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# Pragmatism and practicalities: Residential placement and reintegration of young males who have sexually abused

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## Introduction

Human service responses to sexual abuse perpetrated by young people are often extensive and expensive, and yet many aspects of these responses remain contentious. In 2007, as members of Aotearoa New Zealand Association of Social Workers (ANZASW), we prepared a submission to the Social Services Committee for the Inquiry into the Care and Rehabilitation of Youth Sex Offenders. This paper expands on points made in the ANZASW submission, with a particular focus on availability of suitable residential placements for young men who have sexually abused. The paper then considers issues relevant to reintegration of these youth into the community following a period in residential placement.

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A significant proportion of young men who have engaged in sexually abusive behaviour, and who come to the attention of professionals in Aotearoa New Zealand, are assessed as needing to be temporarily removed from their family home and/or community. When this recommendation is made by a social worker or specialist clinician it is likely to be informed by a vast body of research-based practice guidelines and assessment tools. It may be made because of the assessed risk of reoffending, or other issues, such as ongoing impacts on victim(s) in the home, or risk of retaliation against the youth perpetrator. While most recommendations for alternative placements are made by professionals, some families make the decision themselves that the young person who has perpetrated the abuse should be removed from the family home. And some of these families secure alternative residential placements without statutory involvement. For some, the removal from home becomes permanent.

It is widely recommended that successful rehabilitation requires availability of a continuum of alternative residential placement options for young people who are not able to

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remain at home. Yet in reality, limited options currently exist within New Zealand as this area of practice continues to be under-resourced and 'under-professionalised'. Therefore, new revelations or perspectives about placement of young people who have sexually abused are challenging legislators and services nationally and internationally, with no country having yet forwarded a comprehensive model for this aspect of intervention.

This article focuses on the living or residential placement options available for young men who have engaged in sexually abusive behaviour, their families and the workers who are charged with the task of sourcing and securing placements. We also acknowledge the greater recognition now being given to young women as perpetrators of sexually abusive behaviour (Bumby & Halstenson-Bumby, 1997; Grayston & De Luca, 1999; Harrison, 1994; Johnson & Shrier, 1987; Schwartz & Cellini, 1995). A New Zealand study commissioned by the STOP Adolescent Programme in 2003 (Evans, Cosgrove, Moth, & Hewitson, 2004) recommends that assessment tools and guidelines for intervention be developed to meet the specific needs of young women as perpetrators of sexual abuse as evidence suggests these may differ from that of young men.

## **Treatment**

Specialist treatment programmes in New Zealand for young people who have sexually abused have their origins in North America. While originally lagging behind, the New Zealand treatment programmes have developed to the point that they offer more responsive, holistic and family-focused intervention programmes than their North American counterparts (Lambie, 2007). These community-based specialist treatment programmes in New Zealand work with the majority of adolescents who are engaged in treatment for sexually abusive behaviour.

It is now generally accepted that comparing New Zealand treatment programmes with those in North America is of limited value.

Clinical experience would suggest that a child living in a residential centre in the United States would be living in the community in New Zealand. It is likely that the psychological and safety needs of young people and their families can be better met in community settings (Lambie, 2007, p. 9).

In New Zealand, the majority of young men who receive treatment for their sexually abusive behaviour do so at a non-residential, community-based treatment programme. Such programmes are offered by a number of specialist services (Lambie, McCarthy, Dixon, & Mortensen, 2001; Lambie & Seymour, 2006). While individually tailored, programmes generally include individual, group and family therapy (Lambie & McCarthy, 1995; Lambie et al., 2001). Treatment is relatively holistic and inclusive, with treatment goals targeting sexual abuse-specific areas as well as broader life skills. The treatment frameworks guiding interventions with youth in New Zealand for many years mirrored the 'good lives model' advocated by Ward and others (Ward, 2002; Ward & Stewart, 2003). The outcome data from a New Zealand study has highlighted the effectiveness of this targeted, yet holistic approach in the low rates of sexual reoffending for youth who completed the treatment programme (Lambie, 2007).

A recent outcome evaluation study that involved 682 youth found low levels of sexual recidivism (2%) for youth who had successfully completed treatment (Lambie, 2007). The

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sample was made up of youth who had been referred to one of the three New Zealand community-based treatment programmes. While international variances in treatment programme structure and delivery are acknowledged, this New Zealand research data compares positively with international studies that have found higher sexual reoffending rates for youth in other countries. For instance, an evaluation of reoffending by young people who had completed treatment in Australia found a reoffending rate of 11% (Allan, Allan, Marshall, & Kraszlan, 2003). Despite this positive outcome data, sufficient funding of specialist treatment programmes is required to enable providers to continue to recruit and retain suitable clinical and social work staff and continue to provide effective interventions. This is an essential element in maintaining the interface between the specialist treatment programme and residential providers, and in supporting youth and their families/caregivers.

Most of the community-based treatment programmes in New Zealand operate in large cities with some providing satellite services to other regions. However, these community-based programmes are not residential treatment programmes. This means that while these programmes provide a comprehensive service to youth and their families, they operate in an 'out-patient' mode. Alternative residential placements include living with extended family, general or one-to-one foster carers, in boarding situations, family or group homes. This means that at different times, in concentrated areas of the country, a relatively high number of residential placements for youth attending treatment programmes is being sought.

Young men referred to treatment programmes to deal with their sexually abusive behaviour require safe and appropriate living situations. While some young men may remain in the family home, many will require residential placement outside the immediate family for much of the time they are attending the treatment programme. Effective treatment for sexually abusive behaviour can be lengthy, with the young person and his family attending the programme for a period ranging from several months to three-and-a-half years (Evans, 2007). Therefore, these alternative residential placements are often required for long periods of time.

While they are limited, residential placement options do exist in New Zealand. At one end of the continuum, the Christchurch-based, Barnardos-operated Te Poutama Arahi Rangatahi is the only residential facility with a treatment programme available nationally for youth who have sexually abused (Evans, 2007). Young men residing in this facility are able to attend school and receive treatment for their sexually abusive behaviour. However, specific intake criteria (age, care and protection status, and so on) limit the number of young men who can access residential placement and treatment in this 12-bed unit.

Prison provides another 'residential' treatment opportunity. Currently in New Zealand, there is no comprehensive prison-based treatment specialist programme available to youth who have sexually offended. Limitations within the prison system and the narrow catchment of Te Poutama Arahi Rangatahi draw attention to a significant gap in providing a continuum of both treatment and residential placement within the New Zealand context.

## **Rationale for residential placement**

A recommendation to place a young person in an alternative placement may be made immediately by a statutory social worker (for example, from Child, Youth and Family), or

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later by a treatment programme clinician. The recommendation may be made because of the assessed risk of reoffending or other issues relating to the sequelae of the sexual abuse, such as impact on victim(s) or safety of the family from acts of violence within their community. While the clinical rationale for the decision may be clear, removal from home will have an impact on the young person and his family, including the victim(s), and needs to be a part of a planned process. Clinical assessment for placement out of the home includes an appraisal of the following areas:

- Nature of sexually abusive behaviour.
- Level of risk of reoffending.
- Level of intrusiveness of sexually abusive behaviour.
- Physical, sexual, psychological safety for victims.
- Extent to which victim has disclosed.
- Input from counsellor working with children/siblings.
- Whether sibling(s) receive counselling.
- Parent(s) ability/willingness to maintain safety.
- Parent(s) ability to cope with impact and continue to provide support and supervision.
- Resources: Personal, material, educational.
- Physical, sexual, psychological safety for young man.
- Interpersonal relationships.
- Feasibility of out-of-home placement.
- Availability of suitable placement.
- Level of inappropriate sexual fantasies, arousal, masturbation, risk factors, skills to manage effect.

Further, placement of a young person out of the family home, when siblings have been the victims of the sexual abuse, allows:

- Space for children who have been abused to access treatment.
- The young man to develop strategies to manage inappropriate sexual fantasies, manage affect appropriately, and so on.
- Comprehensive development and implementation of safety plan.
- The experience of consistency in boundaries.
- The experience and development of skills pertaining to peer relationships (if group home or familial/foster placement).

It is clear that in both national and international contexts, there are limited residential placement options available for young people who have sexually abused. Unfortunately, residential placement decisions are often dictated by availability. This may mean that less than adequate attention can be given to: the needs of family of origin and the young person; the level of risk presented by the young person; or the vulnerability of others in the placement setting. International literature reports similar issues. In fact, Araji (1997) cited a report indicating that 50% of sexually aggressive children were not in a placement of choice but in the only placement available. More recently, it has been suggested that 'some young people are directed into expensive and scarce residential programmes without due attention being paid to their specific needs' (Bankes, 2006, p. 77).

Alternative residential placement facilities, such as group homes or foster placements, may also be home to young people with challenging behaviour and/or a history of abuse/

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neglect. In the United Kingdom, those making residential placement recommendations repeatedly highlight concerns about placement availability. These workers emphasise the vulnerability of 'looked after children' that may be in the same residence and, therefore, at risk from young people who have previously engaged in sexually abusive behaviour (Masson, 1997/98).

Similar concerns are raised by social workers and specialist clinicians in this field of practice in New Zealand. While some young people are able to reside in specialist residential placements, others, particularly younger youth, may be placed in generic children's homes or residences. Placement with vulnerable children may be more likely in situations where the perpetrator is also vulnerable and is chronologically or developmentally younger than other young people.

Essentially, there is currently a lack of suitable emergency, and short- and long-term community-based accommodation options in New Zealand. Ultimately, this can lead to engagement in inappropriate options within the community, such as accommodation in motels with minders as well as in institutions or group homes with younger vulnerable children.

## **Challenges**

As in New Zealand, the lack of emergency residential placement facilities for young people who have sexually abused is of significant concern in the United Kingdom (Hackett & Masson, 2006). Emergency residential placements would provide options for social workers when residential treatment or community-based placements have broken down during and after treatment. They could also provide an option for workers and families in the immediate aftermath of disclosure or discovery of abuse. At this time, safety concerns are very apparent and there can be a significant wait for referral to family group conferencing or to a specialist treatment programme, then specialist assessment, engagement in treatment and securing of an ongoing alternative residential placement. The time frames involved in this process can be variable and, depending on individual circumstances, waiting lists and other factors, can range from a few months to a few years.

Young people who have sexually abused should not be placed in foster environments with other vulnerable children due to the risk of the young person perpetrating further abuse or being subject to allegations of abuse. And yet group homes or alternative forms of shared lodgings for these young people are not always appropriate. For some, there is also a reasonable risk that they will abuse each other. Sexually abusive behaviour can also become prevalent in group homes (Green & Masson, 2002). A group home or residential treatment facility charged with caring for young people assessed as at high risk of sexual recidivism can become a closed, institutional environment. Within such an environment, sexist, homophobic and violent behaviour can become common place, and staff can feel uninformed, unsupported and under-resourced (Green & Masson, 2002). For ethical and appropriate services to be delivered, such group homes or residential facilities must be staffed with people who have the necessary training, skills and experience to provide appropriate supervision, care and support for young people. Staff need access to ongoing support around impacts of the work they are engaged in, specific training and quality supervision on an ongoing basis. Making additional resources available to this group of caregivers may increase retention and ultimately grow the workforce capacity in this specialist field.

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In order to address the residential placement needs of this population, it is essential that all providers are resourced to provide specialist residential services. In national and international contexts, indiscriminate placement and a lack of planning can be attributed to limited resources (Bankes, Daniels, & Quartly, 1999; Green & Masson, 2002). This is a serious issue and, as Farmer and Pollock (1998) highlight, a lack of planning is representative of inadequate preparation, training, supervision and support for carers, and low engagement of child protection services. This pattern may result in placement problems, difficulties maintaining the young person in treatment, high stress for caregivers, and problems in managing transition from treatment and from placement as well as negative implications for family reintegration. The question of which services or providers are responsible for ensuring a comprehensive system that delivers a continuum of care is developed remains unanswered.

### **Location, location, location**

While many of the community programmes offer satellite treatment programmes, residential placements are not always available in or close to the young person's local community. Further, youth in rural communities and small towns situated some distance from the community programme they need to attend (i.e., West Coast, Southland, and Oamaru) are likely to have to move to access specialist treatment and a safe and appropriate living environment. These realities create greater demand for residential placement options in concentrated regions.

Another consequence of concentrated service provision is that it can be more difficult for treatment providers to engage family in treatment when the family resides in a geographically remote area and treatment and residential placement occur in main centres. Similarly, concerns have been voiced in the United Kingdom about the impact of this physical distance and limited face-to-face contact on family reunification (Bankes, 2006). While this is a significant issue for all residential providers in New Zealand, it is more critical for a national residential treatment programme such as Te Poutama Arahi Rangatahi that draws clients from around the country. And while the availability of amenities such as a family room is helpful, there are no on-site facilities for families to spend time with their son in a home-like setting. Interactions during visits in artificial environments can be contrived and awkward and bear limited likeness to usual family dynamics and little relationship to successful reintegration.

However, despite the many hurdles identified above, when a young person is placed outside the family home, reunification of some description is most often seen as an important goal. Many young people will seek out family support while they transition from residence – even if they are not returning home (Wade, 2008). Therefore, managing issues of grief, loss and impacts on parents (Evans, 2007), the turbulence that can characterise transition, and the complexities of reconnecting family relationships are critical aspects of work with young people in this field (Evans & Connolly, 2005).

Allardyce and Yates (2009) reported that out of a sample of 34 boys who had sexually abused at home, in the community or both, there were three cases of youth who abused siblings on a visit home during the period of time that they were placed outside the family home. This reinforces the position taken within this paper that contact and reintegration requires careful assessment, planning and implementation.

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## Residential placement – transition to independence

As noted previously, periods of residential care for youth who have sexually abused can be extensive (Evans & Connolly, 2005). And over the course of long-term therapy, there can be increased carer or therapeutic staff changes, residential placement breakdown and frequent moves (Bankes et al., 1999). Youth moving through transition processes face enormous challenges and are more vulnerable than they might otherwise be (Snow, 2008). Youth in these situations require skills to enable them to return to live with their families and for the possibility of independent living. And, of course, the goals of the youth in relation to transition may differ from those of the professionals working with them (McCoy, McMillen, & Spitznagel, 2008).

Access to housing has been identified as a significant issue for youth leaving care, and workers play a crucial role in securing access for many young people (Dixon, 2008; Simon, 2008). Unfortunately, inconsistent support offered by workers during and following transition from residential care has been shown to compound many issues for some youth (Goddard & Barrett, 2008). In order to support youth through transition processes, workers require resources, skills and practice frameworks to approach their work in informed ways.

Social learning and behavioural perspectives inform traditional models of residential care. From these perspectives, difficult or problematic behaviour tends to be contained and controlled (Moore, Moretti, & Holland, 1998). Because of these frameworks and the nature of caring for multiple high-risk youth, residential care environments can be characterised by control, surveillance and lack of privacy. Within the residential care context, youth may have had limited opportunity to develop individuality and prepare for independence (Green & Masson, 2002). For example, opportunities to participate in sporting or vocational activities may be limited by staffing and transport resources.

Balancing community safety with the individual youth's treatment goals is an inherent aspect of a planned transition process. It is important that as each youth's internal control and insight into sexually abusive behaviour increases, the continuing or new residential placement should match this process with reduced surveillance and expanded opportunities for independence. Youth transitioning to independent living or return to family situations during or at the culmination of treatment have specific needs that should inform placement decisions. Yet the difficulties in securing any residential placement for youth in treatment for sexually abusive behaviour (particularly for those aged over 17 years) flow on to even greater difficulty in sourcing 'move-on' or 'step-down' placements for these youth.

It has been argued within this paper, that programmes that provide highly structured residential interventions for youth who have sexually abused, must be part of a transition system that actively addresses factors related to poor outcomes. To realistically provide 'step-down' placements for youth exiting Te Poutama Arahi Rangatahi, statutory social workers need resources to recruit and retain appropriately experienced and qualified caregivers to work mainly or solely with youth in their care who have sexually abused (ANZASW, 2007).

Sourcing an appropriate placement with access to school and follow-up counselling services is especially critical when a youth is transitioning from residential treatment programmes, such as Te Poutama Arahi Rangatahi, as he is likely to have attended school

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and experienced day-to-day life largely within the confines of the institution. It is critical that the youth experience graduations beyond graduation from the care and protection system (Reid, 2007; Vacca, 2008). Many youth in care have achieved low levels of educational attainment and this disadvantage is frequently compounded by lack of attention to their educational needs within the care and protection system (Crawford & Tilbury, 2007; Vacca, 2008). It is argued that attending to the educational needs of youth while they are in residence and as they transition out of residential placement is likely to assist them to develop and consolidate skills related to their future success in the world (Crawford & Tilbury, 2007; Reid, 2007).

Transitions rarely go as planned (Kroner, 1997). A factor that significantly impacts on transition processes is the allocation of resources. Resources need to be allocated to ensure the best possible transition is made from residential placement (and from treatment) to home or independent living arrangements. This will maximise treatment gains and minimise risk of reoffending in the short and long term. Indeed 'there is increasing support that programmes that have adequate discharge planning, provide appropriate community after-care services, and involve significant others reduce recidivism' (Murphy & McGrath, 2008, p. 6).

The ways in which excellence in reintegration planning for people who have sexually abused may promote desistance from reoffending is worthy of exploration (Willis & Grace, 2009). In two studies of clients of New Zealand prison-based treatment programmes for adult men who have sexually abused, those who reoffended had received poorer planning for community reintegration and lower levels of planning for social and employment support (Willis & Grace, 2008; Willis & Grace, 2009).

Existing services in New Zealand could be configured differently to allow for the development of more comprehensive and seamless residential options (ANZASW, 2007). For example, greater partnerships and role clarity between Te Poutama Arahi Rangatahi, other residential providers and the community-based treatment providers could be achieved.

### **When residential placement and/or treatment fail**

The matter of transition or reintegration becomes more complicated for youth who, for a multitude of reasons, do not complete or are unable to complete treatment. Youth who do not complete treatment or are discharged from residences during treatment are a poorly understood and largely neglected population. The availability of many residential placements is contingent on the youth attending a specialist treatment programme. When treatment breaks down, a residential placement change is required. Because the cohort of treatment non-completers has a higher risk of sexual recidivism (Lambie, 2007), what happens to them when they are discharged from treatment is an important community safety issue.

Every youth will ultimately leave the supervision and support of statutory care and protection providers and this will occur whether or not they are ready and well equipped (Kroner, 2007). Indeed, in New Zealand, youth who are approaching or over 17 years of age may move to doss houses or other transitory arrangements with no supervision and minimal or no support. Many of these youth have experienced multiple adversities in their lives and may not yet have consolidated the core skills required to manage an 'accelerated transition to adulthood' and live independently (McElwee, O'Connor, & McKenna, 2007, p. 112).

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Youth who remain in care longer (until the age of 21) have been shown to have better outcomes (Courtney & Dworsky, cited in McCoy, et al., 2008). Interestingly, it has been suggested that male youth should be kept in care until an older age than female youth due to the gender differences in developmental maturity (Kroner, 2007). The challenge to this approach will be how to retain older youth in residential facilities in order for them to receive assistance that the system can provide and to do so in ways that are meaningful for them (McCoy et al., 2008).

Importantly, both youth who complete and those who do not complete sexual abuse-specific treatment have a high rate of non-sexual recidivism (Lambie, 2007). In fact, this is a significant issue with a non-sexual reoffending rate of 38% for youth who completed treatment, 44% for youth who did not receive treatment, and a rate of 61% for youth who dropped out of treatment (Lambie, 2007). Older youth are more likely to drop out of treatment (Lambie, 2007) and a better understanding of the residential and treatment needs of this group is needed within the field of treatment for sexually abusive behaviour. Further understanding of any relationship between the type of residential placement on both treatment completion and on non-sexual reoffending is needed to assist in planning and placement decisions.

## **Conclusion**

Within this paper we have argued that appropriate residential placements from disclosure to post-treatment are related to successful outcomes for youth, their families and the community. The matter of transition from residential placement has been discussed in relation to resourcing issues and a number of areas for development have been highlighted. We also made a number of key recommendations within the ANZASW submission to the Social Services Committee for the Inquiry into the Care and Rehabilitation of Youth Sex Offenders (2007, pp. 8-9). We recommended that:

- More resources be allocated to improve placement options.
- A comprehensive continuum of care and treatment must be developed, that ensures young people can receive appropriate treatment either in residential care, whilst in prison, or in their own community, including being with family / whanau.
- Child, Youth and Family recruit or contract NGO service providers to train suitable foster carers to provide specialist accommodation for young people who have sexually abused.
- Placements should be made on the basis of what is best suited to the young person's needs and level of risk.
- Planning for the care and treatment of young people who have sexually abused must be characterised by adequate preparation, training, supervision and support of carers as well as high engagement of child protection services.

It is accepted that different groups of young people who have sexually abused require tailored interventions that are relevant and appropriate to their needs. This includes a need for specialised residential and treatment services for young women who have sexually abused as well as their male counterparts. Yet gaps that compromise optimal treatment outcomes continue to be identified by researchers and practitioners. Collective responses and shared responsibility from stakeholder groups may provide an opportunity for innovative practice developments in this field.

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