboration

As outlined previously, during the course of their interviews, managers, programme staff and external agency staff were asked to comment on the referral and assessment process and identify factors that contributed to treatment success and failure. They were also asked to identify barriers to referral and treatment for different client groups (ethnic minorities, lower intellectual functioning clients, children, and adolescent girls). Issues related to interagency networking and collaboration were identified as an overarching theme in their responses to these questions. Participants' responses were therefore housed within this category. Four themes were identified from participants' responses: involving wider networks in treatment is essential, placement issues influence treatment outcomes, the programmes need to review their public relations and educative function, and the programmes' relationship with CYF is problematic.

Involving Wider Networks in Treatment is Essential

Many staff highlighted the importance of working with families, other health professionals and providers to ensure that structures and processes were in place to support the young people outside the programme. One programme staff member commented:

> *A positive outcome results from systems that work, when agencies network with one another and the school, when we find them work, find out what their interests are. It's important to have high self-esteem, a useful occupation, then their sexual abuse behaviour won't be so central.*

When participants talked about the importance of involving wider networks in treatment they referred to the programmes' systemic focus as a key strength, involving schools in treatment, benefits of work experience, and poor outcomes associated with systemic failure.

Programmes' systemic focus viewed as a key strength: Many programme staff and external agency staff talked about clients who engaged and participated in treatment when the programmes networked efficiently with family, caregivers, school and external agencies and there was collaboration in treatment and care. The ability of programme staff to promote this involvement by liaising with appropriate personnel was highlighted and identified as a programme strength by several external agency staff.

> *The good outcome had a lot to do with systemic issues - regular strengthening families meetings, getting professionals together, working together, getting family on board - it was collaborative.*
>
> *Intersector co-ordination was pivotal given the extent of his dysfunctional family.*
>
> *What contributed to a positive outcome was good systemic relationships… working holistically…a good application of the multisystemic model.*

One programme staff member attributed an adolescent's positive outcome to liaising with Housing New Zealand to get his family a house which *lifted the family's esteem* and networking with the school regarding his behaviour. The frequent references by external agency staff to *getting everyone on board, working in partnership, it's systemic, we complement each other* and *it was collaborative,* suggested that on many occasions, the programmes were successful at working with other agencies and involving key personnel.

Involving schools in treatment: Several programme staff and external agency staff described the way in which the programmes collaborated with schools in the adolescents' best interests: *we involved the school in his safety plans. He came to understand (what he'd learnt) by going to school, integrating with other kids*. There was comment from a resource teacher of learning and behaviour that there was collaboration between programme staff and the school to ensure there was consistency with *one set of rules* for a boy on the programme and at school.

> *There is an absolute sharing of information between (the programme) and us (the school). It is important so we don't get confused. There is a consistency that everyone is pulling in the right direction…One boy had slight intellectual impairment – and we drew up behaviour plans to keep him safe. Without the two of us working together he wouldn't be where he is at the moment. We complement each other.*

A residential facility staff member talked about the positive effects on a boy of *"good news" meetings* at school which were attended by *important people in his life.* The only rule was to stay positive. The good news was subsequently written up and sent to him in a letter. It was described as a powerful process as it gave him the clear message that he could do something well. Similarly, one staff member described how the involvement of a school in the boy's treatment plan provided him with *affirmation of his leadership qualities,* sponsorship to go sailing on the *Spirit of Adventure* (a yacht which is used as

part of a community initiative to promote youth development), and motivation to start playing rugby league. There was reference to the programme's involvement with another school regarding a boy's treatment which had *fostered his sporting and peer relationships* and he attended school dances for the first time.

Benefits of work experience: If the adolescent was no longer at school, undertaking work experience, training or an occupation provided similar benefits and several staff talked about their role in facilitating these experiences. They described the following outcomes: taking a computer course was *a real turning point* for one client; for another boy who had *bombed out at school* and had *major anxieties about doing any written or academic work,* work experience and completing an engineering course helped him gain confidence; and for a boy with conduct disorder, getting a *physical job* amongst adult men who *took him under their wing* worked well.

Poor outcomes associated with systemic failure: When interviewees attributed poor outcome to systemic failure, they usually described situations where agencies had not worked together effectively.

> *The case was poorly organised. RIDCA (Regional Intellectual Disability Co-ordination Agency), Richmond Fellowship and CYF didn't work together. There was no mental health system in place, there was a mixing up of roles, there were lots of meetings, nothing was being done, residential issues weren't dealt with. The caregivers were unqualified.*

There were references to *inadequate sharing of information*, funding uncertainties, *poor interagency collaboration,* and the *young person not being plugged into the community*. One staff member commented that clients could have negative outcomes if *external supports were not in place, if there is no family in place. If the system is leaking, kids don't get to stop the behaviour so you can work with them. They're still reactive, it's not possible to connect with them.* Another commented that staff were *wasting (their) time if there was no networking with other agencies*.

Placement Issues Influence Treatment Outcomes

All programme staff and external agency staff talked about the influence of placement issues on treatment outcome. While stable living arrangements were viewed as essential, many participants referred to the existence of placement problems and the

impact of this on treatment. As noted in Chapter 3, CYF were responsible for managing the placement of the young person if he or she was unable to remain at home.

Necessity for stable living arrangements: The importance of adolescents having stable living arrangements whilst on the programmes was prioritised by all staff: *they need secure appropriate placements. We can't hold them in treatment and provide positive outcomes (without them).* Irrespective of whether the placement was with family members, a caregiver or a residential facility, the provision of a *structured environment, safe containment* and *good supervision* was viewed as essential. Several staff members commented on the advantages associated with stable living arrangements at one particular residential facility: *Barnardos are consistent, professional, receptive. I can work with them, they've got structures and processes in place and offer good supervision;* and *the Barnardos home created a laboratory experience for him so it was possible to monitor his behaviour and reinforce positive changes.*

Placement problems: There were many descriptions of unsatisfactory arrangements. Examples included: *his living arrangements were inadequate, inconsistent, undermining*; and *the caregiver was naïve, unrealistic, covertly critical of (the programme), undermined treatment approaches and was dismissive of the programme*. There was comment that at one residential facility *there was not enough physical comfort - hugs and cuddles* and that *there was no Mum or Dad figure as all the staff were shift workers*. It was felt *there was too much expected of the boys - there was little leeway for the kids to be kids.*

Impact of unstable living arrangements: Inappropriate placements or unstable living arrangements were cited as having a detrimental influence on treatment outcome. One manager commented *boys who don't have a stable placement lack continuity and caring - it's old fashioned but it's true. Some boys go to prison because of lack of placements.* Another commented that placements with poor boundaries could have an impact on outcome as programme goals could not be reinforced. Maori staff also talked about the problems clients encountered when they were separated or alienated from whanau and experienced discontinuity in their care.

> *Without whanau support it can be too hard to put into practice what they're learning (on the programme). There can be isolation from the whanau here at*

(the programme). They may have lived in a number of different homes and had no stable home environments.

The Programmes Need to Review their Public Relations and Educative Function

In the course of their work, staff and managers liaised with referrers and potential referrers, law enforcement agencies, organisations that offered health and social services, residential facilities and caregivers, community groups and schools. Many programme staff and external agency staff talked about a need for the programmes to network further with external agencies and community groups. Insufficient networking was cited as affecting client access to specialised services and limiting external agency staff access to education and training about sexual abuse.

Inadequate networking limits access to specialised services: Managers and staff at all sites talked about the need to network for more referrals in order to improve access to treatment for ethnic minorities, youth with intellectual difficulties, children, and adolescent females. Comments included: *there's no networking with the Pacific Islands community and they don't come forward for treatment; we need to network more for referrals with primary and intermediate schools and agencies that work with younger children as we move into work with children; we need to alert people to the fact that this agency exists to cater for adolescent female sexual abusers;* and *we need to go out and advertise our service – make it more explicit that we have Maori workers.*

Some external agency staff were unaware of the specialised services provided by the programmes. For example, several experienced CYF staff reported being unaware that the programmes offered specialised treatment for children and a few said they were unaware that the programmes treated females.

> *I understand (the programme) doesn't accept females. It's a male programme. We wouldn't refer females to (the programme) but to individual counsellors. I can only recall possibly one or two females – if I can recall correctly they went to individual counselling.*

One external agency staff member was unsure whether there was a special part of the programme that deals with Maori specifically. Another reported that she had *not received much information from (the programme) … they don't advertise it, who they are, what they do and who their client base is.*

Need to provide education and training about sexual abuse: Many external agency staff said they wanted to know more about programme content, differentiating normal sexual behaviours from sexually harmful behaviours, and to receive more sexual offender-specific training from the programmes. Their comments suggested that this would enable them to be more effective in their roles, and refer more clients if they were provided with this information.

> *It would be helpful if we had a deeper knowledge of the programme. We need training specifically to do with sexual offending. It would help us to do our job better.*
>
> *I would like more training, more resources, reading materials. I need to know about patterns of behaviour. We've been told there are patterns of psychopathic behaviour. How do we deal with this? What does it mean? I would also like more information about therapeutic models.*
>
> *It would have been helpful to have received more information about what is normal sexual behaviour and what is sexual abuse and offending. It would also be useful for parents to know what's normal and what isn't. We can then talk about this with parents as we are usually the first ones to give them information about (the programme).*
>
> *They need to promote their work in the community and especially in schools. They need to do education around date rape – we are getting referrals for this. People don't know it's an offence.*

Several programme staff also talked about the benefits of providing education and training to CYF social workers: *there are differing knowledge levels - things could be improved if social workers were regularly upskilled in the area of sexual abuse and sexually inappropriate behaviour.* Although their comments suggested that this occurred to some extent at all sites, a need was identified for it to carried out regularly given the high staff turnover rates at CYF.

The Programmes' Relationship with CYF is Problematic

Most programme staff and many external agency staff (mainly CYF employees) talked about the need to improve relationships between the programmes and local CYF offices. There were references from programme staff to inexperienced and disengaged CYF social workers, widespread placement problems, and lack of referrals at one site were cited as creating tensions between staff from that programme and CYF. A need for interagency clarity and protocols was identified.

CYF social workers seen as inexperienced and disengaged: Many programme staff members referred to the lack of experienced and engaged social workers at CYF. There were descriptions of inadequately trained personnel who were *complacent* and inattentive.

> *One of the most stressful parts of the job is dealing with CYF and their inadequate personnel and services. The personnel aren't up to it. They don't understand the complexities of what we're trying to do … they're talking Swahili, we're talking English.*
>
> *Some are great but some are useless. It's so variable. Things could be improved if social workers were upskilled in the area of sexual abuse and sexually inappropriate behaviour and also if they provided information and acted early. They often send nothing, it's hearsay or a report that's 3-years-old.*
>
> *The high staff turnover at CYF is a problem. Clients have 3 or 4 changes of social worker – that leads to unhelpful even dangerous practice. It can be fraught. You take pot luck whether someone is experienced or not.*

Several programme staff attributed their clients' poor outcomes to inadequate CYF social worker support: *they were considered a too-hard-basket family, why should (the social worker) bother?*; and *there was lack of support from the social worker who's based in Hamilton. He's 16 and about to leave CYF care*.

Tensions created by placement problems: Many programme staff and CYF staff talked about the tensions that arose when there were difficulties associated with securing and monitoring safe placements. Examples from programme staff included:

> *CYF placed a client in a home with someone who abused him.*
>
> *There was a young boy who had sexually abused his sister. He needed to be out of home and be kept out of the whole area. Our recommendation was 24 hour supervision but CYF wouldn't co-operate as it involved money.*
>
> *CYF stuffed up majorly – at one stage they removed the victim from the house so that the offender could remain with his family.*
>
> *I've got no confidence in CYF caregivers – there's no monitoring. CYF investigate but nothing happens – their threshold is far higher than it should be. It's frustrating and sad.*

Several CYF social workers also talked about the difficulties they experienced trying to place some clients. One referred to an *impasse* between (the programme) and her agency over a placement. CYF had trouble placing a client because *alternatives weren't*

there, and (the programme) had their *professional boundaries*. The agencies could not reach agreement despite *numerous meeting*s. A few CYF social workers made reference to the programmes' strict recommendations that were in some cases impossible to meet. One commented: *therapists' perception of risk can be exaggerated a bit … their expectations of what we can do can be heightened.* Another talked about a boy who had been accepted on to the programme but was *kicked out* when his caregivers had relatives come to stay, *some as young as 12.*

> *(The programme) considered it too risky and withdrew him from the programme. We thought it was on the nose – we considered it low risk. They have a fixed policy - no young children in the house - there's no flexibility.*

Another social worker also talked about (the programme's) insistence that boys be removed from their homes when he did not think it was warranted: *that's a blanket requirement despite the personal circumstances of the client.*

A few CYF social workers talked about the difficulty Maori families face when the programmes stipulate that if clients remain at home, there can be no other children in the house. Given the cultural emphasis on whanau and whanau gatherings, this posed a real problem for some Maori.

> *Even if the families have gatherings the adolescents who are on the programme are not allowed to be left alone for one second. This is especially difficult for Maori. It puts unnecessary pressure on caregivers.*

Tensions created by lack of referrals at one site: Lack of referrals from CYF was a major problem for one site: *we only had two referrals from CYF last year from the whole of (this) region. It was actually awful.* The majority of staff at this site attributed this to cuts in funding at CYF, a poor relationship with CYF and having to reroute referrals from other sources to CYF for funding which was *problematic* and *took time*. However, comments from a few CYF managers suggested a different perspective: some potential referrers were unaware of the programme's existence and services as they did not promote themselves, and referrals were not being received by CYF from the Police or other sources *(we're not covering stuff up).* Although interviewees who talked about this issue all referred to the tension that existed between the programme and CYF, they expressed a willingness to work towards reestablishing a workable relationship. It was reported by a CYF manager that a CYF liaison person had just been appointed to take on the role of building a relationship between the programme and the CYF offices in the

region. At the time of writing this dissertation, the programme manager reported that communication had improved and that referral numbers had increased.

Need for interagency clarity and protocols: Most programme staff and CYF staff thought that formalised arrangements needed to be set in place to ensure they worked more effectively across their agency boundaries. While there were several references to *communication breakdowns* and *a need to have standardised protocols in place,* there were many references to the need for a better understanding about respective roles and agency expectations.

> *There needs to be a better understanding between CYF and (the programme). We, CYF are brokers and have a defined and mandated role.(The programme) needs to understand this so they know what our roles are – sometimes they have unrealistic expectations about what we can do. Sometimes we get embroiled in crossfire – they put in a recommendation that isn't practical or feasible (CYF social worker).*
>
> *There needs to be more clarity about statutory responsibilities. There are certain things we can't do – we shouldn't do – care and protection issues. We work hard for clients and community safety. Sometimes we're demanding of CYF but we're demanding for a good reason (programme staff member).*
>
> *Who is managing the case? (The programme) don't want CYF social workers to be case managers. The (programme psychologist) effectively becomes the case manager. The roles need clarifying. Social workers kind of relinquish their case management role to (the programme). I've had some difficulty with this – I had the feeling I was stepping on their toes. They think if they don't drive the case no-one else will – when perhaps the social worker feels it is his or her role (CYF social worker).*

One external agency staff member (not a CYF employee) also commented on the unsatisfactory relationship between CYF and one programme site and the need for a co-ordinated approach to set up aligned systems.

> *I'd like to see them link up with CYF in a better fashion – they don't use each other to best advantage. We should get everyone together. There needs to be a system where reporting, liaising and sharing information is standardised and what to do in certain circumstances and to clarify roles. We need to establish email systems, have a paper trail, forms and categories – procedures should be formalised – it should be a national process.*

Staff at all sites and most CYF staff talked about wanting closer working relationships (*I would like them to be involved, to be a part of the process)* and several suggested it might help if someone was appointed to liaise between the two organisations.

Summary

Treatment programmes need to develop strong networking relationships with agencies such as social services, police, education, health, and youth justice, to be effective (Morrison, 2006). In this study, the importance of involving the adolescent's wider network in treatment and having stable, suitable placements was emphasised. Findings suggested that programme staff prioritised this area of work and were adept at liaising with personnel from other agencies regarding the adolescents' treatment and care. However, poor placements jeopardised treatment and there were occasions when treatment was unsuccessful as agencies did not work together effectively due to inadequate strategic and operational collaboration. Given the suggestion that practitioners need clear mandates, frameworks and structures to work effectively with other agencies (Morrison, 2006), the programmes may consider reviewing their policy and practice in this area to ensure clarity about roles and responsibilities.

A clear need was identified for the programmes to extend their networking focus beyond the treatment needs of young people, particularly in the area of public relations and education. Calder (2001) points out the importance of enhancing public awareness and knowledge about sexual abuse and the need for a shared understanding between agencies on what constitutes sexual abuse. In this study, there were indications that the absence of public knowledge about sexual abuse coupled with lack of agency awareness about the specialised services offered by the programmes affected the uptake of these services. Furthermore, many CYF social workers identified a need for comprehensive training and education about programme content, and sexual offending, including guidelines for differentiating between normal and abusive sexual behaviour, so they could be more effective in their work. It was therefore recommended that the programmes deliver education to the public and other professionals in health and social services about sexual abuse. The purpose of such education is twofold: first, to provide better access to treatment for ethnic minorities, youth with intellectual difficulties, females and children; and second, to notify relevant people of the specialised treatment services available. Given the high levels of staff turnover in some agencies, this needs to be carried out regularly. It was also suggested that the programmes and local CYF offices develop a collaborative plan to provide regular support and 6-monthly training for social workers in the area of sexual abuse (due to the high turnover of CYF staff). Future staffing and funding levels would need to take this into account.

Given the primary relationship that existed between the programmes and CYF, it is perhaps not surprising that this received considerable coverage during discussion about external networking. Findings suggested that the relationship between CYF and the programmes was problematic to some degree at all sites. Comments from the majority of programme staff and CYF staff indicated that relationships needed to be nurtured and in some cases, differences repaired. From the perspectives of programme staff, obstacles to an effective partnership between the two agencies included the absence of professional standards and poor decision making among some CYF staff regarding placements and care and protection issues, and breakdowns in communication. From CYF staff perspectives, tensions arose when the programmes failed to appreciate their resource constraints regarding placements which was exacerbated by the programmes' prescriptive criteria; this failed to allow for consideration of individual cases.

It has been suggested that programme staff need clear co-ordinated guidance to avoid confusion about roles and responsibilities and tensions that detract from their work (Calder, 2001). In this study, the majority of programme staff and CYF staff agreed that the lack of clarity about respective roles, responsibilities and expectations needed to be rectified. Staff from both agencies indicated their willingness to work on building a relationship based on understanding and trust. To facilitate this outcome, it was suggested that procedures be set in place to resolve the tensions that exist between CYF and the programmes. This could be achieved through regular interagency meetings, the appointment of liaison personnel and/or the secondment of a CYF social worker on to each programme.

Organisational Support for Staff

This category was primarily derived from questions asked of managers and programme staff about their training and supervision arrangements and level of organisational support. They were asked to comment on the adequacy of the arrangements and to make suggestions for improvement. Three themes were identified from participants' responses: having a strong organisational environment is essential, attention to staff wellbeing is necessary, staff training arrangements, and staff supervision arrangements.

Having a Strong Organisational Environment is Essential

Managers and several staff reported that having a well managed organisational environment in which to run the programmes was essential. Their comments suggested that the programmes were endeavouring to provide strong operational frameworks. There were references to strong supportive leadership, *autonomous culture*, *committed and skilled staff*, *effective training and supervision practices,* attention to staff wellbeing, having a positive organisational culture, *evidence-based practices*, and support for staff to be innovative and creative. While some of these areas have already been covered, most are examined below.

Attention to Staff Wellbeing is Necessary

Staff at all three sites reported that although working with adolescent offenders and their families could be rewarding, the nature of the work could also be *toxic* and personally demanding: *I don't like hearing victims' stories. Sometimes I go home and feel sick in my stomach.* Managers' comments suggested they were aware of the need to put systems in place to maintain staff wellbeing so that they could perform effectively at work and in other settings.

> *We have a good culture which says the care of the clients is only as good as the care of staff and of each other.*
>
> *We are a caring organisation. Staff take an interest in each other's life. We're watchful of staff and listen to what they're saying – there's a lot of debriefing. We have an open door policy. The key is knowing what's happening with staff.*

When staff talked about the attention paid to staff wellbeing and support within their agencies, they described high levels of support from colleagues and management, and the freedom to be autonomous. However, many staff also talked about the pressure to overwork and Maori staff reported feeling burdened at times by the additional roles they fulfilled compared to other staff.

High levels of support from colleagues and management: Staff were seen by managers as a great asset: *they're an amazing bunch of people who inspire me with their enthusiasm, passion, energy and humour.* Staff at all sites valued their agencies' commitment to their care and wellbeing and described policies and structures that management had in place to support them. These included effective supervision

practices, *flexibility around work hours*, the *monitoring of caseloads*, *debriefings* after sessions, *check-ins* during team meetings where personal issues could be discussed, setting time aside for staff to socialise off-site, emphasis on team and relationship building, generous leave provisions, and strong peer support networks. Some staff mentioned small gestures that made them feel appreciated such as including partners in social gatherings and giving gifts at Christmas. Many spoke of managers and senior staff having an *open door policy* that encouraged openness and discussion around the impact of the work and personal issues: *(the programme) is the most sensitive employer I've ever worked for in being aware of issues*.

> *The manager's door is always open. When I've been stressed or distressed there are avenues. The staff are supportive. If family issues come up, they come first and foremost.*
>
> *The awareness of the need for self-care is one of the huge strengths of being part of this team. There's a team culture - it's the little things - like who shares offices.*

Maori staff members at all sites reported feeling supported and valued by managers and colleagues. This included being respected for their cultural beliefs and practices.

> *I feel supported in health and wellbeing. There's a real partnership in the way we work together. Whanau are well looked after when they come here and we practice karakia etc. in our meetings.*
>
> *I am well supported by Maori and non-Maori staff. There's an openness to cultural things in our agency. I wouldn't be here if I wasn't supported.*

There were references to feeling *culturally safe,* being supported to attend hui, receiving money for kai (*when there's a powhiri there are no restraints put on me – I don't feel there's any animosity from management)*, feeling supported by management and colleagues during difficult times, and having access to cultural resources when required.

Freedom to be autonomous: Managers talked about the size of the organisations being conducive to team cohesion and the autonomy they had to determine policy direction and organisational culture. The fact that *teams were small and close-knit* allowed for the creation of *a caring organisation*.

> *I like the freedom we have to decide direction and how we work - to create our own policies and our own culture. I do not like being part of a big organisation where roles are tightly defined and constructed.*

The freedom to be autonomous was also reflected in the way that several staff talked about their appointment as therapists. Their comments suggested they were valued as much for their life experiences as their qualifications.

> *My personal experience and qualifications were embraced really well in clinical situations and overall conversation. They were taken on board by the staff over and above textbook and theory.*

> *I was hired without any formal qualifications. I'm valued for what I've done and references from others. My previous life experience was taken into account and is used in the agency.*

Staff also liked having the freedom and being trusted to manage their own time and caseloads.

> *As long as I'm doing my work, I can do it in a way that works for me as well which is a real strength of the agency.*

> *We're allowed the flexibility to manage our time, to set appointments. It's placed in our hands in consultation with the clinical team leader. We've got the autonomy to manage our clients and workload.*

The pressure to overwork: While most staff considered that *self-care (was) one of the huge strengths of being part of the team,* many staff at two sites referred to an *unspoken work ethic* that could be detrimental to staff and their families. They talked about the pressure on them to work *long and hard* to meet the *high expectations* that their agencies placed on them. Some thought it was *hard to change a culture that had been embedded for years* and was *modelled top down.* One staff member described a *very strong drive in the agency* to work long hours which was *an invisible part of the culture.* Other comments included:

> *The busy-ness thing makes you think you don't want to be here - you could have an easier life elsewhere.*

> *A red flag should go up if people are working at home when sick, or coming in at the weekends. We also need to be aware of stressed out staff.*

> *I feel at times that the expectation of hard work is expected and pushed. There's a drive to do ever better and ever more, ever more thoroughly.*

There were references to staff working over and above their allocated hours on a regular basis, feeling responsible for preventing further offending which led them to work longer hours, and not applying for time off in lieu as any accumulation of hours was

actively discouraged by management. While most staff said that the issue of overwork was being addressed *(it is talked about … structures have been put in place)* some staff thought that the *root cause of the culture around the busy-ness of overwork* was not being addressed satisfactorily.

Maori staff burdened by the additional roles they fulfilled compared to other staff: Maori staff at all sites reported feeling overburdened at times by their numerous roles and commitments, even though there was good rapport and an *open door policy* with managers. For example, at one site there was reference to a manager who had invited Maori staff to set up a separate Maori team. However, their capacity to do so was limited by the time taken to fulfil their broader roles: combining clinical work with cultural practices, acting as cultural consultants within their agencies, supporting families, liaising and maintaining links with community groups, and forging links with other health and social services. There was comment that the intensity of services required for working with Maori families was *very demanding of* resources and that this was not always recognised by the agencies.

Managers' comments indicated that none of the programmes had Maori workforce development plans in place and a few Maori staff reported that this *was left to (them).* One Maori staff member pointed out that Pakeha staff did not have to work out their own workforce development issues as the manager fulfilled this role for them.

> *There are a lot of expectations of us. I cannot speak for all Maori but the expectation is that we can make things happen. We have the vision, but there's too much to make it happen, that is doing clinical work and community networking and making this place appropriate for Maori. We work over two teams – adult and adolescent sexual offenders –that other workers don't have to.*

Staff Training Arrangements

In addition to possessing the necessary professional and personal qualities, clinicians require specialist training to work with ASO's. A practitioner may join an agency with considerable experience and professional knowledge but lack sex offender-specific training. New recruits should therefore receive a comprehensive induction and orientation, and training in areas where shortfalls are identified. When talking about the ways in which their training needs were being met, the majority of staff reported that comprehensive arrangements were in place. However, some staff identified a need for

formalised induction training, focused sex offender-specific training and several Maori staff thought training aimed at upskilling Maori staff was needed.

Training is comprehensive: Managers and staff at all sites reported that the training needs of staff were being met in a variety of ways and were comprehensive. Many staff talked about the opportunities they were given to attend conferences, courses, seminars, workshops, and pursue tertiary study. Managers and staff at all sites reported they received training from experienced clinicians on staff and from external specialists. Managers said that the individual training needs of staff were identified during annual performance appraisals and where there were deficiencies, staff received either in-house or external training. Staff made reference to training in the use of psychometrics, risk assessment tools, report writing, therapeutic approaches for working with different populations, and cultural issues. Each agency offered staff an allowance for external training which was perceived by most staff as adequate and in some cases, *generous.*

Need for formalised induction training: While new staff received formalised induction training at one site, managers at the other two sites were aware of the need to provide greater structure to their existing arrangements. Several staff expressed concern and disappointment at the lack of formal induction when they started with their agencies: *it was disappointing that there was no induction programme. They assumed that I knew so much. I learnt by doing. I was chucked in at the deep end and had to fend for myself;* and *people assumed I knew more than I did because of my background.*

Need for more focused sex offender-specific training: Several staff at two sites reported that they would have liked more focused sex offender-specific training: *there's no specific training related to sex abuse. There's a need for sex offender-specific training.*

Need to upskill Maori staff: Most Maori staff reported that they did not do individual work with clients as they *did not have the appropriate clinical skills.* Managers reported that although they were aware of the need to recruit more Maori staff, there were insufficient trained Maori clinicians in the workforce. Some Maori staff suggested that the managers could be doing more to address this issue by providing *dual competency training* for new and existing staff. This would be aimed at ensuring Maori staff developed the skills to deliver clinical interventions that promoted cultural integrity.

However, one interviewee queried the compatibility of cultural competence with clinical interventions: *there's a danger that the programme might become too clinical for Maori. We have different ways of working…this can be overridden by a clinical focus. This clinical focus is creeping in more to the Maori worker's role.*

Staff Supervision Arrangements

Good supervision arrangements provide staff with support and contribute to positive treatment outcomes for clients. Supervision enables staff to process their emotional responses to clients and seek others' information and input regarding the handling of cases. When managers and staff talked about supervision, the majority expressed satisfaction with their supervision arrangements and the measures in place to monitor their work performance. However, many non-Maori staff identified a need for cultural supervision.

Satisfaction with supervision arrangements: Managers and staff at all three sites thought standard supervision arrangements were adequate. These included individual supervision with senior staff, peer and team supervision, and external supervision. Maori staff reported that they received additional cultural supervision from other Maori, usually outside the agency when they needed specialist input on cultural matters, or a different perspective. This was particularly important, as one staff member pointed out, when staff were not from the local iwi.

Satisfaction with measurement of work performance: There were references to annual performance appraisal processes for managers (involving feedback from staff, board members and key stakeholders), and staff (involving feedback from cotherapists, clinical team leaders and managers). Maori staff reported that their performance appraisals were carried out by Maori team leaders and colleagues, with outside Maori input to ensure Maori practices were appropriate.

Staff at all sites also talked about the informal feedback they received from colleagues, supervisors, managers, placement caregivers, system reviews and client evaluation forms. There were no suggestions for improving this process. As one staff member commented: *my performance is constantly under review – there's a constant flow of feedback.*

Need for cultural supervision for non-Maori staff: In all agencies, non-Maori staff worked with Maori clients at various stages of the treatment process. Maori staff therefore had the additional role of acting as consultants/supervisors to non-Maori colleagues who had Maori clients. However, comments from many non-Maori staff suggested they were concerned about the lack of formalised cultural supervision they received. There were references to *having a chat when the need arises* and *conversations in the corridor.* Some attributed this deficiency to the high workloads of Maori staff and the agency not giving this any priority.

> *I get no cultural supervision. It's a huge oversight - really lacking. I really miss it. The Maori team are incredibly busy.*
>
> *Cultural supervision should be a more formal agency process – a stronger requirement. I would like to get cultural feedback from Maori staff about where I am in that process – am I doing the right things? I could take some personal responsibility but this could be assisted by Maori staff and the agency. We all need more feedback from Maori.*

Summary

Organisational support for staff, including staff care has been described as having a significant influence on the quality of service delivery and ultimately on outcomes (Calder, 2001). In this study, the majority of staff at all sites thought their agencies valued them and their work, and put practical measures in place to ensure their mental and emotional wellbeing. However, concerns were expressed about managers and clinical team leaders at two sites working long hours which led to self-imposed pressures on some staff to work beyond their allocated hours on a regular basis. Although managers had attempted to address the issue of overwork, greater efforts appeared to be needed. Similarly, many Maori staff reported they were burdened at times by the expectations placed on them to develop culturally appropriate services for Maori whilst carrying out their work in the mainstream programmes. None of the programmes had Maori workforce development plans in place. Furthermore, the intensity of services required for working with Maori youth and their families was not always recognised by the agencies. Given that Maori models of health emphasise that rehabilitation does not occur in isolation from social, economic, spiritual, cultural, familial and physical factors, it is conceivable this involves more intensive services and deeper consideration of the social and economic challenges faced by some families. It was therefore suggested that recognition be given to the additional expectations on

Maori staff and the greater intensity of services required for working with Maori families. This might involve additional resources being allocated to the Maori teams. It was also suggested that the programmes prioritise Maori workforce development issues in their strategic plans. To further ease the burden for Maori staff it was recommended that the managers and Maori staff at all three sites collaborate with each other and include other professionals, such as Maori psychiatrists and Maori psychologists, to consider planning, development, delivery, and review of services for Maori.

Training has been described as having an important role in terms of developing effective practice by ensuring staff gain relevant knowledge and skills. In order to promote and develop effective practice in this field, practitioners require sex offender-specific training which might include a focus on the modus operandi of ASO's, content and rationale behind assessment frameworks, care and protection issues, and criteria for family rehabilitation (Calder, 2001). Findings from this study suggested that in most respects, staff were provided with a range of learning opportunities to develop and improve their practice. However, at two sites a need was identified for further sex offender-specific training and formalised induction training for new staff. It was therefore suggested that the programmes (at two sites) review their training schedule to ensure that these measures are put in place. From Maori staff perspectives, the majority lacked the appropriate clinical skills to do individual work with clients and a need was identified for them to receive training in this area without compromising their cultural integrity. It was therefore suggested that the programmes assume responsibility for developing clinical and cultural training for new and existing Maori staff.

Supervision provides practitioners with structured opportunities to reflect on and develop their practice. It has been suggested that *normal* supervision is inadequate for staff who are engaged in this type of work and more time should be given to addressing knowledge and skills, monitoring workloads, critically reviewing the work, providing support and promoting staff care (Calder, 2001). Findings from this study suggested that the standard supervision arrangements and performance appraisal processes in place for managers and staff were adequate. Cultural supervision for Maori staff also appeared to work satisfactorily with staff feeling supported within their agencies and having access to external supervision when the need arose. However, a need was identified for non-Maori staff, who all worked with Maori adolescents at some stage of their treatment, to receive cultural supervision.

Funding and Resource Issues

Managers and programme staff were asked to identify factors that impacted on programme operations. However, interviews with all participants were interspersed with generic questions about what was working well and what could be improved. Funding and resource issues were identified as a core category. The following three themes were identified from participants' responses: funding is inadequate, staff recruitment and retention is a problem, and accessibility to services needs to be increased.

Funding is Inadequate

When managers and programme staff talked about the reasons for not getting out into the community to network, educate and promote their services, they cited a lack of resources, specifically, lack of funding, staff and time. One manager commented that *time was really precious* and if the agency *promoted itself too widely it ran the risk of being swamped with referrals.*

> *We don't approach other agencies for referrals as we don't have the funding. It's a bind. We struggle sometimes to cope with what we're doing now.*
>
> *We could network more with schools but this isn't happening because it takes up time.*
>
> *There's a need for community education – is that our role, anyway, and if not, whose role is it? Are we an education agency? Are we a treatment agency? Or are we both? We don't have the staffing or funding to provide everything.*

Staff at all sites viewed lack of funding as compromising programme operations in some way. They provided examples of how the programmes could be improved if funding were increased: *creative development within the programmes*, recruiting more staff and being able to remunerate them competitively, recruiting more Maori workers, developing and implementing Maori models of practice, doing more networking, education and public relations, reducing waiting lists, and setting up satellite programmes.

Staff Recruitment and Retention is a Problem

Managers talked about the difficulty in retaining and recruiting staff in an increasingly competitive market when agency *levels of funding are modest.* One commented: *I stress about money and worry about the agency's ability to compensate its staff ... if the*

goodwill runs out, what then? Sometimes experienced staff were *netted by other organisations* that were in a position to offer higher remuneration. Managers reported that it was essential to be able to recruit and retain quality staff given the increasing number of complex cases and the need to develop specialised services for different populations.

> *We're getting many more complicated cases - chaotic families, poor systems in place, comorbidity, more traumatised kids, psychologically more demanding – it takes more time to deal with these cases and we need to recruit staff with experience.*

There were comments from staff at all sites regarding the difficulty recruiting Maori and Pacific Islands staff at a time when agencies were faced with a growing number of referrals from these groups. Managers and many Maori staff said it was difficult to recruit Maori staff with good clinical knowledge as they were scarce. Some Maori staff thought the programmes needed to be more realistic when it came to assessing potential candidates: *there's always been a clinical approach to how people at (the programme) get hired - there needs to be a bit of give and take* with Maori background and culture given more credence.

At one site, several staff talked about high staff turnover and the impact that this could have on clients: *there have been a lot of changes over the past 12 months - seven new staff over the past 12 months. We have a client with conduct disorder who is working with his fourth clinician*. The manager reported that staff left for good reasons and he was doing as much as possible to retain staff.

Accessibility to Services Needs to be Increased

Some programme staff, external agency staff, parents and caregivers and adolescents talked about the problems caused by the geographical location of the programmes. Their comments suggested a need for further resources so that staff could work with clients in their homes and additional satellite programmes could be established.

Providing resources for staff to work in local communities: Several programme staff and external agency staff talked about the problems *(time consuming, costly,* and *tiring)* faced by some adolescents, families and caregivers having to travel long distances from their homes to the programmes: *the distance to travel to the programmes is a biggie*. There were references to transport problems if there was no

direct public transport and safety issues while adolescents were travelling back and forth. A few CYF social workers said they did their best to support families and encourage them by supplying petrol vouchers and arranging all appointments for the same day so that families did not have to stay overnight.

Despite references from external agency staff to *accommodating* programme staff and recognition that there were *not enough (programme) staff to travel backwards and forwards,* a few thought more could be done: *they're too in-house – they need to be more out and about.* One CYF social worker commented that when families had to travel long distances, the programmes could give consideration to putting resources in place so that staff could travel to the young person's home at least for the assessment interview: *this allows the young person to be seen in their context. It's not so clinical. Young people despise having to go into buildings.* Another commented:

> *Some boys miss a lot of school with all the travelling - it would be good having the programme after school hours. Perhaps they could have individual sessions outside office spaces. The therapists could go to homes. Does therapy have to be restricted to within four walls?*

Some external agency staff from residential facilities talked about the disruption to schooling.

> *My criticism would be that two boys have been in long term care with lots of shifts. Each time they shift, their education gets interrupted – their education is lacking. Coming here takes up so much time. Could therapists come here sometimes? The group therapy sessions are during school times. Could groups be held on Saturday mornings?*

Resourcing programmes to set up satellite programmes: Some programme staff and external agency staff talked about the *huge geographical area to cover* by the programmes which sometimes resulted in boys being placed in different towns from their families. Some adolescents described this as the most difficult aspect of taking part in the programme.

> *The most difficult thing for me was moving away from home. I was living at home, then in CYF care and then at (a residential home). I'd never been away from home before. I was scared coming up here and leaving everyone behind.*

> *The most difficult thing for me was moving away from parents and friends. I don't get to see them as much. I've got no family here at all. I was worried about how I'd cope.*

If I could make changes to the programme, it'd be having them all over the country so I wouldn't have to be away from home.

One programme staff member commented that distance was a major issue where young children were concerned: *should a young child of between 10 and 12 years be removed from home (in another town) and be relocated away from family and friends for 2 years because he touched a couple of kids in school?* Being resourced to set up satellite programmes was the suggestion most often put forward by interviewees to help overcome the problem.

Summary

In order to deliver effective services, programmes require adequate funding and resources, including the recruitment and retention of skilled, motivated and responsive staff (Morrison, 2006). Findings from this study suggested that inadequate funding and staff resources impacted on a broad range of programme operations, including the provision of education, promotion of services, and time spent networking with external agencies and the community. It was suggested that additional funding would allow for further development of the programmes, particularly cultural services for Maori, as well as recruitment of Maori and Pacific Islands staff. Managers expressed concern about the increasing pressures they faced with modest funding levels combined with the need to attract and retain staff with specialist skills to work with complex clients and multiproblem families. Funding levels may therefore need to be increased to the programmes so that they can expand their services to better meet the needs of clients and stakeholders.

In the literature, there have been suggestions that holistic services seek to remove barriers in terms of accessibility and work with clients in community settings, not just in office bases (Morrison, 2006). Findings suggested that the geographical location of the programmes created problems for some adolescents, families and caregivers. A need was identified for the programmes to be resourced so that staff could become more mobile and work with clients in their community context and to establish additional satellite services. For this to occur, staffing and funding levels would need to be reviewed.

The results presented above and in the preceding chapter offer insights into some of the factors that facilitate engagement and lead to changes in the sexual offending behaviour

of adolescents. Although the programmes appear to have kept up-to-date with the latest developments in the field of ASO treatment, there is scope for improvement in the implementation of these developments. A more detailed review and discussion of the findings is presented in the next chapter.

Chapter Six: Review and Conclusions

This chapter begins by reviewing the major methods used in the study. The key findings are then summarised and these provide the basis for outlining the components of an ideal service. Next, the strengths and limitations of this study are examined and this is followed by suggested directions for future research. The chapter concludes with a focus on the utilisation of research findings.

Overview

The aim of the process evaluation was to document the operation and characteristics of the programmes, examine clinical practices that seem to contribute to successes and failures, and identify factors associated with successful programme progress and outcomes. While CYF have a specific interest in the evaluation, the study has significance beyond this domain by providing information that can be applied to programme development and improvement in treatment settings outside New Zealand.

Qualitative research methods were used, as these facilitate a detailed exploration of programme dynamics and processes. Qualitative data was obtained from a series of structured, open-ended interviews with stakeholders, direct observation, and written documentation. A literature review was undertaken as a reference point for prioritising interview questions and comparing findings to practices and interventions that are associated with effective treatment programmes in other countries.

Interviews, which comprised the primary source of information for the evaluation, were conducted with 91 participants from four stakeholder groups at three geographical sites across New Zealand. This occurred between October 2003 and December 2004 and involved programme staff, adolescent clients, family members and caregivers, and external agency staff. To reflect the proportion of Maori clients involved in the programmes, approximately 30% of the participants were Maori. This necessitated close consultation with and involvement of Maori cultural experts. All interviews with Maori participants were conducted by the Kaumatua for the project. The researcher was also guided by the Kaumatua in relation to the interpretation of data involving Maori participants.

The findings suggest there is every reason to feel confident that the ASO programmes in New Zealand are being administered according to underlying theory and philosophy guiding best practice and are therefore able to produce positive outcomes for young people and their families/whanau. This applies, not only in terms of public safety, but also in relation to increased functional competence in adolescents and improved family functioning and wellbeing. While the effectiveness of the programmes was manifest in participants' responses to most aspects of programme operations and delivery, it was particularly apparent in the descriptions given by adolescents, parents and caregivers regarding treatment outcomes.

The programmes' effectiveness has since been confirmed through statistical analysis. The parallel outcome study found reduced rates of sexual and nonsexual reoffending amongst adolescents who completed treatment, compared with those who did not attend or dropped out (Fortune & Lambie, 2006b). Only 2% of adolescents who completed treatment sexually reoffended compared with 6% in the No Treatment group and 10% in the Treatment Dropout group. These results compare favourably to reoffending rates reported in outcome evaluations of community based programmes in Australia, the United States and Canada (Allan, Allan, Marshall, & Kraszlan, 2003; Gretton, McBride, Hare, O'Shaughnessy, & Kumka, 2001; Kahn & Chambers, 1991). The suggested findings relating to outcomes from this study are therefore strengthened by the results of the outcome evaluation. Information about how such outcomes might have been achieved is the domain of this evaluation.

Key Findings

Findings suggest the New Zealand treatment programmes were providing services that reflect the recommended guidelines for best practice which are outlined in the literature. Furthermore, the identified areas for improvement are consistent with the descriptions (found in the research) of best practice parameters for treating ASO's. Thus, the findings from this evaluation support the recent developments in research and treatment for this client group and provide direction for further investigation.

Overall results show parents, caregivers, and adolescents considered they gained significant benefits from their involvement in the programmes. Their comments suggest that participation in treatment had been life changing for many young people and their

families. In fact, there were no reports from adolescents of negative outcomes or nil change. The means by which the programmes achieved this, as well as areas for service improvement are discussed below. It is axiomatic that where new initiatives are suggested additional funding and resources will need to be allocated to the programmes.

Flexible and Integrated Approaches to Treatment are Effective

The programmes' flexible approach to treatment and the integration of holistic approaches into existing traditional sex offender treatment frameworks was supported by all stakeholder groups. Treatment included multiple therapeutic models, multiple treatment targets, individualised plans, creative methods, cultural input, and an emphasis on the therapeutic relationship.

From the outset the programmes appeared to deliver comprehensive assessments that identified specific areas of need and potential strengths, and were endeavouring to tailor treatment to the individual. The outcomes of treatment as described by adolescents, parents and caregivers suggested that the programmes targeted sexually problematic behaviours and sought to promote healthy development within the broader context, by involving family members, schools and community networks. Specialised programmes for youth with intellectual difficulties and children aged 10 to 12 years were available at all sites. Treatment services were also available for females and Maori adolescents. While there was still work to be done in the provision of specialised services for ethnic minorities, the programmes were attempting to meet the cultural needs of Maori clients.

The programmes incorporated traditional treatment modalities with group interventions being the most frequently provided treatment, followed by individual, then family interventions (Willingale & Brown, 2006). Despite strong support for group therapy from adolescents, parents, and programme staff, their comments indicated concern about the potential for harm during these sessions. As mentioned in Chapter 1, the research on iatrogenic treatment effects (Dishion, McCord, & Poulin, 1999) suggests that aggregating young high risk adolescents into therapy groups can lead to an escalation in problem behaviours. Dishion et al., suggest that the group process provides opportunities for inadvertent reinforcement of the problem behaviour as these adolescents derive meaning and a sense of identity from deviant talk and behaviour. However, there are indications that mixing prosocial youth with antisocial youth in

group interventions can be effective in reducing the problem behaviour of the latter, when prosocial youth do not show an interest in deviant talk and behaviour. Overall, these findings suggest that the programmes need to take greater account of the developmental, age, and risk levels of youth when assessing their suitability for group therapy.

Comments from adolescents, parents and caregivers suggest that the programmes' inclusion of traditional treatment components (relapse prevention, sexual abuse cycle, victim empathy, anger management, and social and communication skills training) worked well. Programme staff also commented on the value of these components. Despite concerns in the literature that these components have been imported from adult sex offender treatment programmes without knowing whether or not they are effective with adolescents (Prescott & Longo, 2006), findings from this study suggest they warrant a place on treatment programmes for adolescents. Interestingly, the work on victim empathy appeared to be particularly salient for adolescents. Even so, the usefulness of these treatment components would appear to be enhanced by certain factors. These include the active engagement and involvement of families, an emphasis on client strengths, and the development of prosocial skills and positive life goals. Moreover, staff on these programmes adapted traditional treatment components to suit New Zealand's cultural and community context and the developmental needs of different client groups. There were indications that further understanding of programme components was facilitated by therapists who used the language and concepts of the young people themselves.

Adolescents' comments indicated that many had understood programme material and incorporated it into their everyday lives. This would suggest that existing treatment approaches can be valuable vehicles for change when they are adapted to fit the contextual and developmental needs of clients. The identified needs in this study to further expand family work, provide additional support groups for parents and caregivers, address prior childhood victimisation issues, and incorporate a positive sexuality and healthy relationships curriculum, gives further recognition to the importance of providing integrated services with a holistic focus. Families and caregivers generally felt well supported by the programmes but they raised concerns about the inadequate provision of aftercare services. In view of the finding that adolescents on these programmes were at the highest risk of sexual reoffending within

the first year of completing treatment (Fortune & Lambie, 2006b), the provision of effective aftercare services appears to be particularly apposite. For some families who lived some distance away, travelling to and from the programme was disruptive. It was suggested that the establishment of satellite services or greater mobility of staff would alleviate this.

Helpful Therapeutic Approaches

While it has not been possible to draw conclusions in support of any one theoretical approach to treatment, a number of models were highlighted as being particularly helpful. First, comments from adolescents, parents, caregivers, staff and external agency staff at one site suggested that the innovative Good Way model (Ayland & West, 2006) developed by two clinicians at this site was successful in facilitating engagement, disclosure, and learning about programme concepts. Although this finding only related to one site, it was notable given its mention by the majority of interviewees from each stakeholder group. This included adolescents who were deemed *resistant,* had comorbid mental health issues, had intellectual difficulties, were Maori, ranged in age from 11 to 19 years, and one female.

Next, many adolescent clients responded positively to physical and creative activities within therapy and would have liked more of them. There was particular mention of music, games and play, drawing and writing, and active pursuits and sports. Some programme staff also recognised the value of providing these approaches and thought they should be used more frequently. In the literature, CBT methods (often applied to specific treatment components, such as relapse prevention, the sexual abuse cycle, victim empathy training, and social skills training) have received widespread endorsement. Despite calls to tailor treatment to the developmental and contextual needs of individuals there has been little commentary about what treatment methods might facilitate this. In an attempt to meet these needs, some authors have recommended and described experiential and expressive treatments as part of an integrated approach to treating young people who sexually offend (Bergman, Hewish, Robson, & Tidmarsh, 2006; Lambie et al., 2000; Longo, 2004; Rich, 2003; Tyo, 2005). While the New Zealand programmes also used CBT methods in the teaching of traditional treatment components, the incorporation of creative and physical approaches appeared to facilitate learning of difficult material, enhance therapeutic engagement, provide adolescents with

positive recreational experiences and opportunities to engage prosocially. Furthermore, the exploration of difficult issues through creative and physical activities made it easier for adolescents to open up. Although there is no empirical evidence to support the use of expressive and experiential treatments with this population, from adolescents' perspectives such approaches contributed to their active participation in the treatment process.

Finally, the programmes' multisystemic approach to treatment was seen as effective in bringing about change by all stakeholder groups. While some programme staff and external agency staff referenced this intervention by name, descriptions from many adolescents, parents and caregivers also supported the programmes' use of this approach. Notwithstanding the growing body of evidence that supports MST as an effective treatment for adolescents who sexually offend, few treatment programmes have implemented the model faithfully according to the prescribed quality assurance procedures (Chaffin, 2006). Chaffin has suggested that the expense involved in staff training and licensing and MST's prescriptive implementation criteria are likely to present particular challenges for programmes. Even so, findings from this study suggest that MST interventions can be implemented successfully without strict adherence to the model. Specifically, the emphasis on addressing the individual needs of adolescents and their families, engaging and empowering families, involving other key participants from the adolescent's wider network (teachers, community members, workers from agencies with mandated involvement), emphasis on developing relationships with prosocial peers (involving sports teams, church youth groups, community organisations), and evaluating treatment progress from multiple perspectives (regular system reviews). Consistent with a multisystemic approach, therapist availability beyond session times and normal working hours was valued by family members and further involvement of CYF social workers during treatment was identified by young people as important. Moreover, a need for initial contact with the programmes, assessments and interventions to occur in community settings was identified, particularly for Maori whanau.

Factors that Facilitate Engagement in Treatment

While the therapeutic relationship has been found to play a critical role in diverse types and contexts of treatment involving children and adolescents (Shirk & Karver, 2003), findings from this study suggest that engagement in treatment could also be enhanced

by other factors. A central theme in the stories of all those interviewed was the weight given to engagement across all points of contact with the programmes. For adolescents, parents and caregivers, this went beyond a focus on therapist characteristics and communication styles, to include comments about the factors that promoted initial engagement prior to and during the assessment phase. While programme staff recognised the importance of engagement and the client-therapist relationship, they did not make reference to initial engagement processes during the intake stage of treatment. Comments from adolescents, parents and caregivers highlighted the importance of being provided with a comprehensive array of information and education material at the outset, and for this to be conveyed in such a way as to instil hope for change and positive anticipation of treatment success. From their perspectives, on first arrival at programme premises, being given refreshments and welcomed into conducive physical surroundings were also important.

Findings suggest that once assessment and treatment got underway, most staff possessed the necessary skills and personal characteristics to actively engage clients and families. Strong client-therapist relationships were identified as a particular strength at all sites and this seemed to make a significant contribution to programme progression and therapeutic success. For all youth, having a positive therapeutic alliance provided the framework for improving attitudes and working on programme material. They valued therapists who were nonjudgemental, provided encouragement, demonstrated care and concern, took a personal interest, were available, communicated respectfully at an appropriate level, spent appropriate time on issues, were trustworthy, and down-to-earth.

The vast majority of participants from all stakeholder groups referred to the importance of engaging families in treatment and the vital role that parental involvement and support played in contributing to the adolescents' engagement in treatment. While the programmes' systemic approach to family therapy work appeared to be successful, a need to expand this type of intervention was identified. Compared to individual and group therapy, family therapy was the least frequently provided treatment approach (Willingale & Brown, 2006) and comments from some programme staff, external agency staff, and parents highlighted the need for more family work, particularly in the area of family education and support, and greater inclusion of the wider family system with Maori whanau.

Cultural Services for Ethnic Minorities

Despite acknowledgement of the need to provide services that attend to the cultural context for ethnic minorities, the provision of such services in this treatment area appears to be lacking (Calder, 2006). However, in New Zealand there have been some positive developments with regard to cultural input for Maori clients. The programmes had recruited Maori staff who incorporated cultural components into treatment which from Maori clients' perspectives generated beneficial outcomes. However, the absence of services that were specifically devoted to Maori coupled with the reliance on mainstream psychological models, which may impede the process of engagement for Maori, suggested there was still much work to be done. Moreover, Maori youth who had been referred to the programmes were least likely to commence treatment when compared with Pakeha and Pacific Islands youth. The cited reason for this was their referral to other services which the programmes considered were better able to meet their needs (Fortune & Lambie, 2006b).

Although Maori and non-Maori shared similar views about many aspects of programme delivery and treatment outcomes, there were some notable differences. Engagement with Maori was seen as requiring the crucial process of whanaungatanga and the option of being initially seen or assessed in their own environment away from clinical settings. While the physical characteristics of agency premises were important for many adolescents and their families, a need was identified for the programmes to give consideration to making them more acceptable for Maori service users. Having access to a Maori therapist from the outset and cultural input were also seen as important. Despite the best efforts of staff and managers to match Maori clients with Maori staff, there were insufficiently trained Maori clinicians available to make this possible. Although it is not yet clear whether ethnic matching between therapist and client leads to better treatment outcomes, there are indications that ethnic matching is important because it is related to length of time spent in treatment (Karlsson, 2005; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). The need for the programmes to prioritise Maori workforce development issues in their strategic plan is therefore highlighted.

Some Maori staff pointed out the cultural bias inherent in psychometric tests and the need to be more culturally responsive during clinical interviews. Importantly, this is consistent with the findings of an unrelated study that explored the cultural bias of some

tests used in the neuropsychological assessment of Maori adult males (Ogden & McFarlane-Nathan, 1997). The overall impression gained was that Maori staff were constrained by their subsidiary roles on the programmes. Most Maori staff did not do individual work with clients as they *lacked the clinical skills* and while they worked with Maori whanau in a supportive role, non-Maori staff took the lead role as family therapists utilising a model based on western paradigms. Findings suggest that this model did not always meet the cultural needs of Maori.

Despite the emphasis on family work on the programmes, for some Maori clients there was too much focus on the individual adolescent and not enough on the whanau context. Conceivably, this experience stems from the Maori world view which attributes particular significance to family connections. Maori society tends to be more group-focused than western populations and individual wellbeing is inseparable from the health of the whole group (Huriwai, Robertson, Armstrong, & Huata, 2001). For Maori, the extended family is the primary support system and individuals achieve credibility when they make links to family and tribal groupings. Huriwai et al., suggests that working from a whanau perspective requires knowledge of the dynamics of whakapapa and whanaungatanga. For these reasons, the importance of providing cultural training for non-Maori staff and clinical and cultural training for new and existing Maori staff is emphasised. Conceivably, the establishment of effective working relationships with mana whenua, iwi, hapu and Maori service providers in the community would further assist service development.

While it is inadvisable to assume that all Maori have a strong cultural identity and are comfortable with Maori practices and beliefs (Banks et al., 2006), findings from this study suggest the development and integration of treatment interventions based on Maori cultural paradigms would benefit Maori service users. The application of such interventions for people with different levels of acculturation could be addressed during the assessment phase by culturally competent staff.

While these findings cannot be generalised to other cultures they highlight the importance of providing culturally responsive services. Given indications that there may be a causal link between culturally responsive interventions and outcomes (Sue, Fujino, Hu, Takeuchi, & Zane, 1991), it is important for the New Zealand programmes to attend to the cultural needs of other ethnic minority groups, particularly Pacific Islands

communities. As indicated in Chapter 3, Pacific Islands youth showed a greater propensity to drop out of treatment compared with Maori and Pakeka youth. While the reasons for this are not clear it is perhaps worth noting that significant differences exist between Pacific cultural values and some of the assumptions and goals of western psychological approaches, particularly in relation to family structures (Banks et al., 2006). The need to apply cultural knowledge and principles when working with ethnic minority groups is therefore particularly salient. A useful starting point for the programmes would be to start building relationships based on trust and collaboration with different ethnic groups by networking within their communities.

Organisational Considerations

In Morrison's (2004) discussion about the organisational context that underpins the delivery of effective services for young people who sexually offend, there is reference to the importance of strategic intervention (interagency procedures and allocation of adequate resources); managerial and organisational support for staff; and practice delivery based on a philosophy of intervention that reflects holistic approaches. With regard to the programmes in this study, at the strategic level, findings suggest that the systems, co-operation and communication that existed between the programmes and agencies involved in the identification and management of young people who sexually offend could be improved. Of particular concern was the problematic relationship with CYF, the lack of referrals at one site, widespread placement problems which jeopardised treatment, insufficient networking with external agencies which limited access to treatment for special populations and ethnic minority groups, and uncertainty among some agency personnel about service eligibility criteria and definitions of sexual abuse. To ensure that these programmes are used appropriately and function effectively, agencies need to collaborate and put in place a clear multidisciplinary policy framework that specifies the ongoing roles and responsibilities of all agencies (Morrison, 2004). With regard to resources, inadequate funding was cited as affecting staff recruitment and retention, programme development, and the ability to network effectively with external agencies. Staffing and funding levels need to be reviewed if the programmes are to better meet the needs of referral agents and other stakeholder groups.

Next, findings suggest the programmes had effective operational procedures in place thus providing strong organisational frameworks for the delivery of services. The field

of treating sexual offenders places particular demands on staff and the organisations appeared to be successful in their emotional care of staff. Management had policies and structures in place to support staff which included flexibility around work hours, generous leave provisions, the monitoring of caseloads, and strong peer support networks. Stable and committed leadership was a feature at all sites and quality assurance procedures in place at each site ensured that staff received a high standard of training and supervision. Without exception, Maori staff felt well supported and valued by management and staff at all sites. The impression gained was that managers and staff were extremely hardworking and dedicated and this was reflected in the accolades expressed by adolescents, caregivers and stakeholders. However, a number of areas for improvement were identified, including the need for sexual offence-specific training for staff, induction training for new staff, and cultural supervision for non-Maori staff.

With regard to practice delivery, it was apparent that the programmes' use of holistic approaches based on developmental understandings was in line with recommended guidelines (Morrison, 2006). However, at some sites the documentation of programme philosophy and interventions was inadequate. Given that expert opinion has confirmed the importance of writing down programme aims, protocols and therapeutic methods to ensure there is a shared basis of understanding among workers about how treatment is delivered (Morrison, 2004), a need for the programmes to address this issue was identified.

In summary, if consideration is given to all the factors that contributed to the positive experiences reported by adolescents and their families of the services that were provided by the programmes, then it is suggested that organisational factors and processes played a key role. Similar conclusions have been reached by other researchers conducting process evaluations with youth offending populations (Mears, Kelly, & Durden, 2001). In fact, Mears et al., suggest that organisational characteristics, rather than individual-level factors may be the most determining factor for successful programme progress. While it is beyond the scope of this study to identify which organisational factors facilitate programme progress and impact, the following impressions may provide some insight. It was apparent that the managers of the New Zealand programmes provided high levels of support for their staff. In doing so, this may have had an indirect impact on the creation of an organisational climate that encouraged innovation and creativity, risk taking, autonomy in decision making, cultural responsiveness, respectful practice,

commitment, and reflection. These factors and processes are recognised components of successful programme implementation in other contexts (Cherniss & Fishman, 2004).

Components of an Ideal Service

While it is not possible to make extensive generalisations given New Zealand's unique social, cultural and ethnic context, and the qualitative nature of this study, several programme delivery considerations can be highlighted with a view to providing insight for service improvement in other settings.

1. Programmes should be structured to allow for a flexible and integrated approach to treatment. In this way, existing traditional sex-offender treatment frameworks can be modified to suit the individual characteristics and needs of clients, thus allowing for greater treatment specificity.

2. Programmes should deliver treatment using a variety of methods; namely, individual therapy, group work (reducing potential for harmful effects), family interventions, and psychoeducation. Family involvement in treatment should be prioritised with families being offered a broad range of interventions including family education and support. The traditional reliance on group therapy as the most frequently provided intervention may therefore need to be reviewed.

3. Programmes should employ a range of therapy models with a view to promoting client engagement. This can be achieved by incorporating creative approaches which take into account their unique cultural and community contexts and the developmental needs of clients.

4. Programmes should aim to provide wraparound services by actively engaging adolescents and their families during the intake period and throughout treatment; and providing transitional programmes and aftercare services.

5. Programmes should recognise the importance of engagement across all points of contact with the programme. This goes beyond a focus on the client-therapist relationship to include the provision of good information at the time of referral and assessment, ambient surroundings, refreshments, family support, culturally appropriate communication, and creative and physical activities.

6. Programmes should provide good pre-entry information and educational material that is easily read and understood in order to allay initial fears and anxieties, reduce barriers to participation, instil hope, and enhance anticipation of positive treatment outcomes.

7. Programmes should give recognition to issues of cultural difference by developing and integrating cultural services for ethnic minority groups into all levels of programme delivery.

8. Programmes should make provision for therapists to work in family and community settings. While this has significant funding and resource implications, consideration could be given to allocating such resources for this to occur during the referral and assessment phases of treatment. This may be particularly relevant for some ethnic minority groups.

9. Programmes should provide satellite services within their regions to enable clients to remain near their families, peers, school, and community whilst receiving treatment. This would also help to overcome problems for families created by the distance from the treatment centres.

10. Programmes need to build effective interagency communication and co-ordination through written protocols and the development of systems to ensure adequate monitoring and management of young people, clarification of agency roles and expectations and information sharing about sexual abuse and treatment services.

11. Programmes need to provide strong organisational support for staff through attention to staff wellbeing, and effective training and supervision practices. The importance of creating a positive organisational culture is highlighted.

12. Programmes need to integrate evaluation procedures that give recognition to the importance of obtaining direct feedback from clients and their families about their experiences of treatment services and outcomes. While many programmes are subjected to regular external audits to ensure that certain standards of excellence are being met and maintained, such forms of evaluation do not capture the breadth and depth of information that is captured by studies such as this.

Strengths and Limitations

A particular strength of the present study is its breadth and scope, involving interviews with over 90 participants from four stakeholder groups across three geographical sites. This allowed for a comprehensive view of the programmes and for information to be compared and crosschecked across multiple data sources. Indirect support for the credibility of the findings related to outcomes is derived from the compatibility that exists between the results of this study and the subsequent parallel outcome study.

Another strength of this research relates to the inclusion of Maori participants. In recent years, Maori have often been excluded from sample groups. The reason for this arises from historical mistrust (by Maori) of Pakeha who are not recognised as having the required cultural understanding and sensitivity to research Maori and a prevailing belief that only Maori should research Maori (Tolich, 2002). However, this study demonstrates that a bicultural approach to researching Maori can be undertaken when Pakeha researchers attend to issues of cultural safety through cultural collaboration and consultation. It goes without saying that the voices of Maori participants would not have been heard without Rawiri Wharemate, the Kaumatua for this project. Rawiri's particular skills enabled the research team to gain understandings that would not have been available otherwise. On a more personal note, having the opportunity to work with Rawiri and the success of our collaborative effort was one of the highlights of my involvement with this study. Through the breadth and depth of his knowledge of Maori culture and his ability to relate cross-culturally in all settings, I learned a great deal about issues of cultural difference and the value of working collaboratively. I now consider Rawiri to be a mentor and a friend and we have remained in contact since the completion of this project.

Another value of the present study relates to my role as an interviewer. Patton (2002) firmly believes that the interviewing process changes the way researchers view their world and themselves. At the outset, I did not anticipate that this would necessarily apply to me. However, this proved to be short sighted. As stated in Chapter 2 one of my preconceptions related to the improbability of male adolescents, particularly those from multiproblem families, responding to therapeutic input. I queried the extent to which they could make significant behavioural and cognitive change, given their maturity level and the impact of other influences in their lives. I also anticipated that these young

people would have difficulty articulating responses to my questions. However, throughout the interviews I was struck by the ability of most young people to talk about their thoughts and feelings whilst reflecting on their lives and the programmes. Without exception, they were co-operative and respectful. Certainly, there were a few boys who seemed quiet and shy and others who came across as edgy with short concentration spans. However, all young people reported having made some progress as a result of therapeutic input from the programmes and for some it appeared as if their lives had turned around. The interview process therefore enhanced my learning about factors that can contribute to such change and created a shift in my belief system to include a more optimistic view about the responsiveness of male adolescents to therapeutic input.

Patton (2002) has also suggested that the power of interviewing can be transforming. During some of my interviews with parents, I was reminded of these words. Some parents were visibly moved when they reflected on family life prior to their contact with the programmes, the barriers they faced at the time of referral, the process of engagement and change, and where they were now as participants in the programme. At these times I responded empathically to their stories and on a few occasions I became aware that I was taking part in a special or *heartfelt* process. Looking back, I can still recall particular interviewees, the interview setting, certain phrases they used to tell their stories and the emotional impact that this had on us both. A few programme staff gave me informal feedback that some parents had enjoyed the opportunity to talk about their experiences as it enabled them to appreciate how far they had come.

A limitation in any qualitative study arises from problems of objectivity and bias. Thus the influence of my involvement with interview participants, data analysis and interpretation cannot be ruled out. This raises the possibility that I may have given selective attention to particular aspects of the programme that interested me or confirmed what I already believed. Participants may not have seen my role as independent from the programmes and demand effects may have led them to exaggerate the positive aspects of the programme. While there is general acceptance for the view that complete objectivity is not achievable, steps were taken to ensure that a *reasonable* level was attained (Spencer, Ritchie, Lewis, & Dillon, 2003). These included the time given to informed consent procedures, reassurances about confidentiality, my awareness of some of the preconceptions or biases I brought to the research, and search for negative cases during the interviews. By describing the research process and procedures

and documenting my own subjectivity, it is hoped that readers have enough information to find the results credible. Another factor that may have affected participant's responses was the payment they received for taking part in the study. However, I tried to ameliorate the potential for bias by making it clear that the vouchers were given in exchange for their valuable input and time, not for their responses.

Another limitation of the study relates to the consumer sample group. Virtually all adolescents and family members talked about the significant personal growth that had occurred as a result of their participation in these programmes. Although the interview sample included *resistant* adolescents and external agency staff with *known negative views,* the analysis of negative cases did not include examination of feedback from adolescents who had dropped out of treatment, nor their families. While consideration was given during the planning stages to including dropouts in the sample, this was not pursued due to anticipated problems with locating their whereabouts and obtaining their consent for participation in the study. Furthermore, we did not want to jeopardise the co-operation that existed with the programmes by requesting that they facilitate our access to *treatment failures.* Nevertheless, dropout feedback may have provided further insights into how the programmes operated and affected participants as well as critical information about programme improvement. It is possible that some findings could have been different.

Generalisability has also been highlighted as a limitation of qualitative research. The demands of qualitative work mean that observations are typically carried out at one setting or interviews are conducted with a small number of people. Consequently, qualitative researchers cannot rely on representative sampling to strengthen their claims about the generalisability of their findings (Spencer, Ritchie, Lewis, & Dillon, 2003). Nevertheless, the programmes in this study were derived from established practice traditions and they have been described in such a way as to provide enough information to allow readers to consider the extent to which the New Zealand context can be applied to other settings. Furthermore, the interview sample was chosen to represent a range of characteristics and views (which have been described in Chapter 2) thus allowing readers to gauge whether key comparisons can be made to other contexts.

Finally, a particular limitation of the study concerns the issue of establishing cause and effect relationships. While this study describes programme processes and outcomes and

identifies some of the elements that have contributed to successful programme progress, it does not elucidate causal linkages between processes (or programme components) and outcomes. Process evaluations are concerned with how programmes operate to aid our *understanding* of the factors that contribute to programme successes and failures rather than exploring linear relationships between independent and dependent variables (Patton, 2002a). However, this does not prevent researchers who have spent considerable time in the field interviewing people and reflecting on the themes that run through the data, from making inferences and offering hypotheses about relationships. For example, Maori youth who had been referred to the programmes were least likely to commence treatment when compared with other ethnic groups and they were generally referred elsewhere, to services which the programmes thought were better able to meet their needs (Fortune & Lambie, 2006b). This suggests the need for the programmes to further develop and expand their cultural services for Maori. Moreover, based on my *understanding of the process-outcomes relationship* (Patton, 2002a), I draw conclusions about the programme elements that seemed to generate positive treatment outcomes which are outlined in the previous section.

Directions for Future Research

The findings from this study suggest several avenues for future research. First, an area for possible investigation is the identification of process variables that influence treatment outcomes for ASO's. This study suggests that the therapeutic relationship played a pivotal role in treatment collaboration. Given the consistent association between the therapeutic relationship and treatment outcome in child and adolescent therapy (Shirk & Karver, 2003), the identification of process variables that contribute to the formation of a positive therapeutic relationship is critical. Conceivably, the factors that generate an effective therapeutic alliance among ASO's may be different from those with other problematic behaviours. Considering the importance of family support and involvement in treatment, the role of the therapeutic alliance and identification of relationship variables in family therapy may also warrant further investigation. The role of relationship processes in this particular field of treatment is relatively unexplored. It is suggested that future research might focus on clients' perceptions of the relationship to identify effective therapist features and relate these features to different treatment formats (individual, group, and family).

Second, while this study did not examine which aspects of treatment produced which outcomes, findings suggest the need to isolate the critical components of treatment and further explore effective combinations of treatment. Given the potential for harm in group interventions and the predominance of this treatment format on most programmes for this population, research is now needed to explore the relationship between group therapy and behaviour change with ASO's. Closer examination of issues related to age, offender subtypes, risk level, and dosage might assist treatment providers to optimise the benefits associated with group therapy. Also, given the positive comments about the Good Way model, research that examines the efficacy of this model seems warranted. If found to be effective, the identification of youth for whom it works combined with the elucidation of treatment components that contribute to its effectiveness could make an important contribution to ASO treatment.

Third, while findings from this study highlight the importance of providing cultural services for Maori, there is scant mention in the literature about attending to the cultural context for ASO's from ethnic minority groups. In New Zealand, future research could focus on the area of Maori adolescent sexual health with a view to developing and integrating Maori models of practice in this field of treatment. This would be an important step towards identifying the components of a culturally appropriate service that is devoted specifically to Maori. This research suggestion equally applies to programmes in other settings that need to provide cultural services for their indigenous populations and/or migrant ethnic groups.

Fourth, further exploration of the organisational characteristics that play a role in influencing programme implementation and delivery is suggested by the findings in relation to programme operations. The identification of leadership, organisational and cultural climate factors that impede or promote programme delivery and positive outcomes, would provide valuable insights to inform programme and policy changes.

Finally, future research should also seek to examine the factors that influence adolescents to drop out of treatment. This would assist treatment programmes to identify what additional services and/or resources they might need to put in place to reduce this risk. This could be achieved by obtaining the perspectives of youth, family members and carers regarding the barriers to treatment maintenance and what could have been done to remove these barriers.

Utilisation of Research Findings

As indicated in Chapter 2, a draft report of findings with site-specific commentary and recommendations for improvement was submitted to the CYF Evaluation Advisory Group and the programme managers at all sites for review. Although programme managers had been shown sections of the report as it was being prepared, this was the first time they had viewed it in its entirety. Feedback indicated that the report was positively received overall. However, while there were a few factual errors that required correction, programme managers challenged some of the interpretive aspects of the report and this necessitated further discussion and clarification to ensure that the integrity of findings was not compromised. While this process was not comfortable for me given the relationships I had developed with staff during the evaluation, decisions about what was changed and what remained the same were made in consultation with members of the research team and the CYF Evaluation Advisory Group. The report was subsequently finalised and published (Geary & Lambie, 2005). It concluded that the programmes were providing an essential treatment service, and as such warrant long-term secured funding and support from the government.

With regard to my relationship with staff, from the outset I was aware of the need to enter into a process of engagement and trust with staff to engender co-operation. This process deepened over time as I came to appreciate the value of personal involvement and interest in the programmes being evaluated, not only for data gathering but also for interpretation. Prior to and during data collection at each site, staff were generous with their time, hospitality and assistance and in some cases a special rapport developed between particular staff members and me. Peer supervision assisted me to try and maintain a balance between neutrality and engagement. Following completion of the report, there were occasions when I met with staff to present and discuss findings. At this point, I became aware that there had been a shift towards a more neutral relationship. While time had passed and the dissemination process required a different level of engagement which may have affected their level of engagement with me, I also wondered whether the documentation of areas for improvement was challenging for some staff and construed as evidence of failure. In hindsight, I could have foreseen this and given more time to clarifying my role as an interested and involved researcher who also had responsibilities and a commitment to account to an external audience. At the

same time, talking with staff about the challenge of contemplating change as an occasion for growth and viewing recommendations for improvement as a reference point for further examination may have assisted in the preservation of our level of engagement.

As mentioned, following the completion of the report I took part in a series of oral and visual presentations to staff to disseminate and discuss findings. I also took part in a symposium at the 2006 Australia and New Zealand Association for the Treatment of Sexual Abusers Conference, held in Australia which was attended by several staff from the New Zealand programmes. Following this presentation, discussions were held with programme planners from a regional state within Australia who wanted information regarding the factors that might explain the success of the New Zealand programmes to guide their decisions about the development and implementation of a programme in their area. Following presentations and during informal conversations with staff from the New Zealand programmes I was informed that recommendations in the report were being discussed (at all sites) and put into effect where deemed appropriate. The clinicians who developed the Good Way model at one site reported that they had received government funding to further develop their model on the basis of the CYF report (Geary & Lambie, 2005) and they wanted to work collaboratively with me on an article that could be prepared to submit for publication. Indirect dissemination of findings has also been conducted through the publication of two journal articles written by different authors (Ayland & West, 2006; Lambie & Seymour, 2006) and I am currently preparing an article to submit for publication based on this dissertation.

Thinking back to the practical purpose of this evaluation which was to gather information and generate findings that are useful, it seems reasonable to conclude that the utilisation process is underway. For those who make decisions about the programmes, the report's recommendations have provided the basis for considering and implementing change; and the dissemination process has involved audiences beyond immediate intended evaluation users. Findings may therefore be applied to different contexts. This leads me to conclude that if we are to successfully modify existing treatment programmes and enhance aspects of treatment that work, we need the type of information provided by process evaluations. Future studies of this type will assist us to move closer to identifying and understanding the factors involved in the successful treatment of adolescents who sexually offend.

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Appendix A:
Interview Schedules and Additional Questions

Interview: Managers' Perceptions of the Adolescent Programme

Section 1: Background Information

A. First of all, I would like to ask you some questions about your role in the organisation so that I get a few background details.

1. To start, can you tell me about what you do in your organisation?

2. How long have you been working for the organisation?

3. What kinds of work experience do you bring to your current job?

B. I'd now like to ask you some questions about training, supervision and organisational support.

1. Over the past 2 years, what in-house staff training has been available for staff in this organisation? Obtain description.

Checklist: Job induction/orientation training, individualised training goals/training programme.

2. What training have you received since commencing employment with this organisation?

3. How is your work performance measured?

Checklist: Annual performance reviews/performance appraisals, client/family/whanau feedback (system reviews), supervision, self-appraisal.

4. As a manager, what are your arrangements for receiving supervision?

5. What systems are in place for ensuring that staff get adequate supervision?

6. Thinking about supervision arrangements for staff in this agency, do you have any suggestions for improvement?

7. a. What are your arrangements for receiving cultural supervision for Maori staff?

b. Do you have any suggestions for improvement?

8. a. How does your agency demonstrate its awareness of the need for staff self-care?

Checklist: Creating opportunities for collaboration, good clinical supervision, opportunities for continued learning, stress reduction, opportunities for discussing personal impact of work, balanced caseloads, monitoring workloads.

b. Do you have any suggestions for improvement?

Section 2: Referral Processes

In the next section, I'll be asking you some questions about your agency's liaison with referrers.

1. a. I understand that the majority of referrals come from CYFS. Can you think of any other agencies that SAFE/WellStop/STOP should be networking with? Obtain detail.

b. If yes, why is this not happening?

2. Thinking about your agency's relationship with referrers, what could be improved?

Section 3: Assessment

I'd now like to ask you some questions about the assessment process in your organisation. I'd like to start by getting some background information.

1. a. Before the assessment interview takes place, what systems do you have in place for matching clients to staff?

Prompt: What procedures are in place to ensure that clients are allocated to staff member most appropriate for their needs e.g. culture, personal circumstances, risk level, gender, special needs.

b. What could be improved?

2. a. What systems are in place for assessing clients with complex backgrounds e.g. multiagency involvement and comorbid conditions?

b. Do you have any suggestions for improvement?

Section 4: Client Groups

In the next section, I'll be asking you some questions about the availability of treatment for different types of adolescent sex abusers. I'll also be asking you some questions about the specialised services within your organisation.

1. a. Up till now, only small numbers of adolescent girls have taken part in the programme. Why do you think this is?

b. Looking at their access to treatment – do you have any comments?

Prompts: Could it be improved? How could it be improved?

2. What do you think are the barriers to treatment (if any) for clients in the following groups? At the same time, I'll be asking you about what you believe can be done to remove these barriers. (Try to elicit up to 3 for each group).

a. Children aged 10-12 years

Barriers:

Solutions:

b. Maori clients

Barriers:

Solutions:

c. Pacific Islands clients

Barriers:

Solutions:

d. High risk clients

Barriers:

Solutions:

e. Lower intellectual functioning clients

Barriers:

Solutions:

3. Thinking about high risk clients, what specialised services are offered for this particular group?

Checklist: Situational factors, multiagency involvement, comorbid conditions, hands on (assaults involving penetration, indecent exposure).

4. Thinking about low risk clients, how does your agency cater for these individuals?

Checklist: Situational factors, hands off (pornography, phone calls, prowling, stalking, voyeurism, propositioning).

5. What specialised services are available for clients in these groups?

a. Children aged 10-12 years

b. Maori clients

c. Pacific Islands clients

d. Females

e. Lower intellectual functioning clients

Section 5: Cultural Services

Section 6: Programme Delivery and Outcomes

I'll now be asking you some more questions about the adolescent programme. To start, I'll be asking about the implementation of programme goals, the therapeutic models used and your preferences. I am also interested in finding out about the factors that contribute to positive and negative outcomes. As we go along, I'll be asking you for suggestions for improvement.

1. Thinking back to this agency's inception, how did the programme develop?

2. In what ways has the programme changed over time? And why?

Prompt: What changes have taken place?

3. I understand that the goals of the programme are….(read list).

How were these programme goals derived?

4. Do you think that these goals are being met? In what ways (be specific)?

Checklist: Changing sexually inappropriate behaviour, fostering sexually/socially appropriate behaviour, developing equal relationships and respect for others, taking responsibility, awareness of offence cycle, sex education, supporting parents.

5. In your opinion, how could programme goals be improved? (Try and name 3).

6. What are the dominant therapeutic approaches to working with adolescent clients in this agency?

Checklist: Individual/group/family.
CBT/psychodynamic/behavioural/pharmacological/MST/psychodrama

7. Can you think of any modifications that have been made to these therapeutic approaches within your agency? (Obtain detail). And why?

8 a. What is your opinion of the treatment models used in this programme?

b. What would you like to see more of? And why?

c. What would you like to see less of? And why?

9. a. Thinking back over your involvement with the programme, can you give an example of a client who has done particularly well?

b. In your opinion, what were the contributing factors that assisted this client to do really well?

Checklist: Stable living arrangements, involvement of family, stability of school, support systems in community, positive peer relationships, prosocial hobbies and interests, therapeutic relationship, accurate assessment of risk and need, staff characteristics.

10. a. Can you give an example of a client who has not done well on the programme?

b. What were the contributing factors that made it difficult for him to do well?

Checklist: Impulsivity, high stress family environment, parental rejection, lack of family involvement, frequent changes of address, peer influences, substance abuse, comorbidity.

11. So in general, what do you think are the factors that most contribute to successful treatment outcome? (Try and name 3). And why?

12. Similarly, what do you think are the factors that contribute to poor outcomes? (Try and name 3). And why?

13. To summarise, what would you like to see happen to:-

a. Access more clients

b. Reduce waiting lists?

c. Reduce dropout rates?

d. Improve therapy engagement and co-operation?

Prompt: What do you think the programme needs to do to change/improve this?

14. a. What systems are in place for making important clinical decisions (with reference to high risk clients)?

Checklist: Key workers, group responsibility, assignment of complex cases, assigning responsibility for case management, terminating treatment, external consultation.

b. Can you think of any ways that this could be improved?

15. Do you have any other concerns about programme operations?

Probe for:

Staff conflicts	Organisational support	Agency co-ordination
Staff turnover	Follow-up support	Cultural processes
Funding	Inappropriate referrals	Availability of resources
Allocation of resources	Admission criteria	

16. Overall, what aspects of the programme are working well?

17. What aspects of the programme could be improved?

Prompts: Strengths/weaknesses, things liked/disliked, best components/poor components.

18. Is there anything you don't like about working in this agency?

19. What do you like best about working in this agency?

20. Do you have any further comments?

Thank you for participating in this research.

Interview: Programme Staff Perceptions of the Adolescent Programme

Section 1: Background Information

A. First of all, I would like to ask you some questions about your role in the organisation so that I get a few background details.

1. To start, can you tell me about what you do in your organisation?

2. How long have you been working for the organisation?

3. What kinds of work experience/life experience do you bring to your current job?

4. What are your qualifications?

B. I'd now like to ask you some questions about training, supervision and organisational support.

1. What in-house staff training have you received since commencing employment with this organisation? Obtain description.

Checklist: Job induction/orientation training, individualised training goals/training programme.

2. How is your work performance measured?

Checklist: Annual performance reviews/performance appraisals, client/family/whanau feedback (system reviews), supervision, self-appraisal.

3. What are your arrangements for receiving supervision?

Checklist: Internal clinical supervision, external professional supervision, group supervision (team supervision, family therapy supervision, peer supervision).

4. Do you have any suggestions for improvement?

5. What are your arrangements for receiving cultural supervision for Maori clients?

6. What are your arrangements for receiving cultural supervision for Pacific Islands clients?

7. a. What are your arrangements for receiving cultural supervision for other ethnic identities?

b. Do you have any suggestions for improvement?

8. a. How does your agency demonstrate its awareness of the need for staff self-care?

Checklist: Opportunities for collaboration, clinical supervision, training opportunities, stress reduction, discussing personal impact of work, balanced caseloads, monitoring workloads.

b. Do you have any suggestions for improvement?

Section 2: Referral Processes

In the next section, I'll be asking you some questions about your agency's liaison with referrers.

1. a. I understand that the majority of your referrals come from CYF. Are there any other agencies that SAFE/WellStop/STOP should be networking with? Obtain detail.

b. If yes, why is this not happening?

2. Thinking about your agency's relationship with referrers, can you think of any ways that it could be improved? (Try and name 3)

Section 3: Assessment

I'd now like to ask you some questions about the assessment process in your organisation. I'd like to start by getting some background information.

1. a. Before the assessment interview takes place, what systems do you have in place for matching clients to staff?

Prompt: What procedures are in place to ensure clients are allocated to staff member most appropriate for their needs e.g. culture, personal circumstances, risk level, gender, special needs.

b. What could be improved?

2. During the assessment interview with the client, what risk assessment tools do you use?

3. a. What other sources of information are used in determining the level of risk of clients?

b. Can you think of any ways that this could be improved?

Prompt: In order to increase the accuracy of the information that is being used in forming risk predictions

4. a. What systems are in place for assessing clients with complex backgrounds e.g. multiagency involvement and comorbid conditions?

b. Do you have any suggestions for improvement?

5. a. Following the assessment process, to whom do you provide feedback?

b. How is this done?

c. When is it done?

d. Do you have any comments to make about the feedback process?

e. What suggestions do you have for improvement?

Section 4: Client Groups

In the next section, I'll be asking you some questions about the availability of treatment for different types of adolescent sex abusers.

1. a. Up till now, only small numbers of adolescent girls have taken part in the programme. Why do you think this is?

b. Looking at their access to treatment – do you have any comments?

Prompts: Could it be improved? How could it be improved?

2. What do you think are the barriers to treatment (if any) for clients in the following groups? At the same time, I'll be asking you about what you believe can be done to remove these barriers. (Try to elicit up to 3 for each group).

a. Children aged 10-12 years

Barriers:

Solutions:

b. Maori clients

Barriers:

Solutions:

c. Pacific Islands clients

Barriers:

Solutions:

d. High risk clients

Barriers:

Solutions:

e. Lower intellectual functioning clients

Barriers:

Solutions:

Section 5: Cultural Services

In the next section I'll be asking questions about the ways in which the cultural needs of Maori are addressed in this organisation. I am interested in any suggestions you have for improvement.

1. What is the ratio of Maori staff to Maori clients?

2. Are Maori clients seen by Maori staff? If yes, please describe how this occurs. If no, why not? Do you have a future plan to address this?

3. a. Can you please comment on how appropriate the programme is in meeting the needs of Maori.

b. Do you have any suggestions for improvement?

4. a. As a Maori staff member how supported are you in this agency? In what ways?

b. Do you have any suggestions for improvement?

Section 6: Programme Delivery and Outcomes

In the next section, I'll be asking you some more questions about the adolescent programme. To start, I'll be asking about the implementation of programme goals, the therapeutic models used and your preferences. I am also interested in finding out about the factors that contribute to positive and negative outcomes. As we go along, I'll be asking you for suggestions for improvement.

1. As I understand it, these are the programme goals of your agency……(read list).
   Do you think these goals are being met? In what ways? (Be as specific as possible).

Checklist: Changing sexually inappropriate behaviour, fostering sexually/socially appropriate behaviour, developing equal relationships and respect for others, taking responsibility, awareness of offence cycle, sex education, supporting parents.

2. In your opinion, how could programme goals be improved? (Try and name 3).

3. I understand that the dominant therapeutic approaches to working with adolescent clients in this agency are…..

Checklist: Individual/group/family.
CBT/psychodynamic/behavioural/pharmacological/MST/psychodrama.

   a. What is your opinion of the treatment models used in this programme?

   b. What would you like to see more of? And why?

   c. What would you like to see less of? And why?

4. a. Thinking back over your involvement with the programme, can you give an example of a client who has done particularly well?

b. In your opinion, what were the contributing factors that assisted this client to do really well?

Checklist: Stable living arrangements, involvement of family, stability of school, support systems in community, positive peer relationships, prosocial hobbies and interests, therapeutic relationship, accurate assessment of risk and need, staff characteristics.

5. a. Can you give an example of a client who has not done well on the programme?

b. What do you think were the contributing factors that made it difficult for him to do well?

Checklist: Impulsivity, chaotic family environment, parental rejection, lack of family involvement, frequent changes of address, influence of peer associates, substance abuse, comorbidity.

6. So in general, what do you think are the factors that most contribute to successful treatment outcome? (Try and name 3). And why?

7. Similarly, what do you think are the factors that contribute to poor outcomes? (Try and name 3). And why?

8. Thinking about programme operations, do you have any other concerns that have not been covered in this interview?

Probe for:

Staff conflicts	Organisational support	Agency co-ordination
Staff turnover	Follow-up support	Cultural processes
Funding	Inappropriate referrals	Availability of resources
Allocation of resources	Admission criteria	

9. Overall, what aspects of the programme are working well?

10. What aspects of the programme could be improved?

11. Is there anything you don't like about working in this agency?

12. What do you like best about working in this agency?

13. Do you have any further comments?

Thank you for participating in this research.

Interview: Adolescent Perceptions of the Adolescent Programme

Section 1: Background Information

First of all, I would like to ask you some questions about yourself so that I get a few details about your background.

1. How old are you? Age:

2. What part of Auckland/Wellington/Christchurch do you live in?

3. How long have you lived there?

4. Who do you live with?

Probe for: Family/foster parents/residential facility.

5. Are you still at school?

   If yes, what year are you? Year:

   If no, how far did you get in school? Year:

6. If no longer at school, are you working now?
   If yes, what kind of work do you do?

   How long have you worked there?

   If no, what kind of work or training would you like to do?

7. Can you tell me a bit about how you like to spend your spare time? (Hobbies, any particular interests, music, sports).

8. How long have you been going to the programme?

Section 2: Referral Process

In this next section I am going to be asking you some questions about what it was like for you when you first found out that you'd be going to the programme at SAFE/WellStop/STOP.

1. How did you find out about the programme?

2. a. Thinking back to this time, what can you remember about the sorts of things were you told about the programme?

b. What other things would have been helpful for you to know?

3. Can you tell me about some of things that went through your mind when you found out that you'd be going to the programme?

4. What did your Mum/Dad/whanau/foster parents think about you going to the programme?

5. a. Thinking back to this time, what was the most difficult thing for you?

b. What would have made it easier for you?

c. What helped you the most?

Section 3: Assessment Process

I'm now going to be asking you some questions about how things were for you when you first went to SAFE/WellStop/STOP to be assessed.

1. Who went with you to your first appointment?

2. Can you tell me a bit about what it was like when you first got there, (some of your first impressions)?

Checklist: Location, building, reception, staff, assessment interview.

3. a. Suppose I had been with you during your first interview, what sorts of things would I have heard you talking about?

Checklist: Family background and involvement, school, friendships, hobbies, interests, sports, sexual abusing.

b. What did you find most helpful?

c. What did you find most difficult?

d. What would have made it easier for you?

4. a. What information were you given about the programme?

b. What was most helpful?

c. What other information would you have liked?

Section 4: Programme

A. I'd now like to ask you some questions about the programme at SAFE/WellStop/STOP.

1. Can you tell me about some of the things that you have been doing on the adolescent programme?

2. Thinking about the individual sessions you've attended over the last couple of months, what are some of the things you have been talking about that are important for you to remember? I'd also like to find out why you think they are important. Try and name 3 things.

3. For the group therapy sessions that you've attended over the last couple of months, what are some of the things you have talked about that are important for you to remember? I'd also like to find out why you think they are important. Try and name 3 things.

4. For the family sessions that you've attended over the last couple of months, what are some of the things you have talked about that are important for you to remember? I'd also like to find out why you think they are important. Try and name 3 things.

5. a. Thinking about your individual, group, family sessions, what have you found most helpful? And why?

b. What has been most difficult? And why?

6. a. Suppose I was with you during one of your review meetings, what sorts of things would I see happening?

Prompts: What sorts of things do you talk about? What would be going on? Describe to me what one of those sessions is like.

b. What have you found most helpful in these meetings?

c. What sorts of things have been unhelpful?

7. a. Do you have any comments to make about the staff you have dealings with at the programme?

b. Thinking about the staff, what has been helpful?

c. Has anything been unhelpful?

B. I'd now like to ask you some questions about the ways in which your Mum/Dad/whanau/foster parents take part in the programme.

1. a. Firstly, how have Mum/Dad/whanau/foster parents been involved in the programme?

b. In what ways has this helped you?

c. Can you think of anything that could be done to make it better?

2. a. Since you have been going to the programme, has anything changed about your relationship with your Mum/Dad/whanau/foster parents?

Checklist: Living arrangements, contact with family members, interpersonal relationships, conflict resolution.

b. What do you think are the reasons for this?

Section 5: Cultural Services

In the next section I'll be asking you some questions about the ways in which the programme meets your cultural needs. I am interested in any suggestions you have for improvement.

1. To start, can you tell me what is your experience about being a Maori?

2. As a Maori, how comfortable have you felt about being at SAFE/WellStop/STOP?

3. What did they do at SAFE/WellStop/STOP to address your Maori issues?

4. What suggestions do you have that would make things more comfortable? How could things be improved?

Section 6: Improvements and Outcomes

Finally, I'd like to ask you some questions about how you think the programme has helped you and how you think the programme could be improved.

1. a. Think back about your time on the programme. Can you name 3 things that have been helpful? I'd also like to know why they were helpful.

b. Can you name 3 things that have been unhelpful? Once again, I'd like to know why they were unhelpful.

2. Since you started the programme what has changed for you?

Checklist: Living arrangements, family support, healthy outlets, positive sexual knowledge, attitudes, interests and behaviours, peer relationships.

3. a. Since you have been going to the programme, has anything changed in terms of your abusing?

Probe for thoughts, feelings, behaviour, victim awareness and empathy.

b. Can you tell me what you think the reasons are for making those changes?

c. Can you think of any things that are stopping you from making changes?

Probe for aspects of the programme.

4. If you were able to change 3 things about the programme – what would they be?

5. Is there anything else you would like to say about the programme?

Thank you for participating in this research.

Additional Questions: Adolescents

1. If the young person has an assigned social worker, ask the following:

   Can you tell me a bit about your experience of the social worker you have dealings with (while you have been on the programme)?

   What works well?

   What could be improved?

2. How many changes of SAFE/WellStop/STOP staff have you had since you started treatment here?

   How has this affected your experience of being on the programme?

3. Thinking about the kind of work you have been doing here, what has helped you to learn and understand the material?

Probe for therapeutic models/ways of working/therapist relationship.

Has anything been unhelpful?

4. Do you have any particular strengths or difficulties that the programme paid particular attention to?

Prompt: Think of your risk factors eg., bad sexual fantasies, drug problems, anger problems, communication difficulties. Do you think that these were addressed on the programme? In what ways?

5. Do you have any special treatment needs that the programme did not take into account?

Probe for school issues, family functioning, social and emotional functioning, coping strategies, problem solving, interpersonal skills, self-esteem issues, early victimisation issues, offending issues, attachment issues.

Interview: Parents/Guardians/Whanau Perceptions of the Adolescent Programme

Section 1: Background Information

First of all, I would like to ask you some questions so that I get a few background details.

1. To start, do you mind telling me what your relationship to the young person/whaiora is on the adolescent programme?

2. Does he live with you?
   If yes, who else lives in the household?

   If no, who does he live with?

3. How long has your child been attending the programme?

4. How long have you been associated with the programme?

Section 2: Referral Process

I would now like to ask you a few questions about the time when you first heard about the adolescent programme.

1. Going back a bit, how did you first hear about the programme?

2. a. Thinking back to this time, what sort of information about SAFE/WellStop/STOP was available to you?

   b. What other things would have been helpful for you to know?

3. a. Did you / your family have any particular concerns about going to the programme?

b. What would have made it easier?

4. a. Did your child have any particular concerns about going to the programme?

b. What would have made it easier?

5. a. Thinking back to this time, what helped you / your family the most?

b. What helped your child the most?

Section 3: Assessment Process

I'm now going to be asking you some questions about how things were for you and for your child when your child first went to SAFE/WellStop/STOP to be assessed.

1. a. Did you go with your child to the assessment interview?

b. If yes, what were some of your first impressions when you got there?

Checklist: Location, building, reception, staff, assessment interview.

2. Thinking back to the assessment interview, what sorts of things were talked about in relation to your child?

Checklist: Family background and involvement, school, friendships, hobbies, interests, sports, sexually abusive behaviour, setting goals.

3. What input did you have during this assessment? Please comment on whether or not this felt adequate.

4. a. Around the time of the assessment, what did you find most helpful?

b. What did your child find most helpful?

5. a. Around the time of the assessment, what did you find most difficult?

b. What would have made this easier?

c. What did your child find most difficult?

d. What would have made this easier?

6. a. At this stage, what information were you given about the programme?

b. What was most helpful?

c. What other information would you have liked?

Section 4: Programme Delivery

A. I'd now like to ask you some questions about the adolescent programme at SAFE/WellStop/STOP.

1. a. What involvement have you had in the programme since your child first started attending the programme?

b. In what ways has this been helpful?

c. What other support or assistance would you like?

2. a. What information have you received about sexual abuse?

b. What other information would be helpful?

B. I'd now like to ask you a few questions about your opinion of the staff you have had dealings with at SAFE/WellStop/STOP.

1. How would you describe staff in terms of their friendliness? Can you give an example?

2. In your dealings with staff, how easy has it been to understand or follow what they have been saying?

If any difficulties reported ask: Can you give an example?

3. a. How have staff kept you informed about your child?

b. Please comment on whether or not this has been adequate. If not, what would have made it better?

4. Do you have any comments to make about the ways in which staff have helped your child?

Section 5: Cultural Services

In the next section I'll be asking you some questions about the ways in which the programme meets your cultural needs. I am interested in any suggestions you have for improvement.

1. To start, does your whanau have a strong Maori background?

2. Do you consider that your child has improved as a result of the cultural input he has received as part of his treatment? In what ways?
   If no, why not?

3. Do you think that having a Maori therapist has made a difference? In what ways?

4. Can you suggest other ways that staff could assist whanau to be more comfortable about being at SAFE/WellStop/STOP?

Section 6: Programme Improvements and Outcomes

Finally, I'd like to ask you some questions about how you think the programme has helped you and your child, and how you think the programme could be improved.

1. Thinking back to when the decision was made for your child to attend the programme, what were the expectations about coming to the programme?

   a. For your child?

   b. For yourself and your family?

2. Are these expectations being met? In what ways?

   a. For your child?

   b. For you and your family?

3. a. What kinds of differences have you noticed between your child's behaviour before and after commencing treatment? (State as specifically as possible).

Probe for: Increased sense of personal responsibility, increased self esteem, improved ability to identify high risk situations, better skills in areas of avoiding/coping with high risk situations, prosocial hobbies, maintaining positive peer relationships.

   b. In relation to each, what do you think brought that change about? When you answer this question I'd like you to consider whether the programme has been responsible for those changes compared to other things that were going on in his life at this time. (State as specifically as possible).

4. Do you have reason to believe that your child is beginning to accept responsibility for his abusing? What makes you think this? (Describe specific behaviours)

5. a. Since he started the programme, have you noticed any other positive changes in your child. (Obtain behavioural definitions).

b. If yes, why do you think this is?

6. a. Since he started the programme, have you noticed any negative changes in your child? (Obtain behavioural definitions).

b. If yes, why do you think this is?

7. Do you have any comments to make about whether the programme has helped you to feel more confident about keeping children safe from sexual abuse? In what ways?

8. a. Based on your experiences, what would you say are the strengths of this programme? Try and name 3.

b. What are the weaknesses? Try and name 3.

9. a. What are some of the things that you have really liked about the programme?

b. What about dislikes?

10. Overall, if you had the power to change 3 things about the programme, what would you make different?

11. Do you have any further comments?

Thank you for participating in this research.

Additional Questions: Caregivers

1. If the child participant has an assigned social worker, ask the following:
   Can you tell me a bit about your/your family's experience of the social worker you have dealings with (during your child's involvement on the programme)?

2. Can you tell me a bit about your child's experience of the social worker you have dealings with?

   What works well?

   What could be improved?

3. How many changes of SAFE/WellStop/STOP staff have you had since your child started treatment here?

   What impact has this had on you/your family?

   What impact has this had on your child?

4. Thinking about the kind of work that you have been doing here, what has helped you to learn and understand the material about sexual abusing?

Probe for therapeutic models/ways of working/therapist relationship.

5. Thinking about the kind of work your child has been doing here, what has helped your child learn and understand the material about sexual abusing?

Has anything been unhelpful for you/your family?

Has anything been unhelpful for your child?

6. Was there anything special about your child's treatment needs that the programme took into account?

Prompt: Think of their risk factors eg., bad sexual fantasies, drug problems, anger problems, communication difficulties.

7. Did your child have any special treatment needs that the programme did not address?

Probe for school issues, family functioning, social and emotional functioning, coping strategies, problem solving, interpersonal skills, self-esteem issues, early victimisation issues, attachment issues

Interview: External Agency Staff Perceptions of the Adolescent Programme

Section 1: Background Information

First of all, I would like to ask you some questions about your agency so that I get a few background details.

1. To start, can you tell me what your role is in this agency?

2. How long have you worked here?

3. Can you tell me about the types of services you/your agency offers.

4. Can you tell me about the relationship between yourself and SAFE/WellStop/STOP.

5. In general, what type of contact do you have with SAFE/WellStop/STOP?

Checklist: Mail, phone, site visits, personal contact with individual staff.

Section 2: Referral and Assessment Process

In this next section I am going to be asking you some questions about the referral process between your agency and the SAFE/WellStop/STOP programme. I'll also be asking you some questions about the assessment process.

1. Can you tell me about the procedures that are in place for making referrals to or receiving referrals from the programme?

2. a. Do you have any comments to make about the adequacy of the referral process?

b. What suggestions do you have for improvements?

3. a. Do you receive feedback about clients that you have referred?

b. How is this done?

c. When is it done?

d. Do you have any comments to make about the usefulness/appropriateness of feedback?

Probe for effectiveness of communication.

e. What suggestions do you have for improvement?

4. a. Thinking back over your involvement with the programme, can you tell me about any occasions when a client you referred was not accepted onto the programme.

b. What were the reasons?

c. Do you have any comments to make about the feedback you received on this/these occasions?

5. a. What input do you have in relation to the assessment and treatment planning process?

b. What are your expectations regarding consultation during this process?

c. Are these expectations being met? In what ways?

6. Overall, how well do the treatment services offered by the programme support your own services?

7. Thinking about clients that you refer for assessment and treatment, do you have any thoughts about the programme's location?

Section 3: Client Groups

In the next section, I'll be asking you some questions about the availability of treatment for different types of adolescent sex abusers.

1. a. Up till now, only small numbers of adolescent girls have taken part in the programme. What do you think are the reasons for this? (Try to name 3).

Prompt: Can you think of any barriers to their being referred?

b. Are they are able to get accepted onto the programme as easily as boys? If not, what might improve it?

2. What do you think are the barriers to treatment (if any) for clients in the following groups? At the same time, I'll be asking you about what you believe can be done to remove these barriers. (Try to name 3 for each group).

a. Children aged 10-12 years

Barriers:

Solutions:

b. Maori clients

Barriers:

Solutions:

c. Pacific Islands clients

Barriers:

Solutions:

d. High risk clients

Barriers:

Solutions:

e. Lower intellectual functioning clients

Barriers:

Solutions:

Section 4: Cultural Services

In the next section I'll be asking you some questions about the ways in which the cultural needs of Maori are met in this organisation. I am interested in any suggestions you have for improvement.

1. How culturally appropriate is SAFE/WellStop/STOP?
   What are they doing to meet the cultural needs of clients?

2. How has this benefited/not benefited your clients?

3. Do you have any suggestions for improvement that would assist SAFE/WellStop/STOP to better meet the cultural needs of clients?

4. a. How would you describe SAFE/WellStop/STOP's relationship with the Maori community?

   b. Do you have any suggestions for improvement?

Section 5: Programme

I'd now like to ask you some questions about the adolescent programme, its effectiveness and any improvements that you think could be made.

1. a. What information have you received from SAFE/WellStop/STOP about the programme?

b. What other information would be helpful?

2. a. Based on information you have received, what is your understanding of the goals of the programme?

b. Do you think that these goals are being met? In what ways?

3. a. Thinking back over your involvement with the programme, can you give an example of a client who has done really well?

b. In your view, what were the contributing factors that assisted this client to do well?

Checklist: Involvement of family, stability of school, support systems in community, positive peer relationships, prosocial hobbies and interests, quality of therapeutic relationship.

4. a. Can you give an example of a client who has not done well on the programme?

b. What do you think were the contributing factors that made it difficult for him to do well?

Checklist: High stress family environment, unstable living arrangements, parental rejection, lack of family involvement, impulsivity, influence of peer associates, substance abuse, comorbidity, parental psychopathology.

5. a. Do you receive feedback from clients and caregivers about SAFE/WellStop/STOP? If yes, what type, when and how much?

Note: Assess whether stakeholder is able to give an informed answer about programme effectiveness given the amount/type of information received.

b. Based on information you get, what is your view of the effectiveness of the programme?

6. a. Can you please comment on the effectiveness of programme staff in achieving programme goals?

b. How could staff effectiveness be improved?

7. Overall, what does the programme do really well? Try and name 3 things.

8. To summarise, can you tell me about any other ways in which the programme could be improved? Try and name 3.

9. Do you have any further comments?

Thank you for participating in this research.

Additional Questions: External agency staff

1. Thinking back over your involvement with SAFE/WellStop/STOP over the past 2 years, how many changes of staff have you experienced in relation to each child that you have had dealings with?

What impact do you think this has this had on the child and their family?

What impact has this had on your involvement with the programme?

2. Thinking about the boys that you have had dealings with on the programme, was there anything special about their treatment needs that the programme took into account?

Did any of the boys have any special treatment needs that the programme did not address?

Probe for school issues, family functioning, social and emotional functioning, coping strategies, problem solving, interpersonal skills, self-esteem issues, early victimisation issues, offending issues, attachment issues.

3. It is generally accepted that treatment is most successful when everyone works together as part of a wider system. This might include collaboration among family members, foster parents, caregivers, residential staff, and other significant adults such as social workers, teachers, care workers, and mental health professionals etc.

Do you have any comments to make about this in relation to the programme at SAFE/WellStop/STOP? Do you think the system that worked with the young person was able to meet their needs adequately?

Do you have any suggestions for how it could have been improved?

4. Over the past 2 years, what training/education have you received from SAFE/WellStop/STOP?

Has this been adequate?

What could be improved?

5. Is there anything else that you would like to say about the stakeholder relationship you have with SAFE/WellStop/STOP?

Appendix B:
Information Sheets

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STAFF INFORMATION SHEET

Improving treatment services offered by the SAFE/WellStop/STOP adolescent programme

The Project

This project forms part of an evaluation of the three main community based adolescent sexual offender treatment programmes in New Zealand. It aims to evaluate current service goals, practice and processes at the SAFE/WellStop/STOP adolescent programmes in Auckland, Wellington and Christchurch. As someone who is employed at one of these sites, we would like to talk to you about the operation and characteristics of your particular treatment programme. This information will then be used both to improve the services offered by your organisation, and to inform the work done by other organisations that provide similar services in New Zealand and overseas. It is hoped that this information will contribute to the protection of victims and their families, and enhance the rehabilitation prospects of adolescent sexual abusers.

The project is being carried out by a team of three people based at the University of Auckland. Dr Ian Lambie, a senior lecturer is the project supervisor; Associate Professor Dr Fred Seymour is a senior researcher and advisor; and Jan Geary, a research assistant is a postgraduate student studying for a Doctorate in Clinical Psychology. The research has the support of Child Youth and Family Services, who are funding this project. This study will form the basis of Jan's doctoral thesis. While working on this research, Jan will be subject to SAFE/WellStop/STOP policies, procedures and standards, particularly those relating to ethical practice and confidentiality.

Your Participation

Participation in this research is entirely voluntary. If you do agree to take part in the study, there is no obligation to answer every question and you can withdraw from the project at any time up until one month after your interview. You do not have to provide a reason.

The interview will take between 45 to 60 minutes. Jan will be asking you about your perceptions of the adolescent treatment programme at your work site. We are interested in finding out about your particular role, service delivery practices within your agency, what works well and what could be improved. There will be no forms for you to fill in. Jan will be conducting face-to-face interviews at your workplace. She will be writing down your responses and she would like to tape record your interview because we have found that this is the best way of making sure that we record what you say correctly.

Confidentiality

Jan will be the only person who will know what you have said. Programme directors and other programme staff will not see this information. To make sure of this we will put a number on your consent form. Jan will lock all the consent forms in a filing cabinet and this is stored separately from all other data. The tapes and interview notes will be identified with this number and they will also be kept in locked filing cabinets. If other people on the research team need to see the information it will only show your number. The information will not be shown to anyone outside the project team. At the end of the project the results will be reported back in a way that will not allow you to be identified. If direct quotations from your interview are used in the final report, they will be anonymous, with any potentially identifying details changed. The programme will be given a copy of the final report and Jan will send you a summary of this report.

Thank you for considering participating in our study. If you have any questions about this project at any time please contact:

Jan Geary at the above address or on 09 4889381 or at jan.geary@xtra.co.nz

OR

Ian Lambie (Project Supervisor) at the above address or on 09 3737599 Ext 85012 or at i.lambie@auckland.ac.nz

For any queries about ethical concerns please contact:

The Chair, The University of Auckland Human Subjects Ethics Committee, The University of Auckland, Research Office – Office of the Vice Chancellor, Private Bag 92019, Auckland.
Tel. 373-7999 Ext 87830.

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ADOLESCENT INFORMATION SHEET

The study

You are invited to take part in a study to give your ideas about the SAFE/WellStop/STOP adolescent programme. This study is being carried out in Auckland, Wellington and Christchurch and it has the support of Child Youth and Family Services.

What is the study about?

We are looking at how best to help young people who are attending the SAFE/WellStop/STOP adolescent programme. Because you are attending the programme right now, we would like to hear what you think. We would like to learn from you about what things are helpful and what you think could be done better. By talking to you we hope to learn how to help you and other young people in similar situations.

Who will talk to me?

Jan Geary would like to talk to you. Jan is studying psychology at the University of Auckland and she is receiving some payment from Child Youth and Family Services to do this study. Jan is interested in learning how to improve the treatment programmes for young people in New Zealand who experience difficulties with sexually abusive behaviour.

What sorts of questions will I be asked?

Jan will ask you about what it is like going to the adolescent programme and if it has been making a difference to your behaviour. Jan will not ask you why you are attending the programme – this is not what she is interested in. You will not have to fill out any forms or do any writing. Jan will be making notes during the interview and she would like to tape record what you say to her, so that she knows that she heard you correctly. It is important that you know that you don't have to take part in this study if you don't want to. If you do decide that you don't want to talk to her, this will not affect your treatment at SAFE/WellStop/STOP.

How long will it take?

Jan would like to talk to you for about 45minutes to an hour. We know that this takes up a lot of your time so we will be giving you a movie voucher at the end of the interview.

Who will know what I have said?

Jan will be the only one who will know what you have said to her. The only times that Jan might tell anyone else what you have said is if you tell her that you or someone else is in danger, or if you tell her about any offending behaviour that has not been reported. Jan will write a report based on what you and other young people like you, say. She will not put your name in this report and she will make sure that there is no way that you can be identified.

Can I pull out later if I want to?

Yes. You can tell us that you don't want to be a part of this project up to one month after your interview. You don't have to give a reason.

Who can I talk to if I have a question?

You can ask Jan questions when she comes to talk to you, or you can call her at any time on 09 4889381 or at jan.geary@xtra.co.nz.

OR you can get in touch with Ian Lambie (Project Supervisor) at the above address or on 09 3737599 Ext 85012 or at i.lambie@auckland.ac.nz

For any queries about ethical concerns please contact:

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CAREGIVER INFORMATION SHEET (with child participant)

Improving treatment services offered by the SAFE/WellStop/STOP adolescent programme

The Project

This project forms part of an evaluation of the three main community based adolescent sexual offender treatment programmes in New Zealand. It aims to improve the services offered by these programmes. We would like to learn from you what things have been helpful and what you think could be improved. This information will provide feedback to the people running the programme about changes that can be made to improve it. It is hoped that this information will contribute to the protection of victims and their families, and improve the rehabilitation prospects of adolescent sexual abusers.

The project is being carried out by a team of three people based at the University of Auckland. Dr Ian Lambie, a senior lecturer is the project supervisor; Associate Professor Dr Fred Seymour is a senior researcher and advisor; and Jan Geary, a research assistant is a postgraduate student studying for a Doctorate in Clinical Psychology. The research has the support of Child Youth and Family Services, who are funding this project. This study will form the basis of Jan's doctoral thesis. Jan would like to interview both you and your child.

Your Participation

Participation in this research is entirely voluntary. Your decision whether or not to participate in our study will not in any way affect your child's treatment at the adolescent programme. Even if you do agree to take part in the study, you and your child can pull out of the project at any time up until one month after your interviews. You do not have to provide a reason.

Each interview will take between 45 to 60 minutes. Jan will be asking you about your experiences at the adolescent programme. Jan will not ask you anything about the behaviour that resulted in your child's attendance at the programme – this is not what she is interested in. There will be no forms for you to fill in. You and your child will only need to talk about the things that you want to. There is no obligation to answer every question if you don't want to. Jan will be writing down what you say and she would like to tape record your interviews because we have found that this is the best way of making sure that we record what you say correctly.

It is possible that you or your child may find talking or thinking about some aspects of your experiences to be distressing. Should this happen, or should you wish to discuss

any issues arising during the interview, Jan's supervisor, Dr Ian Lambie is available at the number below. In recognition of the time that participation in this study involves, parents and guardians will receive petrol vouchers, and children will be given movie vouchers for agreeing to be interviewed.

Confidentiality

Jan will be the only person who will know what you and your child have said. The people you have been dealing with at the adolescent programme will not see this information. The only times that I would be obliged to disclose interview information to an outside agency is if you or your child indicate that you or your child are being harmed or is in danger, and that information has not already been reported to Child, Youth and Family Services or the police. Similarly if you or your child discloses any information to me regarding any offending that has not been reported, I may have to inform others so that action can be taken. Apart from these exceptions, we can assure you that no one else will know what you have said.

To make sure of this we will put a number on your Consent Form. Jan will lock all the Consent forms in a filing cabinet. The tapes and interview notes will be identified with this number and they will also be kept in separate locked filing cabinets. If other people on the research team need to see the information it will only show your number. The information will not be shown to anyone outside the project team. At the end of the project the results will be reported back in a way that will not allow you or your child to be identified. If direct quotations from your interviews are used in the final report, they will be anonymous, with any potentially identifying details changed. Jan will send you a summary of the report.

Thank you for considering participating in our study. If you have any questions about this project at any time please contact:

Jan Geary at the above address or on 09 4889381 or at jan.geary@xtra.co.nz

OR

Ian Lambie (Project Supervisor) at the above address or on 09 3737599 Ext 85012 or at i.lambie@auckland.ac.nz

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CAREGIVER INFORMATION SHEET

Improving treatment services offered by the SAFE/WellStop/STOP adolescent programme

The Project

This project forms part of an evaluation of the three main community based adolescent sexual offender treatment programmes in New Zealand. It aims to improve the services offered by these programmes. We would like to learn from you what things have been helpful and what you think could be improved. This information will provide feedback to the people running the programme about changes that can be made to improve it. It is hoped that this information will contribute to the protection of victims and their families, and improve the rehabilitation prospects of adolescent sexual abusers.

The project is being carried out by a team of three people based at the University of Auckland. Dr Ian Lambie, a senior lecturer is the project supervisor; Associate Professor Dr Fred Seymour is a senior researcher and advisor; and Jan Geary, a research assistant is a postgraduate student studying for a Doctorate in Clinical Psychology. The research has the support of Child Youth and Family Services, who are funding this project. This study will form the basis of Jan's doctoral thesis.

Your Participation

Participation in this research is entirely voluntary. Your decision whether or not to participate in our study will not in any way affect your child's treatment at the adolescent programme. Even if you do agree to take part in the study, you can pull out of the project at any time up until one month after your interview. You do not have to provide a reason.

The interview will take between 45 to 60 minutes. Jan will be asking you about your experiences at the adolescent programme. Jan will not ask you anything about the behaviour that resulted in your child's attendance at the programme – this is not what she is interested in. There will be no forms for you to fill in. You will only need to talk about the things that you want to. There is no obligation to answer every question if you don't want to. Jan will be writing down what you say and she would like to tape record your interview because we have found that this is the best way of making sure that we record what you say correctly.

It is possible that you may find talking or thinking about some aspects of your experiences to be distressing. Should this happen to you, or should you wish to discuss any issues arising during the interview, Jan's supervisor, Dr Ian Lambie is available at

the number below. In recognition of the time that participation in this study involves, parents and guardians will receive petrol vouchers for agreeing to be interviewed.

Confidentiality

Jan will be the only person who will know what you have said. The people you have been dealing with at the adolescent programme will not see this information. The only times that I would be obliged to disclose interview information to an outside agency would be if I decided that either you or someone else may be at risk of being harmed, and that information has not already been reported to Child, Youth and Family Services or the police. Similarly if you disclose any information to me regarding any offending that has not been reported, I may have to inform others so that action can be taken. Apart from these exceptions, we can assure you that no one else will know what you have said.

To make sure of this we will put a number on your Consent Form. Jan will lock all the Consent forms in a filing cabinet. The tapes and interview notes will be identified with this number and they will also be kept in separate locked filing cabinets. If other people on the research team need to see the information it will only show your number. The information will not be shown to anyone outside the project team. At the end of the project the results will be reported back in a way that will not allow you to be identified. If direct quotations from your interview are used in the final report, they will be anonymous, with any potentially identifying details changed. Jan will send you a summary of the report.

Thank you for considering participating in our study. If you have any questions about this project at any time please contact:

Jan Geary at the above address or on 09 4889381 or at jan.geary@xtra.co.nz

OR

Ian Lambie (Project Supervisor) at the above address or on 09 3737599 Ext 85012 or at i.lambie@auckland.ac.nz

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EXTERNAL AGENCY STAFF INFORMATION SHEET

Improving treatment services offered by the SAFE/WellStop/STOP adolescent programme

The Project

This project forms part of an evaluation of the three main community based adolescent sexual offender treatment programmes in New Zealand. It aims to evaluate current service goals, practice and processes at the SAFE/WellStop/STOP adolescent programmes in Auckland, Wellington and Christchurch. As someone who refers clients to/receives clients from the programme we would like to talk to you about your perceptions of the services they deliver. This information will provide feedback to the programme providers about changes that can be made to improve their services. It is hoped that this information will contribute to the protection of victims and their families, and enhance the rehabilitation prospects of adolescent sexual abusers.

The project is being carried out by a team of three people based at the University of Auckland. Dr Ian Lambie, a senior lecturer is the project supervisor; Associate Professor Dr Fred Seymour is a senior researcher and advisor; and Jan Geary, a research assistant is a postgraduate student studying for a Doctorate in Clinical Psychology. The research has the support of Child Youth and Family Services, who are funding this project. This study will form the basis of Jan's doctoral thesis.

Your participation

Participation in this research is entirely voluntary. If you do agree to take part in the study, there is no obligation to answer every question and you can withdraw from the project at any time until one month after your interview. You do not have to provide a reason.

The interview will take between 45 to 60 minutes. Jan will be asking you about your perceptions of the SAFE/WellStop/STOP adolescent programme and the services they deliver. We are interested in finding out how useful you perceive the programme to be and how well you believe that the programme's services integrate with your own. There will be no forms for you to fill in. For reasons of convenience Jan will be conducting the interviews by telephone at your workplace. She will be writing down your responses and she would like to tape record your interview because we have found that this is the best way of making sure that we record what you say correctly.

Confidentiality

All information obtained in the research will be treated confidentially. To make sure of this we will put a number on your consent form. Jan will lock all the consent forms in a filing cabinet and this is stored separately from other data. The tapes and interview notes will be identified with this number and they will also be kept in locked filing cabinets. If other people on the research team need to see the information it will only show your number. The information will not be shown to anyone outside the project team. At the end of the project the results will be reported back in a way that will not allow you to be identified. If direct quotations from your interview are used in the final report, they will be anonymous, with any potentially identifying details changed. Jan will send you a summary of the report.

Thank you for considering participating in our study. If you have any questions about this project at any time please contact:

Jan Geary at the above address or on 09 4889381 or at jan.geary@xtra.co.nz

OR

Ian Lambie (Project Supervisor) at the above address or on 09 3737599 Ext 85012 or at i.lambie@auckland.ac.nz

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STAFF INFORMATION SHEET (Maori)

Improving treatment services offered by the SAFE/WellStop/STOP adolescent programme

The Project

This project forms part of an evaluation of the three main community based adolescent sexual offender treatment programmes in New Zealand. It aims to evaluate current service goals, practice and processes at the SAFE/WellStop/STOP adolescent programmes in Auckland, Wellington and Christchurch. As someone who is employed at one of these sites, we would like to talk to you about the operation and characteristics of your particular treatment programme. This information will then be used both to improve the services offered by your organisation, and to inform the work done by other organisations that provide similar services in New Zealand and overseas. It is hoped that this information will contribute to the protection of victims and their families, and enhance the rehabilitation prospects of adolescent sexual abusers.

The project is being carried out by a team of people based at the University of Auckland. Dr Ian Lambie, a senior lecturer is the project supervisor; Associate Professor Dr Fred Seymour is a senior researcher and advisor; and Jan Geary, a research assistant is a postgraduate student studying for a Doctorate in Clinical Psychology. The research has the support of Child Youth and Family Services, who are funding this project. This study will form the basis of Jan's doctoral thesis. In addition, we have a Kaumatua for the research project, Rawiri Wharemate. He will be interviewing all the Maori participants while Jan writes down what you say. While working on this research, Rawiri and Jan will be subject to SAFE/WellStop/STOP policies, procedures and standards, particularly those relating to ethical practice and confidentiality.

Your Participation

Participation in this research is entirely voluntary. If you do agree to take part in the study, there is no obligation to answer every question and you can withdraw from the project at any time up until one month after your interview. You do not have to provide a reason.

The interview will take between 60 to 90 minutes. Rawiri will be asking you about your perceptions of the adolescent treatment programme at your work site. We are interested in finding out about your particular role, service delivery practices within your agency, what works well and what could be improved. There will be no forms for you to fill in. Rawiri will be conducting face to face interviews at your workplace. Jan would

also like to be present at the interview so that she can write down your responses. We would like to tape record your interview because we have found that this is the best way of making sure that we record what you say correctly.

Confidentiality

Rawiri and Jan will be the only people who will know what you have said. Programme directors and other programme staff will not see this information. To make sure of this we will put a number on your consent form. Jan will lock all the consent forms in a filing cabinet and this is stored separately from all other data. The tapes and interview notes will be identified with this number and they will also be kept in locked filing cabinets. If other people on the research team need to see the information it will only show your number. The information will not be shown to anyone outside the project team. At the end of the project the results will be reported back in a way that will not allow you to be identified. If direct quotations from your interview are used in the final report, they will be anonymous, with any potentially identifying details changed. The programme will be given a copy of the final report and Jan will send you a summary of this report.

Thank you for considering participating in our study. If you have any questions about this project at any time please contact:

Rawiri Wharemate on 021 460 764

OR Jan Geary at the above address or on 09 4889381 or at jan.geary@xtra.co.nz

OR Ian Lambie (Project Supervisor) at the above address or on 09 3737599 Ext 85012 or at i.lambie@auckland.ac.nz

For any queries about ethical concerns please contact:

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PSYCHOLOGY DEPARTMENT
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ADOLESCENT INFORMATION SHEET (Maori)

The study

You are invited to take part in a study to give your ideas about the SAFE/WellStop/STOP adolescent programme. This study is being carried out in Auckland, Wellington and Christchurch and it has the support of Child Youth and Family Services.

What is the study about?

We are looking at how best to help young people who are attending the SAFE/WellStop/STOP adolescent programme. Because you are attending the programme right now, we would like to hear what you think. We would like to learn from you about what things are helpful and what you think could be done better. By talking to you we hope to learn how to help you and other young people in similar situations.

Who will talk to me?

Rawiri Wharemate would like to talk to you. Rawiri is the Kaumatua for the Children's & Women's Hospital in South Auckland, he is Ngapuhi/Tainui descent. He is also the Kaumatua for this research project. He is interviewing all the Maori people who agree to take part in this study. Jan Geary would also like to be at the interview to write down what you say. She is studying psychology at the University of Auckland. Jan and Rawiri are receiving some payment from Child Youth and Family Services to do this study.

What sorts of questions will I be asked?

Rawiri will ask you about what it is like going to the adolescent programme and if it has been making a difference to your behaviour. Rawiri will not ask you why you are attending the programme – this is not what we are interested in. You will not have to fill out any forms or do any writing. Jan will be making notes during the interview and we would like to tape record what you say, so that we know that we heard you correctly. It is important that you know that you don't have to take part in this study if you don't want to. If you do decide that you don't want to talk to us, this will not affect your treatment at SAFE/WellStop/STOP.

How long will it take?

Rawiri would like to talk to you for about 45minutes to an hour. We know that this takes up a lot of your time so we will be giving you a movie voucher at the end of the interview.

Who will know what I have said?

Rawiri and Jan will be the only ones who will know what you have said to them. The only times that they might tell anyone else what you have said is if you tell them that you or someone else is in danger, or if you tell them about any offending behaviour that has not been reported. Rawiri and Jan will write a report based on what you and other young people like you, say. They will not put your name in this report and they will make sure that there is no way that you can be identified.

Can I pull out later if I want to?

Yes. You can tell us that you don't want to be a part of this project up to one month after your interview. You don't have to give a reason.

Who can I talk to if I have a question?

You can ask Rawiri questions when he comes to talk to you, or you can call him on 021 460 764.

OR you can ask Jan questions at the time of your interview or you can get in touch with her by phoning 0211549313 or at jan.geary@xtra.co.nz.

OR you can get in touch with Ian Lambie (Project Supervisor) at the above address or on 09 3737599 Ext 85012 or at i.lambie@auckland.ac.nz

For any queries about ethical concerns please contact:

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CAREGIVER WITH CHILD PARTICIPANT INFORMATION SHEET (Maori)

Improving treatment services offered by the SAFE/WellStop/STOP adolescent programme

The Project

This project forms part of an evaluation of the three main community based adolescent sexual offender treatment programmes in New Zealand. It aims to improve the services offered by these programmes. We would like to learn from you what things have been helpful and what you think could be improved. This information will provide feedback to the people running the programme about changes that can be made to improve it. It is hoped that this information will contribute to the protection of victims and their families, and improve the rehabilitation prospects of adolescent sexual abusers.

The project is being carried out by a team of people based at the University of Auckland. Dr Ian Lambie, a senior lecturer is the project supervisor; Associate Professor Dr Fred Seymour is a senior researcher and advisor; and Jan Geary, a research assistant is a postgraduate student studying for a Doctorate in Clinical Psychology. The research has the support of Child Youth and Family Services, who are funding this project. This study will form the basis of Jan's doctoral thesis. In addition, we have a Kaumatua for the research project, Rawiri Wharemate. Rawiri is also the Kaumatua for the Children's and Women's Hospital in South Auckland, he is Ngapuhi/Tainui descent. Rawiri will be interviewing all the Maori participants while Jan takes notes.

Your Participation

Participation in this research is entirely voluntary. Your decision whether or not to participate in our study will not in any way affect your child's treatment at the adolescent programme. Even if you do agree to take part in the study, you and your child can pull out of the project at any time up until one month after your interviews. You do not have to provide a reason.

Each interview will take between 45 to 60 minutes. Rawiri will be asking you about your experiences at the adolescent programme. Rawiri will not ask you anything about the behaviour that resulted in your child's attendance at the programme – this is not what we are interested in. There will be no forms for you to fill in. You and your child will only need to talk about the things that you want to. There is no obligation to answer every question if you don't want to. Jan would also like to be at the interview to write down what you say. We would like to tape record your interview because we have found that this is the best way of making sure that we record what you say correctly.

It is possible that you or your child may find talking or thinking about some aspects of your experiences to be distressing. Should this happen, or should you wish to discuss any issues arising during the interview, Jan's supervisor, Dr Ian Lambie is available at the number below. In recognition of the time that participation in this study involves, parents and guardians will receive petrol vouchers, and children will be given movie vouchers for agreeing to be interviewed.

Confidentiality

Rawiri and Jan will be the only person who will know what you and your child have said. The people you have been dealing with at the adolescent programme will not see this information. The only times that we would be obliged to disclose interview information to an outside agency is if you or your child indicate that you or your child are being harmed or is in danger, and that information has not already been reported to Child, Youth and Family Services or the police. Similarly if you or your child discloses any information to us regarding any offending that has not been reported, we may have to inform others so that action can be taken. Apart from these exceptions, we can assure you that no one else will know what you have said.

To make sure of this we will put a number on your Consent Form. Jan will lock all the Consent forms in a filing cabinet. The tapes and interview notes will be identified with this number and they will also be kept in separate locked filing cabinets. If other people on the research team need to see the information it will only show your number. The information will not be shown to anyone outside the project team. At the end of the project the results will be reported back in a way that will not allow you or your child to be identified. If direct quotations from your interviews are used in the final report, they will be anonymous, with any potentially identifying details changed. Jan will send you a summary of the report.

Thank you for considering participating in our study. If you have any questions about this project at any time please contact:

Rawiri Wharemate on 021 460 764

OR Jan Geary at the above address or on 09 4889381 or at jan.geary@xtra.co.nz

OR Ian Lambie (Project Supervisor) at the above address or on 09 3737599 Ext 85012 or at i.lambie@auckland.ac.nz

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CAREGIVER INFORMATION SHEET (Maori)

Improving treatment services offered by the SAFE/WellStop/STOP adolescent programme

The Project

This project forms part of an evaluation of the three main community based adolescent sexual offender treatment programmes in New Zealand. It aims to improve the services offered by these programmes. We would like to learn from you what things have been helpful and what you think could be improved. This information will provide feedback to the people running the programme about changes that can be made to improve it. It is hoped that this information will contribute to the protection of victims and their families, and improve the rehabilitation prospects of adolescent sexual abusers.

The project is being carried out by a team of people based at the University of Auckland. Dr Ian Lambie, a senior lecturer is the project supervisor; Associate Professor Dr Fred Seymour is a senior researcher and advisor; and Jan Geary, a research assistant is a postgraduate student studying for a Doctorate in Clinical Psychology. The research has the support of Child Youth and Family Services, who are funding this project. This study will form the basis of Jan's doctoral thesis. In addition, we have a Kaumatua for the research project, Rawiri Wharemate. Rawiri is also the Kaumatua for the Children's and Women's Hospital in South Auckland, he is Ngapuhi/Tainui descent. Rawiri will be interviewing all the Maori participants while Jan takes notes.

Your Participation

Participation in this research is entirely voluntary. Your decision whether or not to participate in our study will not in any way affect your child's treatment at the adolescent programme. Even if you do agree to take part in the study, you can pull out of the project at any time up until one month after your interview. You do not have to provide a reason.

The interview will take between 45 to 60 minutes. Rawiri will be asking you about your experiences at the adolescent programme. Rawiri will not ask you anything about the behaviour that resulted in your child's attendance at the programme – this is not what we are interested in. There will be no forms for you to fill in. You will only need to talk about the things that you want to. There is no obligation to answer every question if you don't want to. Jan would also like to be at the interview to write down what you say. We would like to tape record your interview because we have found that this is the best way of making sure that we record what you say correctly.

It is possible that you may find talking or thinking about some aspects of your experiences to be distressing. Should this happen to you, or should you wish to discuss any issues arising during the interview, Jan's supervisor, Dr Ian Lambie is available at the number below. In recognition of the time that participation in this study involves, parents and guardians will receive petrol vouchers for agreeing to be interviewed.

Confidentiality

Rawiri and Jan will be the only people who will know what you have said. The people you have been dealing with at the adolescent programme will not see this information. The only times that we would be obliged to disclose interview information to an outside agency would be if we decided that either you or someone else may be at risk of being harmed, and that information has not already been reported to Child, Youth and Family Services or the police. Similarly if you disclose any information to us regarding any offending that has not been reported, we may have to inform others so that action can be taken. Apart from these exceptions, we can assure you that no one else will know what you have said.

To make sure of this we will put a number on your Consent Form. Jan will lock all the Consent forms in a filing cabinet. The tapes and interview notes will be identified with this number and they will also be kept in separate locked filing cabinets. If other people on the research team need to see the information it will only show your number. The information will not be shown to anyone outside the project team. At the end of the project the results will be reported back in a way that will not allow you to be identified. If direct quotations from your interview are used in the final report, they will be anonymous, with any potentially identifying details changed. Jan will send you a summary of the report.

Thank you for considering participating in our study. If you have any questions about this project at any time please contact:

Rawiri Wharemate on 021 460 764

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EXTERNAL AGENCY STAFF INFORMATION SHEET (Maori)

Improving treatment services offered by the SAFE/WellStop/STOP adolescent programme

The Project

This project forms part of an evaluation of the three main community based adolescent sexual offender treatment programmes in New Zealand. It aims to evaluate current service goals, practice and processes at the SAFE/WellStop/STOP adolescent programmes in Auckland, Wellington and Christchurch. As someone who refers clients to/receives clients from the programme we would like to talk to you about your perceptions of the services they deliver. This information will provide feedback to the programme providers about changes that can be made to improve their services. It is hoped that this information will contribute to the protection of victims and their families, and enhance the rehabilitation prospects of adolescent sexual abusers.

The project is being carried out by a team of people based at the University of Auckland. Dr Ian Lambie, a senior lecturer is the project supervisor; Associate Professor Dr Fred Seymour is a senior researcher and advisor; and Jan Geary, a research assistant is a postgraduate student studying for a Doctorate in Clinical Psychology. The research has the support of Child Youth and Family Services, who are funding this project. This study will form the basis of Jan's doctoral thesis. In addition, we have a Kaumatua for the research project, Rawiri Wharemate. He will be interviewing all the Maori participants while Jan takes notes.

Your participation

Participation in this research is entirely voluntary. If you do agree to take part in the study, there is no obligation to answer every question and you can withdraw from the project at any time until one month after your interview. You do not have to provide a reason.

The interview will take between 45 to 60 minutes. Rawiri will be asking you about your perceptions of the SAFE/WellStop/STOP adolescent programme and the services they deliver. We are interested in finding out how useful you perceive the programme to be and how well you believe that the programme's services integrate with your own. There will be no forms for you to fill in and there is no obligation to answer every question if you don't want to. Jan would also like to be at the interview to write down what you say. We would like to tape record your interview because we have found that this is the best way of making sure that we record what you say correctly.

Confidentiality

All information obtained in the research will be treated confidentially. To make sure of this we will put a number on your consent form. Jan will lock all the consent forms in a filing cabinet and this is stored separately from other data. The tapes and interview notes will be identified with this number and they will also be kept in locked filing cabinets. If other people on the research team need to see the information it will only show your number. The information will not be shown to anyone outside the project team. At the end of the project the results will be reported back in a way that will not allow you to be identified. If direct quotations from your interview are used in the final report, they will be anonymous, with any potentially identifying details changed. Jan will send you a summary of the report.

Thank you for considering participating in our study. If you have any questions about this project at any time please contact:

Rawiri Wharemate on 021 460 764

OR Jan Geary at the above address or on 09 4889381 or at jan.geary@xtra.co.nz

OR Ian Lambie (Project Supervisor) at the above address or on 09 3737599 Ext 85012 or at i.lambie@auckland.ac.nz

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Appendix C:
Consent Forms

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STAFF CONSENT FORM

Improving treatment services offered by the SAFE/WellStop/STOP adolescent programme

I have read and understood the information sheet for volunteers taking part in this research project. I have had the opportunity to discuss the research/evaluation, ask questions and have them answered.

I understand that I may withdraw myself or any information traceable to me at any time up to one month after the interview, without giving a reason.

Please tick:

( ) I agree to take part in this research/evaluation project.

( ) I agree that the interview will be audiotaped.

Name:

Signature

Date:

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ADOLESCENT CONSENT FORM

Improving treatment services offered by the SAFE/WellStop/STOP adolescent programme

I have read the information sheet telling me about this project. This project has been explained to me by.....

I have had the chance to ask questions about it and have them answered.

I know that I do not have to take part in this project. I can stop being part of this project for up to one month after my interview. I don't have to say why.

I do not have to answer any questions that I do not want to. I can ask for the audiotape to be turned off whenever I want.

Please tick:

( ) I agree to take part in this research/evaluation project.

( ) I agree to have my interview audiotaped.

Name:

Signature:

Date:

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CAREGIVER CONSENT FORM

Improving treatment services offered by the SAFE/WellStop/STOP adolescent programme

I have read and understood the information sheet for volunteers taking part in this research project. I have had an opportunity to ask questions and have them answered.

I understand that I may withdraw myself or any information traceable to me at any time up to one month after the interviews without having to give reasons.

Please tick:

( ) I agree to take part in this research/evaluation project.

( ) I agree that my interview can be audiotaped.

Name:

Signature:

Date:

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CAREGIVER CONSENT FORM (with child participant)

Improving treatment services offered by the SAFE/WellStop/STOP adolescent programme

I have read and understood the information sheet for volunteers taking part in this research project. I have had an opportunity to ask questions and have them answered.

I understand that I may withdraw myself/my child or any information traceable to me/my child at any time up to one month after the interviews without having to give reasons.

Please tick:

( ) I agree to take part in this research/evaluation project.

( ) I agree that.....who is under my guardianship may take part in this research/evaluation project.

( ) I agree that my interview can be audiotaped.

( ) I agree that the interview of....., who is under my guardianship, can be audiotaped.

Name:

Signature:

Date:

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EXTERNAL AGENCY STAFF CONSENT FORM

Improving treatment services offered by the SAFE/WellStop/STOP adolescent programme

I have read and understood the information sheet for volunteers taking part in this research project. I have had the opportunity to discuss the research/evaluation, ask questions and have them answered.

I understand that I may withdraw myself or any information traceable to me at any time up to one month after the interview, without giving a reason.

Please tick:

( ) I agree to take part in this research/evaluation project.

( ) I agree that the interview will be audiotaped.

Name:

Signature

Date:

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Glossary of Maori Terms

aroha	love
hangi	feast where food is cooked in earth pits
hapu	subtribe of a large tribe
hinengaro	mind, heart, intellect, conscience, psychology
hui	meeting or gathering together of people for a specific reason
iwi	tribal group
kai	food
kaimahi	worker, staff
kapa haka	Maori performing arts group
karakia	incantation, prayer
Kaumatua	male elders who often act as speakers and callers, or guardians of knowledge and traditions
kaupapa	theme, philosophy, strategy
korero	speak, discuss
Kuia	female elders
mana whenua	the home people of a local area or region
marae	central meeting area of family, subtribe or large tribe; a symbol of tribal identity and solidarity
mihi	greeting, speech
Pakeha	non-Maori, white New Zealander
pounamu	greenstone
poutama	steps, pattern
powhiri	traditional Maori welcome for visitors
rangatahi tautoko	youth support
tamariki	children
tangata whenua	local people
tangi	to cry or grieve, a wake or funeral
taonga	treasure, something of value
te reo	Maori word for language
te whare tapa wha	Maori model of health that emphasises balance across spiritual, mental, physical and social dimensions (literal meaning; four sides of the house)
tikanga	Maori customs, values, principles
tinana	physical body, oneself
waiata	song, poetry, chant
wairua	attitude, spirit, mood

waka	canoe
whaiora	consumer, client
whakairo	carvings
whakama	embarrassed, shy, shame
whakaotinga	conclusion, accomplishment
whakapapa	genealogy, lineage, descent
whakatauaki	Maori proverb, saying
whanau	family
whanaungatanga	developing relationships, rapport, therapeutic alliance
whare	house, building, dwelling