

Children and young people who have engaged in harmful sexual behaviours: using evidence to support treatment

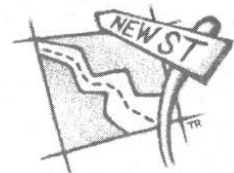
**Children in Care Collective Forum:
Children with Harmful Sexual Behaviors in Care
PwC, Barangaroo, Sydney, 16 November 2018**

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SCHN & NSW Ministry of Health



- Safety
- Multi-agency platform
- Supervision
- Improving responses for Aboriginal young people
- Adequacy of responses
- Unstable residence
- Availability of parallel specialist services
- Family involvement
- Peer relationships
- Online/ technology
- Outreach
- Poor data available
- Model of care
- Information for parents & carers
- Support and therapy for parents & carers
- Organisational strategies include HR
- Training staff
- Supervision
- Physical environment
- Assessing risk
- Case management
- Advocacy
- OOHC
- Prioritising service populations

Treatment service challenges

- Supervision
- Adequacy of responses
- Pressure to find and hold placements
- Therapeutic care
- Complex needs
- Availability of specialist services
- Family involvement
- Peer relationships
- Online/ technology
- Workforce management
- Opportunities for developing peer relationships
- Poor data available
- Training of carers
- Information for carers
- Organisational strategies include HR
- Physical environment
- Awareness of risk
- Case management
- Advocacy
- Risk of exploitation
- Space for normative development
- Sibling connections
- Risks associated with early sexual engagement

Range of OOHC issues

- Poor OOHC data internationally

Moore et al 2016

International research shows:

- Higher prevalence of child sexual abuse in OOHC compared with general population, with highest rates in residential care
- Child and young person self-report identifies significantly higher rates than noted by professionals working with them
- Disclosure increases after leaving care

Euser et al 2013

- Evidence children in residential care at risk from peers and staff in these settings

Schwartz 2014

Data re OOHC

- Children who have displayed PSB or HSB prior to coming into care. Of these some are known, some unknown. Of the known group, some come into care as a consequence of displaying this behaviour
- Children who first display PSB/HSB after coming into care
- Same observations in relation to being sexually exploited or harmed

Children in care and PSB/HSB

Rapid Evidence Assessment: Principles and approaches of best and promising practice in therapeutic treatment of children with problem sexual behaviour, sexually harmful behaviour, and children who have sexually offended.

Shlonsky, A., Albers, B., Tolliday, D., Wilson, S., Norvell, J., Kissinger, L. (2017). Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney.

Note also: Goodman, Epstein & Sullivan (2017), Beyond the RCT: Integrating Rigor and Relevance to Evaluate the Outcomes of Domestic Violence Programs, American Journal of Evaluation, pp1-13

Evaluation

- Review of Randomised Controlled Trials and Quasi-Experimental Design studies
- 3 target groups
- Not limited to Institutional settings
- International review
- Rapid review
- Published, grey literature, meta-analyses*
- Systematic review strategy – transparent and replicable research strategies
- Content specialist provided additional studies
- Review of data from Australian jurisdictions

Only 27 studies met RCT/QED criteria ...what does this mean? Most more than 6 years old

- 2 for under 10's
- 1 for children 10-17 with HSB (New Street)
- 24 for children 10-17 who have sexually offended (MST strongest*)

- Insufficient statistical strength to demonstrate difference in repeat harming
- Marked difference in completers Vs non completers
- Different profiles and outcomes for girls
- Unique outcomes in relation to the subsequent safety and wellbeing of children referred for HSB

New Street Evaluation 2006, 2014

- Holistic and ecosystemic
- Family /care and context focussed
- Developmentally appropriate
- Coordinated multi-agency in partnership with families
- Individually assessed and unique therapeutic processes (with specialist approach to the HSB)

**Key elements for programs
(Royal Commission research)**

- Non specialist service response
- Engaging, supporting and reflecting alone insufficient
- Manualised group based programs
- Group programs which can produce peer contagion
- Aggregating children based on sexual behaviours
- Failing to attend to trauma

Features to avoid (RC research)

- Same time at RC research, different research strategy –qualitative synthesis
- Mirrored the RC recommendations with exception of one approach, MST (though noted research*)
- Recommends all treatment be family engaged, holistic, developmental and engage multiple systems
- Based on individual assessment of C&YP
- HSB requires specialist work

2016 NICE (The UK National Institute of Health Care and Excellence) Review

Factors such as:

- Non-integrated service system
- Competition for funds
- Expertise not being available in correct place
- Shortening funding cycles

can make commercial products attractive, especially where systems have been incapable or unwilling to invest in service development.

Despite convenience and claims of superior performance, commercial products may not deliver

A note on commercial products

- Multiple trials internationally have failed to demonstrate claimed results in USA are transferable or can be generalised
- Cautious recommendation in RC report
- Poor Cochrane review 2006
- Updated review presented at GEIS by Prof, Julia Littell (Melbourne, November 2018)
- MST research predominantly by developers or collaborators
- Non-publication of poor or equivocal MST results. Most recent example STEPS-B project in UK (London) 2015-2017

MST-PSB a case in point

- Principal investigator Prof Peter Fonagy. Research team a mix of MST collaborators and external including Dr Michael Seto
- Multi-site trial failed. Did not recruit expected numbers
- First extensive publication of MST research strategy and results
- Aim to reduce OOHC placement of young people displaying HSB and to reduce repeat harm
- Nil difference in OOHC success and worse outcomes MST for HSB, though returned to nil difference when outlier removed from data set

Fonagy et al (2017) *Children's Social Care Innovation Programme Evaluation Report 42*, UK Department for Education

STEPS-B

- Study design marginal in achieving RCT status
- High level of exclusions
- Inequity between treatment providers
- Professional ethical issues under articulated
- Raises questions re MST research more broadly, particularly as a large general MST trial in UK also failed in 2017
- MST failures typically presented as local service system failures to recruit sufficient or suitable participants, absence of skilled local therapists and failure to achieve fidelity to treatment model. After numerous failures this must now cast doubt over the transferability of MST at the very least

STEPS-B

Qualitative review with MST team:

- Surprised and disappointed at results
- Felt achieved high level of family engagement
- Therapists reported the model and personnel were not equipped to manage complex trauma. Skill and time deficits identified

No qualitative review was undertaken with MAU therapists

MST-PSB unlikely to be trialled again in the UK (personal communication with Prof Peter Fonagy). Preference to building an enduring local capacity for therapy programs which incorporate the elements identified as effective in the literature

STEPS-B

- Assessing and intervening in relation to harming sexual behaviours has a distinct knowledge and skill base
- Has not been demonstrated in any research that non-specialist or mixed service provision is effective
- While many of the children and young people referred have trauma histories, some do not. The understanding and management of safety including potential for harming of others has distinct differences to other sexual harm intervention
- It is a responsibility of specialist services in OOHC or therapeutic responses to collaborate as while specialist services are important, no single agency can manage on their own

Why specialist?

- Structured but flexible to meet the needs and developmental status of the child
- Comprehensive assessment of child and their family, carers and social context
- Developmental stage, gender, learning ability, culture, religion
- Factors that may have contributed to HSB: Trauma, past experiences, current safety
- Dynamic and ongoing assessment of the HSB

Recommended HSB intervention

- Safety planning: immediate and prospective
- Creating safety to address HSB
- Overcoming denial: systems, care agency, family, child
- Addressing trauma and its effects including improving capacity to self-regulate
- Cultural care – genuine
- Relational work and family connection
- Sex and relationship education
- Life story
- Identity
- Peer relationships
- Education engagement
- Residential stability – belonging
- Community integration

Elements

Farmer and Pollock (2002, 2003) suggested 4 components:

1. Supervision
2. Sex Education
3. Modification of inappropriate sexual behaviour
4. Therapeutic attention to needs underlying these behaviours

Early work on HSB and OOHC

Little published on the topic. An exception is Helen Masson et al (2013)

- To be provided with information regarding the child's history at time of placement
- Training for carers
- Support for care of child including connection with specialist services
- Safety management
- Managing around contact child has with family

Carers opinions

- Note higher levels of risk for children in OOHC and need for sex ed and space for normative sexual development
Timmerman & Schreuder (2014)
- Ensuring care is a place of belonging and “home”
- Avoid sexual saturation of living environment
- Support children through safe, stable and enduring relationships
- Target areas of general as well as individual risk. E.g accessing sexually explicit material online
- Substantial workforce issues
- Not underestimating underlying factors which may trigger or drive HSB

In relation to OOHC

- Who has primary responsibility for family?
- Supporting birth family to process own trauma
- Recognising significance of family to identity, and long term connection and attachment ... including return of children to family after leaving care
- Potential of working towards return to family, relationally as minimum
- Supporting and managing contact and evolving relationships

Family

Harmful Sexual Behaviour Framework (2017)

NSPCC and Durham University

An evidence informed operational framework
including self-audit tools for organisations working
with children with HSB

Useful tool

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