

ASSESSMENT OF CHILDREN AND YOUNG PEOPLE

DISPLAYING HARMFUL SEXUAL BEHAVIOUR IN THE U.K.

CHILDREN & YOUNG PEOPLE

“For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier”
(UNCRC, Article 1)

Similarly, for the purposes of this paper, children and young people refers to those under the age of 18 years.

WHAT IS IT?

Assessment is the process by which the historical, current and offence-related information about a young person is gathered for analysis; conclusions are then drawn about the associated risks and needs.

Assessments inform clinical interventions, general case planning (e.g. accommodation & education) and risk-management considerations, as well as criminal Court sentencing, Family Court decisions and, occasionally, mental health assessments.

HISTORY

A key milestone in the emergence of systems and services to deal with this kind of behaviour in the UK was the Committee of Enquiry into Children and Young People who Sexually Abuse Other Children¹. The Committee reported in 1992 and made a number of recommendations about assessment; among them: abusive behaviour should not be looked at in isolation but the strengths of young people should also be considered; as should the degree of acceptance of responsibility for the behaviour; family background, particularly the existence of abusive behaviour towards the child concerned; and the level of risk posed to and from the child being assessed².

In the time since the enquiry, the provision of services and the associated systems have improved significantly. Alongside this, the practice of assessment has developed from one which mirrors that provided for adult sex offenders, to models more suited to the specific needs of children and young people. Research has consistently shown that adolescence is a time of rapid change across all areas of personality³, including sexual arousal⁴. As such, it is important not to apply adult models to children and young people; they are not valid.

Recognising that children and young people who display harmful sexual behaviours are first and foremost children, ways of engaging the subject of the assessment should be child centred and developmentally orientated. Assessments should engage with the child's parents and / or carers as well as with the young person. Assessments need to be alert to the child's

¹ NCH, 1992

² NCH, 1992:32

³ Prentky & Righthand, 2003

⁴ Prescott, 2006

own vulnerabilities and note any risks to the young person as well as risk that they may present to others.

CURRENT PRACTICE

Despite improvements in recent years, the provision of services for children and young people displaying harmful sexual behaviour is still patchy across the UK. During a mapping exercise conducted in 2003⁵, 42% of responding agencies rated local assessment services as either “inadequate” or “entirely unsatisfactory.”

Agencies and organisations providing assessment include those from the private, voluntary and statutory sectors (e.g. health, social services). Assessment services are available in the community, in custody and in residential settings. There is no national agreement in place guiding the nature of such assessments or prescribing by whom they should be conducted.

Recent research into the impact of trauma on the developing child, strongly suggests that such experiences can have profound and lasting effects. A young person’s sexual behaviour occurs within this context. It is important therefore that assessments should generate outcomes that address key aspects of young people’s trauma and broader neuro-psychological functioning (Creeden, 2013). Issues that might be assessed include: executive function; current trauma symptoms; memory; auditory processing; visual and spatial functioning. Ideally, these issues need to be known in order for properly targeted, offence-specific assessment and treatment planning to occur. Such assessments are normally conducted by a clinical, forensic and/or educational psychologist.

Unlike in the adult field, there are no empirically validated actuarial risk assessment instruments currently available for children and young people; so a psychometric measurement of likely future risk of re-offending is not possible.

Unaided clinical judgment assessments alone, despite high levels of practitioner confidence, have been shown to have poor predictive ability in terms of risk of future offending⁶.

There are a number of assessment tools and instruments available to guide assessment of children and young people with harmful sexual behaviour. There follows a very brief summary of the main ones⁷:

- **AIM2** – a UK derived initial risk assessment process to help determine the level of supervision needed for adolescent sexual offenders
- **ERASOR**⁸ – an empirically guided checklist to assist in the estimation of short term risk of sexual recidivism. For use with males and females aged 12-18
- **JRAS**⁹ – an empirically guided clinical instrument for the assessment of adolescent sexual offenders. Used to assess males and females aged 18 and younger (no lower age limit cited). Validity study sample were males aged 11-19

⁵ Hackett, Masson & Phillips, 2003

⁶ Hanson & Brussiere, 1998:348-362

⁷ Listed alphabetically. For fuller treatment of these instruments see Rich, 2009 and Prescott, 2006

⁸ Author: James Worling – www.forensicare.org/images/ERASOR2.0.pdf

⁹ Available at www.state.nj.us/lps/dcj/megan/jras_manual_scale_606.pdf

- **J-RAT**¹⁰ – literature and empirically-based instrument for the structured clinical assessment of male adolescent sexual offenders, or those alleged to have offended, aged 12-18
- **J-SOAP-2**¹¹ – an empirically guided checklist for the review of those factors identified as being associated with sexual and non-sexual offending. For use with 12-18 year old males who have offended or who have a history of sexually abusive behaviour
- **JSORRAT-2**¹² – actuarial assessment instrument for males aged 12-18; assesses risk of recidivism before 18 where a young man has a least one prior sexual conviction committed between the age of 12-17. Research tool.
- **MEGA**¹³ - clinical instrument designed to assess potential risk of sexually abusive behaviour for males and females up to age 19.
- **RSBP<12**¹⁴ - literature and empirically-based instrument for the structured clinical assessment for risk of continued harmful sexual behaviour in male and female children aged under 12

For a fuller treatment of the factors currently thought to be associated with risk of sexual recidivism, see Prentky et al, 2009. The assessment tools listed above take account of such factors, though the combinations used and the outcomes generated differ between instruments. It should be noted that an assessment tool is a means to evaluating level of risk – the assessment of child or young person involves a process of engagement with the child and relevant adults to ascertain what risk management is appropriate and what interventions may reduce risk over time. Rich (2009) provides a good overview of the indicative content of a comprehensive assessment of risk and need in relation to children and young people who display harmful sexual behaviours.

Any assessment of problematic sexual behaviour should, by definition, take account of what would be normative sexual behaviour for a child of any particular stage of development. A useful summary of this can be found in the Brook Traffic Light Tool¹⁵.

Young people are still in the process of considerable growth and development, and a risk assessment is likely only to be relevant for a fixed period of 6 months to a year. Reports should note when risk would need to be re-assessed.

CONCLUSION & NOTA POLICY

The assessment of harmful sexual behaviour in young people is a specialist task that requires training and clinical oversight in order to be done competently. Best practice suggests that assessments should include a preliminary examination of trauma symptoms and contextual neuro-psychological functioning

Given what we know from the current research and practice of risk assessment in the United Kingdom, NOTA suggests the following policy items:

¹⁰ Author: Stetson School – www.stetsonschooll.org/Clinical_Materials/Assessment_Tools/assessment_tools.html

¹¹ Authors: Robert Prentky & Sue Righthand – www.csom.org

¹² Author: Douglas Epperson – dle@iastate.edu

¹³ Author: L.C. Miccio-Fonseca – lcmf@cox.net

¹⁴ Author: Tracey Curwen – tracey@nipissingu.ca

¹⁵ Available at: <http://www.brook.org.uk/index.php/traffic-lights>

- That the term “assessment” be adopted, on the understanding that this will incorporate risks (to and from the young person) and needs (treatment, educational, social, psychological, etc.).
- That use of the term “risk assessment” should be avoided as this suggests that the only issue being considered is the young person’s potential to harm others or themselves.
- Assessments should take full consideration of the young person’s intellectual and neuro-psychological functioning and be formulated in such a way as to gather the most accurate and pertinent information. This will ensure that any clinical interventions are maximised and that needs planning and risk management can be focussed properly.
- Where pertinent, assessments should offer a view as to the systemic issues currently at stake; for example, child protection registration, Family Court considerations and criminal Court sentencing.
- Ideally, conclusions about level of risk should include a specific statement about their time-limited validity; this reflects the developmental fluidity of young people’s functioning and the potential for both positive and negative shifts in risk status.
- NOTA does not recommend any specific instrument for the purpose of assessment of harmful sexual behaviour in young people.

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By Jonny Matthew & Stuart Allardyce
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