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Consumer perspectives of New Zealand community treatment programmes for sexually abusive youth

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Abstract   *The aim of this process evaluation was to identify consumer perspectives of strengths and weaknesses of programme delivery at three New Zealand community treatment programmes for sexually abusive youth. Qualitative methods were employed, with data being obtained from in-depth interviews with 24 sexually abusive youth and 23 caregivers across three sites. Results indicated that clients value good pre-entry information to reduce barriers to participation; engagement in treatment is facilitated by the quality of the client–therapist relationship, family involvement, culturally appropriate communication and creative and physical activities; and post-treatment support is important. Findings highlight the importance of engaging adolescents and their families actively during the intake period, the treatment phase and post-treatment transition. They also support the use of flexible and integrated approaches to treatment that attend to the cultural context for ethnic minorities. This suggests that programmes should aim to provide wraparound services that promote engagement during the referral phase and offer transitional programmes and aftercare follow-up. Recognition should also be given to issues of cultural difference by ensuring that cultural services for ethnic minorities are integrated into all levels of programme delivery.*

Keywords   *process evaluation; sexually abusive adolescents; treatment*

Introduction

Adolescents in particular, and also children, account for a significant amount of child sexual abuse (Snyder, 2000) and some go on to offend further as adults (Hunter, 2006). However, despite the fact that the first specialized treatment programmes for sexually abusive adolescents started during the 1980s, there has been little evaluation of these programmes (Prescott & Longo, 2006). Research that has considered programme evaluation has tended to focus on treatment outcomes, with little attention paid to what happens during programme implementation. Nevertheless, there have been calls to examine the continued reliance on treatment models found to be effective with adult sex offenders (Longo & Prescott, 2006), and for programmes to address developmental and contextual issues (Ryan, 1997) and attend to the cultural context of different communities (Myers, 1998).

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Our understanding of treatment programmes is further limited by the lack of published material on process evaluations. Process evaluations seek to understand how programmes work, with a view to identifying the particular processes that contribute to different outcomes and improving programme implementation (Patton, 2002). There is a focus on the nature of people's experiences that make the programme what it is, programme strengths and weaknesses are reported from a variety of perspectives, and the nature of provider–recipient interactions is examined. The identification of factors that either impede or promote programme delivery and positive outcomes helps to inform the direction of best practice for programmes in other settings, and should also be accessible to other professionals working in the field through publication (Wolfe, Guydish, Woods & Tajima, 2004). In process evaluation it is also considered important to ask young people and their families for direct feedback on their experiences of treatment services and outcomes.

In New Zealand, treatment programmes for sexually abusive adolescents have been operating since the early 1990s. Currently there are 10 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 (Ministry of Social Development, 2006). The majority of referrals received by the adolescent programmes are from CYF (Fortune & Lambie, 2006).

In 2003, CYF commissioned a research team to conduct a process and outcome evaluation, along with a cost-effectiveness analysis of the three main community treatment programmes: SAFE Network Auckland, WellStop in Wellington and STOP Christchurch (Geary & Lambie, 2005; Lambie, Geary, Fortune, Willingale & Brown, 2007). This paper draws upon the process evaluation component of the research project. Results from the three sites have been combined and the focus is on consumer perspectives of programme delivery. In the broader process evaluation (Geary, 2007; Geary & Lambie, 2005), staff perspectives (n = 44) of programme operations and delivery were also included.

Research context

The New Zealand programmes initially incorporated aspects of interventions designed for adult offenders (cognitive behavioural approaches with a strong relapse prevention component) and for adolescent offenders (such as therapeutic wilderness programmes). However, the treatment focus broadened over time, as managers and staff furthered their knowledge by visiting "successful" programmes overseas, attending conferences, liaising with recognized experts in the field and keeping abreast with the latest research. Treatment providers also became increasingly aware of the need to adapt international practices to the New Zealand setting and to attend to the cultural context of ethnic minorities (Lambie, McCarthy, Dixon & Mortensen, 2001). Māori, who are the indigenous people of New Zealand, make up around 15% of the population (Statistics New Zealand, 2006).

At the time of the evaluation, the adolescent programmes offered treatment for up to two years for 10–18-year-olds. They catered for male and female adolescents, individuals with intellectual difficulties and developmental delay, and children. Although there were no specialized programmes for Māori, Māori clients were offered varying degrees of cultural input depending on staff availability and circumstances. The programmes incorporated traditional treatment modalities, with group interventions being the most frequently provided treatment, followed by individual, then family interventions (Willingale & Brown, 2006).

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 orientating them to treatment and providing information about sexual abuse. At four to six-monthly intervals, review meetings were held with the young person, family members and support people, members of the clinical team and professionals such as social workers, teachers, police and probation officers. At these meetings the young person's progress was reviewed and goals evaluated. Throughout treatment programme staff worked in collaboration with community and government agencies. These included CYF, police, youth justice, health organizations, residential placement facilities, schools, workplaces and youth groups. Social work support was provided by the programmes to assist adolescents with safety plans, 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.

The therapeutic approaches used by the programmes were generally consistent with the favoured treatment models described in the literature (Longo & Prescott, 2006; National Adolescent Perpetrator Network, 1993; Print & O'Callaghan, 2004; Rich, 2003). There was a strong focus on cognitive behaviour therapy and relapse prevention, family therapy and motivational interviewing. However, the programmes also incorporated models that are unique to the New Zealand context; namely, the Good Way model (Ayland & West, 2006) and Māori health models (Durie, 1994), which provide concepts and guidelines for working with Māori. The Good Way model is strengths-based, encompasses relapse prevention and incorporates language that is accessible for individuals with a concrete thinking style. It was developed by two clinicians at one site originally for use with adolescents with intellectual difficulties. Programme staff also included experiential and expressive activities as part of treatment, notably role-plays, music, games and play, drawing and writing, and active pursuits and sports. Treatment goals focused on issues of responsibility, distorted thinking patterns, empathy, relapse prevention, communication and social functioning, anger and impulsivity, previous childhood victimization and trauma, and family relationships.

An outcomes study found reduced rates of sexual and non-sexual re-offending among adolescents who completed treatment compared with those who did not attend or dropped out (Fortune & Lambie, 2006). Only 2% of adolescents who completed treatment sexually re-offended compared with 6% in the no treatment group and 10% in the treatment dropout group. These results compare favourably to re-offending rates reported in outcome evaluations of community-based programmes in other countries (Allan, Allan, Marshall & Kraszlan, 2003; Gretton, McBride, Hare, O'Shaughnessy & Kumka, 2001; Kahn & Chambers, 1991). The current study facilitates our understanding about how these outcomes might have been achieved.

Method

Qualitative data were obtained from a series of structured, open-ended interviews with 47 consumers. The study was approved by the CYF Research Access Committee and ethical approval was granted by the University of Auckland Human Participants Ethics Committee.

Interviews with key stakeholders

Consistent with qualitative approaches, relatively small samples were purposefully selected for in-depth study and to ensure maximum variation on dimensions of interest (Patton, 2002). Interviews were conducted with adolescents (n = 24), family members and caregivers (n = 23) at three geographical sites (approximately eight participants in each sample group at each site). For inclusion in the study, all participants had been involved with the programme for at least six months. Overall, Māori adolescents represent just under one-third of the total number of referrals (Fortune & Lambie, 2006).

Interview schedules were developed in consultation with programme staff, CYF personnel and Māori consultants (Geary & Lambie, 2005). The overall focus of enquiry for each interview centred on strengths, weaknesses and suggestions for improvement. Consumers were asked about the referral and assessment process, their experiences of treatment (including their opinions of staff), programme effectiveness and outcomes. Māori participants were asked the same questions as non-Māori and additional questions about the ways in which the programme met and/or did not meet their cultural needs. Handwritten notes were taken during each interview and all sessions were tape-recorded.

Adolescents

A sample of 24 adolescents with an age range of 11–19 years was purposefully selected for maximum variation by including *engaged* participants (those who demonstrated good attendance and participated in sessions), *resistant* participants (those with poor attendance and who appeared unwilling to engage in therapy), Māori, young people with intellectual difficulties and females. Programme staff were asked to approach every young person and conduct informed consent procedures. Following consultation with senior clinicians, potential participants were allocated into the categories developed for sampling. Sampling stopped once the planned numbers were reached. All interviews were conducted face-to-face in one session and ranged in length from 45 to 60 minutes.

Of the 24 adolescents interviewed, only one was female. It was not possible to recruit others, as there were only two girls in treatment at the time. The majority of adolescents (nearly 80%) were in the 13–17-years age group, with only 4% of the sample aged less than 13 years. Just over 25% of the sample identified as Māori. The length of time on the programme spanned 6 months to more than 24 months. Those who had been in the programme longer than 24 months (30%) either had intellectual difficulties or had required greater intensity of treatment. 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 (62%) were living in caregiver situations away from home. Additional problems included intellectual difficulties (33%), conduct disorder (21%), substance abuse problems (17%), attention deficit/hyperactivity disorder (12%) and autism (4%).

Family members and caregivers

Interviews were conducted with 23 caregivers. Programme staff were asked to approach all family members and caregivers of adolescents who had been engaged in the programme for at least six months (whether or not they were linked to an adolescent client interviewed). To ensure variation, we sought to interview similar numbers of foster placement caregivers and biological family members. Following completion of informed consent procedures and once numbers had been reached, face-to-face interviews were conducted with 20 participants and

telephone interviews conducted with the remainder. All interviews were conducted in one session and ranged from 60 to 90 minutes in length. Approximately one-third of the sample were male and approximately one-third were Māori. A range of caregiver roles (parent, extended family member, step-parent, placement caregiver) was represented, with around half being family members.

Data analysis

Interview data were analysed by flexibly applying the method of thematic analysis (Braun & Clarke, 2006). 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, and potentially useable quotes transcribed in full. An initial coding system was developed that reflected the focus of enquiry and issues of interest in the data. Coded data were sorted into themes and subthemes which were then reviewed and refined. Coding consistency checks (Thomas, 2004) were carried out during this process. Independent personnel were employed to code data, review findings and take part in discussions about the meaning of outliers and atypical cases. Following consensus, the scope and content of each theme was clearly identified, defined and named. The final analysis was carried out during the writing of the CYF report (Geary & Lambie, 2005). Although percentages have been used to represent the prevalence of themes in the data, it is important to bear in mind the following points. Firstly, the open-ended nature of the interviews resulted in some topics emerging spontaneously; the mention of a particular issue or topic by some participants does not mean others did not agree with the point being made. Perhaps they did not think to mention it and were not prompted to do so. Secondly, weight may have been given to the comments of several participants when they were also consistent with the interviewer's observations of programme activities and informal interactions with consumers and staff.

Results

Participants' responses were organized into six main categories, and these form the basis for discussion. The order of categories mirrors the process that an adolescent would follow in the programme: (a) the process of initial engagement; (b) engaging in treatment; (c) perspectives on therapeutic approaches; (d) perspectives on treatment modalities; (e) treatment components that facilitated change; and (f) treatment outcomes. Themes have been identified within each category.

The process of initial engagement

Interviewees 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. Four themes were identified.

Provide good programme information prior to assessment. Many adolescents (66%), parents and caregivers (74%) identified the need for more information about the programmes prior to assessment. This included information about assessment procedures, programme content and duration, placements, therapists, and confidentiality. There was also comment from some parents and caregivers (26%) that information on re-offending rates post-treatment and general information on impacts of sexual offending would have been helpful. Several parents

and caregivers (17%) would have preferred a programme staff member to visit them in their homes during the referral phase to explain information.

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. 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. When participants talked about feeling nervous or anxious, they nearly always followed this by saying that therapeutic and reception staff had alleviated their fears and apprehension by being friendly, approachable and respectful. For one parent, smiles were deemed "enough to create a different atmosphere when you bring a boy in".

Physical surroundings matter. Comments from adolescents, parents and caregivers suggested that the physical environment can have an impact on the way in which clients respond and participate in a programme. Privacy was valued by all interviewees and there was a preference for discreet buildings. While the programmes' premises all had negative points, such as appearing too sterile, shabby, being inconveniently located or having insufficient parking, several adolescents were impressed with items such as "nice bouncy furniture" and a fish tank at reception.

Some Māori parents and caregivers (43%) would have preferred that first contact with the programmes occurred in the client's home where he or she would "feel safer". There was also comment that a Māori presence within the agency could be made more visible by putting artwork on the walls and displaying Māori pamphlets more prominently.

Receiving refreshments is important. The vast majority of interviewees (87%) talked about the importance of being offered hot drinks and biscuits, especially during the referral and assessment phase. Comments about being offered refreshments, irrespective of when, nearly always occurred together with a positive comment about a therapist or another member of staff. One adolescent commented:

> 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.

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.

Therapist characteristics influence engagement in treatment. Most interviewees (81%) made positive comments about therapists and in so doing identified therapist features that helped to generate good alliances and enhance engagement in the treatment process. They valued therapists who were understanding, caring, encouraging, challenging and supportive, and respectful and non-judgemental. 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 many adolescents (62%) 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. For example, a boy who was "mad on cars" reported that his therapist helped him to explore his angry feelings by referencing his interest in cars; when the boy "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 that involved reciting to himself the alphabet linked to makes and models of vehicles—"A: Alpha Romeo, B: Bedford" and so forth.

Negative therapist behaviours identified by a few interviewees (17%) included the expression of anger, lateness for appointments, swearing, using difficult language, and failure to notify parents and caregivers about changes of session times and appointments.

Attending to the cultural context is important for Māori. Most Maori interviewees appreciated the same therapist characteristics as non-Māori. However, they also referred to the importance of having access to a Māori therapist from the outset (this did not always occur), being given sufficient time at the beginning of treatment to establish *whanaungatanga* (rapport) and communicating in culturally appropriate ways. One parent commented:

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

There were several references to slowing the pace for Māori clients and allowing them time and space to open up, as this facilitated engagement and a positive response to treatment. Many Māori parents and caregivers (86%) referred to the ability of Māori therapists to engage the adolescents using *tikanga* (Māori customs, values and principles) and other methods that they knew the young people would respond to. There were references to *wairua* (attitude or spirit), *te reo* (language), *karakia* (prayer), *mihi* (greeting), *waiata* (song), *kapa haka* (performing arts group), *kai* (food) for meetings and receiving *taonga* (something of value) at graduation.

Family support is crucial. For most adolescents (83%), irrespective of ethnicity, the participation and support of family members made a significant contribution to their involvement in treatment. Family involvement was viewed by most participants (85%) as integral to successful engagement because it provided the adolescent with support. One parent commented:

> 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, but gave him the opportunity to talk. He knew someone was sticking up for him.

For one adolescent, his parents' participation demonstrated that they still loved him despite his offending. Another adolescent commented: "If it wasn't for my parents I wouldn't be doing it".

Perspectives on therapeutic approaches

In response 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. Participants' responses were coded into three themes.

The Good Way model is effective. Comments from the participants at the site where this model was developed indicated its success in facilitating engagement, disclosure and learning about programme concepts. Young people (83%) and parents (60%) at this site described concepts from the model in detail and related incidents when they had applied these concepts to their own problems and behaviours in a wide range of situations.

Creative and physical activities are effective. Of the many adolescents (71%) who mentioned creative and physical activities, all made positive comments about these approaches and would have liked more of them. They appeared to facilitate learning of difficult material, enhance engagement in treatment and strengthen the client–therapist relationship. Participation in experiential and expressive therapies also enabled them to talk more freely. One young adolescent commented:

> It was good working in the sandpit and playing K'nex… playing and talking without knowing what I'm saying. I'd have a few laughs and just spill.

Involving the adolescent's wider network in treatment is beneficial. Comments from many interviewees (85%) suggested that the success of the programmes was attributable largely to family and caregiver involvement, and the adolescents' involvement in school, work, sports teams, church youth groups and other community activities. Parents and caregivers spoke of the benefits that accrued to young people when 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.

Several parents and caregivers (26%) made comments about staff that assisted them to develop strategies for improving communication and resolving conflicts. Some parents (27%) talked about the way therapists helped them with their own personal issues, such as relationship problems, parenting issues and prior sexual victimization experiences. Several caregivers (40%) talked about 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, as it increased the adolescents' involvement in prosocial recreational activities and provided opportunities for meaningful interactions with others. One Māori caregiver from a residential home commented:

> In terms of being Māori it is useful working with the boys—I do things differently—I take them out eeling, teach them how to do a *hangi* (feast where food is cooked in an earth pit) and teach them respect.

Despite a few references to "cool" CYF 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, missing sessions, not returning phone calls, "not getting anything done on time", high staff turnover and not being notified of changes in staff. A clear need was identified for CYF social workers to become more involved in the programmes.

The absence of post-treatment services for adolescents at programme completion was a concern for the parents and caregivers of adolescents who were nearing the end of the programme. There was also comment about the need for the programmes to take more responsibility for ensuring a smooth transition back into the community.

Perspectives on treatment modalities

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

Mixed experiences of education groups. Education groups were a significant component of treatment for parents and caregivers. They served as an induction for parents, providing them with information on sexual abuse and "how it affects the whole community, not just the abuser". Some parents (56%) described how sharing their experiences reduced their feelings of isolation and guilt. Several parents (27%) talked about how listening to the stories of adolescents who had completed the programme engendered "hope for the future". However, for some parents (36%), talking about their child's offending and listening to other people's stories was very difficult. Several parents (27%) reported they would have liked the option of attending a parent support group.

Individual therapy is valued highly. Individual therapy was valued highly by all adolescents ("you learn heaps when you do individual work with counsellors"). There were references from adolescents, parents and caregivers to the bond or friendship that developed between some therapists and adolescents. Many adolescents (79%) talked about how individual therapy provided them with opportunities to "talk privately" about topics they were struggling with, learn problem-solving skills and carry out in-depth work on personal issues which was not possible in a group setting.

Group therapy is both helpful and potentially harmful. Most adolescents, parents and caregivers shared similar views about group therapy. Many adolescents (62%) 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 destigmatizing and reduced their sense of isolation. Some adolescents (58%) valued the support of group members and learnt from being challenged. Similarly, the majority of parents and caregivers (65%) valued the way groups provided opportunities for adolescents to challenge and support each other and some caregivers (40%) identified group work as a key strength of the programmes. However, there were some negative responses to the group process. Several adolescents (21%) 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. Several parents and caregivers (17%) expressed concern about their children being exposed to harmful information and the negative influence of others.

Family therapy facilitates positive outcomes. Participants' responses to family work were overwhelmingly positive. Many adolescents (83%) and parents (82%) talked at length about issues within their families and how they had worked on them in family therapy. 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. Several adolescents (12%) also suggested that family therapy provided them with an opportunity to review their progress on the programme and their safety plans.

Although there were no negative comments about family therapy, a need was identified to expand family work, particularly in the area of family education and support, and for greater inclusion of the wider family system with Māori *whanau* (families). Some Māori parents and caregivers (57%) thought too much emphasis was placed on the individual child and "there wasn't enough consideration of the wider family context". Conceivably, this experience stems from the Māori worldview which attributes particular significance to family connections. Māori society tends to be more group-focused than western populations, and individual wellbeing is inseparable from the health of the whole group (Durie, 1994; Huriwai, Robertson, Armstrong & Huata, 2001). For Māori, the extended family is the primary support system and individuals achieve credibility when they make links to family and tribal groupings.

Review meetings place treatment into context. When young people talked about the 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. As one adolescent commented:

> 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.

Treatment components that facilitated change

These were identified from responses given by interviewees 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. Participants' comments suggested that the programmes' inclusion of traditional components (relapse prevention, sexual abuse cycle, victim empathy, anger management, and communication and social skills training) worked well. Responses revealed that adolescents, parents and caregivers attributed significance to the same components which were coded into five themes.

Treatment produces victim empathy. Victim empathy received the greatest mention by adolescents, parents and caregivers at all sites. One comment reflects the impact of this component:

> 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.

When young people recalled what they learnt about victim empathy, they mentioned putting themselves in the victim's shoes, the wider impact of their offending, apologizing and showing remorse to victims, thinking errors, minimizing, and exerting power over others. Longo and

Prescott (2006) found that fewer than 7% of adolescent programmes incorporated empathy training.

Therapy helps break the cycle of offending. Many young people (79%) and parents (63%) described what they had learned about the cycle of offending. There were a number of accounts that revealed young people had an understanding about what led to their offending, knew what they needed to do to break the pattern and were putting this into effect. This appeared to facilitate the breakthrough required for adolescents to accept responsibility for their behaviour. One adolescent commented:

> 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... break the pattern. I'm trying to live a normal life.

Relapse prevention enhances safety. The majority of adolescents gave detailed comments about safety plans and the rules they needed to abide by to prevent re-offending. Their comments suggested a clear understanding of the material. Many identified their triggers and high-risk situations and described strategies for dealing with them. Several parents and caregivers commented on the part they played in helping to keep young people safe. 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 when introduced with language that invited engagement with the material and took into account developmental and contextual issues.

Treatment helps manage anger. Anger and violence directed at parents, siblings and peers were problems that many of the young people (58%) referred to. It was evident that the programmes provided them with the concepts and skills to understand and develop prosocial attitudes and behaviours. One adolescent commented:

> 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 four or five year old, more like 12 or 13.

Several parents and caregivers (22%) described different situations where they and their children applied strategies to manage anger and impulsivity.

Learning communication and social skills is helpful. Most adolescents (71%) described learning how to communicate more effectively while attending the programmes and many parents and caregivers noticed striking improvements in this area. Adolescents described instances of talking openly and honestly about their feelings; resolving conflict by talking rather than using their fists, becoming aggressive or resentful; and using language more effectively instead of swearing or being monosyllabic.

Discussion

This study provides important information about the perceptions and experiences of sexually abusive adolescents, family members and caregivers during their involvement with community treatment programmes in New Zealand. Findings support the recent developments in research and treatment for this client group. Consumers endorsed the programmes' flexible

approach to treatment and the integration of holistic approaches into existing traditional sex offender treatment frameworks. The study also reveals areas where improvements might be made and highlights strengths that should be preserved. The clear finding about the importance of engagement from the first point of contact with the programmes went beyond a focus on the client–therapist relationship. It included the provision of good pre-entry information to reduce barriers to participation; actively engaging adolescents and their families from the intake phase through to post-treatment transition; using culturally appropriate communication; incorporating active and physical activities; and aftercare services.

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). Findings suggest the provision of good pre-entry information that is easily read and understood would allay fears and anxieties, reduce barriers to participation, and instil hope for successful treatment. For some families, engagement would have been enhanced if this introductory material had been delivered verbally in their homes. This may be particularly relevant for Māori clients. On first arrival at programme premises, being given refreshments and welcomed into conducive physical surroundings were also important.

While support for the influence of the therapeutic alliance in enhancing engagement was evident in this study, family involvement and support was vital to the adolescents' engagement in treatment. There has been little evaluation on the use of a family-focused approach with sexually abusive youth and many community-based treatment programmes prioritize individual and group therapy at the expense of family involvement (Rich, 2003). Findings from this study suggest that family involvement in treatment should be prioritized, with families being offered a broad range of interventions including family education and support. Thus, the traditional reliance on group therapy as the most frequently provided intervention may need to be reviewed alongside the need to reduce potential for harmful effects. This study highlighted the need for the programmes to take greater account of developmental and risk levels of youth when assessing their suitability for group therapy. This supports the research on iatrogenic treatment effects (Dishion, McCord & Poulin, 1999) which raises the possibility that uninformed mixing of disturbed youth with less impaired youth in therapy groups for sexual offending may be harmful (Hunter, 2006).

Despite acknowledgment 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 Māori clients. Interviews with Māori participants highlighted the importance of having a Māori therapist and communicating in culturally appropriate ways. However, despite the best efforts of staff and managers to match Māori clients with Māori staff, there were insufficiently trained Māori clinicians available to make this possible (Geary & Lambie, 2005). While these findings cannot be generalized 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) and that ethnic matching may be related to the length of time spent in treatment (Karlsson, 2005; Sue et al., 1991), it is important for programmes to attend to the cultural needs of ethnic minority groups.

Despite calls to tailor treatment to the developmental and contextual needs of individuals (Ryan, 1997), 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 sexually abusive youth (Bergman, Hewish, Robson & Tidmarsh, 2006; Lambie et al., 2000; Longo, 2004; Rich, 2003; Tyo, 2005; Worling, 2004). Findings from this study suggest that the incorporation of creative approaches which take into account clients' cultural and community context and their developmental needs, appears to facilitate the exploration of difficult issues and greatly assist engagement in treatment. Conceivably, these activities also provide adolescents with positive recreational experiences and opportunities to engage prosocially.

It has been suggested that aftercare is a critical component of treatment (Calder, 2001), and in this study families and caregivers raised concerns about the inadequate provision of aftercare services on the New Zealand programmes. In view of the finding that adolescents on these programmes were at the highest risk of sexual re-offending within the first year of completing treatment (Fortune & Lambie, 2006), the provision of effective aftercare services appears to be particularly apposite.

Conclusion

This study suggests the importance of integrating evaluation procedures that incorporate direct feedback from clients and their families about their experiences of treatment services and outcomes. While the findings confirmed high levels of consumer satisfaction and provide some understanding about what promotes positive outcomes for young people and families, they also highlighted areas for improvement. A full report of findings with site-specific commentary and recommendations for improvement was delivered to CYF (Geary & Lambie, 2005), and this has provided the basis for considering and implementing change. While it is not possible to make extensive generalizations, given New Zealand's unique social, cultural and ethnic context, and the qualitative nature of this study, the most salient recommendations outlined below may offer potential insights for service improvement in other settings, particularly for programmes that are sensitive to stakeholders' needs. Firstly, 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. Secondly, 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.

Researchers emphasize routinely the need for outcome research to inform our understanding and knowledge of treatment effectiveness. However, if we are to modify existing sex offender treatment models successfully and enhance aspects of treatment that work, we need the type of information provided by process evaluations. This form of evaluation also complements the external audits that many programmes are subjected to by capturing greater breadth and depth of information. Future studies of this type will assist us to move closer to identifying and understanding the factors involved in the successful treatment of sexually abusive adolescents.

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