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Responding to Adolescent Sexual Offending

Recommendations for a Regional Protocol

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hope
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care

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INTRODUCTION

In Canada, only the provinces of British Columbia and Nova Scotia have mandated, coordinated protocols for various systems' responses when adolescent sexual offending has occurred. This document was created out of recognition of the need for a coordinated, systemic response to adolescent sexual offending in Ontario. It is our position that effective management of adolescents who commit sexual harm is greatly enhanced by working collaboratively with the various systems within the adolescent's circle of care. As such, we have aimed to prepare a document that provides recommendations for a responding protocol by police, child protection services, and judicial services, from the point of allegations to referral for assessment and treatment.

Although we are aware that the recommendations expressed in this document represent the ideal continuum of care, and that a number of communities may not have the necessary resources available to provide this scope of care or response, we believe it is vital to provide communities with information regarding best-practice of care for adolescents who have sexually offended and their families. It is our belief that implementation of a regional protocol, along the lines of that recommended in this document, will have a direct impact on the protection of our community through responsible and ethical treatment of adolescents who have engaged in sexual offences, victimized individuals, and their families.

ACKNOWLEDGEMENTS

In preparing this document, we are grateful for contributions made by the Halton Adolescent Sexual Offence Steering Committee, a group of organizations and individuals dedicated to improving a coordinated response to community safety. These agencies include the Ministry of Children and Youth Services/Youth Justice, Halton Regional Police Service – Diversion Program, Halton Children's Aid Society, and the Reach-Out Centre for Kids (ROCK). Within these organizations and agencies, there are numerous dedicated professionals with whom we have developed supportive and collaborative working relationships, and we are very grateful for these. We would also like to recognize the Ministry of the Attorney General for its funding support of this project. Without this investment, this project would not have been possible. Thanks, as well, to David Bookalam and Margaret McConnell, for their creativity in developing the layout of this document, and to Camilla Graziani for her editorial contribution.

Although the Halton Trauma Centre has been delivering specialized services for this population of clients for a relatively short period of time, we are extremely fortunate to have recruited a clinical team we believe to be comprised of leaders in the field of interpersonal abuse, both in terms of clinical practice and research development. We thank the clinicians we work with on a daily basis at the Halton Trauma Centre for their ongoing willingness to share their wisdom, experiences, and expertise. We are particularly grateful to Dr. James R. Worling for his years of training, support, and willingness to pass on his extensive knowledge regarding adolescent sexual offending, as well as his thoughtful and invaluable review of several drafts of this document.

It would not be possible to create this type of document without acknowledging the many adolescents and their families with whom we and our colleagues have worked over the years. From these individuals, we have learned that much is possible when there is hope and a commitment to healing.

In addition to formalizing a protocol in Ontario as is recommended in this document, the next steps in the development of a continuum of care for this field would entail the development of agreed-upon practice standards regarding the treatment and community reintegration of adolescents who have committed sexual offences. We hope that this document becomes a catalyst for other professionals, agencies, and community groups to expand on the recommendations made here. As we consider this to be an evolving document, we welcome comments and suggestions from those who have attempted to implement the recommendations we have made.

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FOREWORD

Adolescents are responsible for a considerable number of sexual offences in Canada, particularly sexual offences against younger children and other teens. Although adolescent sexual offending was historically minimized by both professionals and the public, it is now known that sexual offences by adolescents are at least as damaging as those perpetrated by adults. The long-term consequences for some people who have been sexually abused can be considerable and, unfortunately, sexual assault continues to be one of the most underreported violent crimes in Canada.

With the growing recognition of the importance of addressing adolescent sexual offending, specialized treatment programs were developed in the early 1980s in Canada and the United States. When these programs were in their infancy, there was very little research or clinical expertise to guide assessment and treatment practices. This was also the case for those involved in the legal and child protection fields. As a result, many professionals erroneously relied on procedures designed for adults who had offended sexually.

Fortunately, the last three decades have witnessed a considerable increase in knowledge regarding adolescent sexual offending. Indeed, there is now research and clinical expertise from around the world to guide investigations, assessments, placement, treatment, and family reunification. There are also several best-practice guidelines that professionals can now call upon when working with adolescents and their families regarding sexual offending and sexual victimization. Furthermore, there is now research that indicates that specialized treatment significantly reduces the risk of further sexual and nonsexual reoffending by adolescents.

Despite these important scientific and clinical advances, however, there have yet to be any formal protocols to coordinate investigation, assessment, and treatment efforts in Ontario. As a result, there are currently tremendous disparities – both between and within the various regions in Ontario. Take, for example, three separate adolescents who have offended sexually against a much younger child in their community. Within one region, it is possible that one adolescent will be criminally charged and convicted, removed from the home, and placed in a residential facility for a lengthy period without specialized assessment or treatment. In this same region, another youth may simply be cautioned by authority figures. The third adolescent with the same behaviour may be criminally charged and then supported to participate in specialized assessment and treatment while living at home. Of course, there are many other possible variations, including outcomes that involve the adolescent and his or her family receiving treatment services from therapists without specialized training or experience. This disparity within any one region in the Province is not unusual, and there is considerable variability across Ontario as well.

This document represents an important first step to address some of these considerable disparities. The authors have stressed the importance of collaborative relationships among child welfare, police, courts, and clinicians, and they have carefully outlined a protocol that leads professionals from disclosure to referral for treatment services. It is also commendable that the authors have taken care to address the unique issues and struggles that are often involved when an adolescent has sexually assaulted a younger sibling. The authors have also clearly stressed the need to take a victim-centred approach to working with adolescents who have offended sexually, and they have tied the various steps in their detailed protocol to current best-practices in the field.

This protocol reflects the specialized training and extensive clinical experiences of the authors. The steps outlined herein should go a long way to ensure that adolescents who offend sexually within one region are dealt with in a similar manner - and according to current best-practice guidelines. Through more coordinated investigation, assessment, and treatment efforts, we should ultimately reduce sexual offending by adolescents.

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BACKGROUND & INTRODUCTION

During the past several decades, the issue of adolescent sexual offending has received increased clinical, empirical, and legal attention. Research findings have demonstrated that many adults who have committed sexual offences began offending as adolescents and 50% of adults who have committed sexual offences report that they experienced deviant sexual interests prior to age 18 (Barbaree, Hudson, & Seto, 1993). In Canada, 20% of those charged with sexual assault are between 12 and 17 years of age (Statistics Canada, 2007).

Research regarding sexual offending has demonstrated a relationship between sexual victimization and subsequent sexual offending. Although most survivors of sexual abuse do not go on to commit sexual offences themselves, research findings have consistently demonstrated that significant numbers of individuals who have sexually offended were sexually victimized during childhood or adolescence (Barbaree, Marshall, & McCormick, 1998; Burton & Hedgepeth, 2001; Cooper, Murphy, & Haynes, 1996; Romano & De Luca, 1997; Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996). Costin (2004) notes that “devoting resources to the issue of sexual offending has the potential to interrupt the victim-to-victimizer phenomenon; decreasing the frequency of offences and reoffences will reduce the number of future victims and this, in turn, will reduce the number of future sexual offenders” (p. 3).

In Canada, legal sanctions regarding youth are governed by the Youth Criminal Justice Act (YCJA, 2002). The YCJA (2002) identifies the need for meaningful consequences that take into account the young person’s needs and level of development and “where appropriate, involve the parents, the extended family, the community and social or other agencies in the young person’s rehabilitation and reintegration” (Section 3.c.ii). A focus on the rehabilitation of young persons is a critical component of the YCJA, along with the expectation that the least restrictive means or consequences are

implemented in sanctions for youth. While assessment and treatment options for sexually offending youth are certainly compatible with the YCJA, these are not always pursued.

INTRAFAMILIAL AND SIBLING-ON-SIBLING SEXUAL ABUSE:

The past two decades have seen a tremendous increase in publications on the subject of family sexual abuse, evidently reflecting society’s growing awareness and recognition of a problem previously hidden behind a veil of denial, secrecy, and disbelief. While the literature and professional community have focused greater attention on father-daughter incest, there is general agreement that the most prevalent type of incestuous behaviour occurs between siblings (Finkelhor, 1990; Lindzey, 1967). Furthermore, research findings and clinical experiences indicate that sibling incest can be highly intrusive and often occurs for long periods of time. For example, O’Brien (1991) found that nearly 45% of sibling offenders had durations of abuse that extended beyond one year. It is also noteworthy that opportunity is an essential element in carrying out a sexual assault (Cohen & Felson, 1979). White, Kadlec, and Sechrist (2006) found that sexual assaults by adolescents tended to occur immediately after school and, on non-school days, between 12 pm and 1 pm. Certainly, these times may correspond with limited adult supervision.

When legal sanctions include an order for assessment or treatment of an adolescent who has sexually offended, the implications are often farther reaching than to the adolescent alone. In particular, in cases of intrafamilial sexual abuse (i.e., inclusive of extended family) or, specifically, sibling incest, primary consideration must be given to the needs and wishes of the victimized individual(s), regardless of the adolescent’s participation in, or completion of, treatment.



In certain families, contact with the offending adolescent may be determined to be in the best interest of the victimized sibling(s) or relative (e.g. cousin). Although contact and reintegration will be different for every family, reunification is a goal for many families when sibling incest and/or intrafamilial sexual abuse has occurred (Association for the Treatment of Sexual Abusers, 2003). However, not all victimized siblings will desire or be emotionally capable of resuming contact with the offending adolescent. As such, in addition to assessing the offending individual's risk for reoffending and progress in treatment, as well as the development of appropriate safety plans for contact, the practice standards and guidelines published by the Association for the Treatment of Sexual Abusers (2003) stipulate the need for ensuring the victimized individual's interest in, and readiness for, reunification. Therefore, in cases of sibling incest and intrafamilial sexual abuse, intensive assessment and treatment services are necessary for the offending adolescent, victimized sibling(s)/relative(s), and other family members.

In its Best Practice Guidelines for Working with Children, Youth, & Families Who Have Experienced Abuse (2004), the Sexual Abuse Treatment Services City-Wide Steering Committee within the City of Toronto states that “contact and/or access between a child who has been abused and the offender must be determined following a comprehensive process that includes an assessment of the child, family and offender” (p.19). In addition, the guidelines state, “prior to family reunification a number of factors must be considered”. These include but are not limited to: “...the offender's ability to take responsibility for the abuse and to demonstrate cognitive and behavioural changes that significantly lower the risk of reoffence and the willingness of the family as a whole to reunify and follow any rules or restrictions that are implemented” (p.25). Although these guidelines were developed collaboratively by a number of agencies working with sexual abuse, there is no mandate by the various systems to implement them.

JUSTIFICATION FOR A COORDINATED PROTOCOL

While the statistics regarding sibling-on-sibling sexual abuse and adolescents who commit sexual offences against children are daunting, and some best-practices guidelines have been put forward, there are few, if any, mandated protocols and safeguards for victimized children and adolescents (or potentially vulnerable individuals) in these abusive scenarios. Although sexual abuse-focused organizations such as the Association for the Treatment of Sexual Abusers (ATSA) and agencies/programs within the Greater Toronto Area have developed empirically guided best-practice guidelines in favour of the “best interest of child victim(s)”, there are no regionally mandated protocols requiring Children's Mental Health Agencies, Child Welfare, Police, and Judicial services of Ontario to work collaboratively and consistently with families in the implementation of these practice standards. In Canada, only the provinces of Nova Scotia and British Columbia have systemic and coordinated responses to adolescent sexual offending.

As a result of the lack of mandated protocols, adolescents who offend sexually often remain in contact with the children they have victimized (or potentially vulnerable individuals) with few implemented safeguards. In cases where precautions are taken regarding only the physical safety of victimized children (or potentially vulnerable individuals), little regard or consideration are given to issues of emotional or psychological safety. In such circumstances, children who are victimized sexually may suffer further psychological impact as a result of the lack of attention to their emotional fears, reactions, and needs.

In addition to contact issues that arise when adolescent sexual offending has occurred, the lack of mandated protocols results in varied and, at times, seemingly arbitrary responses to allegations. Investigation outcomes, placement/residence decisions, and dispositional outcomes are largely determined by the professional involved and can vary considerably, both from region to region and within regions. Given the variability in responses, decisions do not consistently integrate and reflect current best-practices. As such, a coordinated protocol for addressing adolescent sexual offending, in both intra- and extrafamilial abuse scenarios, is much needed.

Responding to Adolescent Sexual Offending – Recommendations for a Regional Protocol

Responding appropriately to sexual offending by adolescents is a multi-level process. This process requires involvement from the many systems that are responsible for various aspects of the response such as investigation, adjudication, assessment, treatment, and supervision (Center for Sex Offender Management, CSOM, 2008). According to Talbot, Gilligan, Carter, and Matson (2002), the primary goal of any intervention is preventing future sexual victimization. These authors, and others, suggest that reducing recidivism requires multidisciplinary, multi-agency, and collaborative responses on both case management and policy levels.

Those who should be involved in collaboration when a sexual offence has been committed by an adolescent include criminal justice system personnel such as judges, crown and defence attorneys, and law enforcement officers; corrections officials; victim advocates (CSOM, 2000a); social service providers; child protection services; and school administration (Talbot et al., 2002). However, coordinating the activities/policies of different stakeholders may be difficult. Therefore, effective intervention requires cooperation and collaboration among individuals and agencies, as well as a unified goal of protecting victimized individuals and the community (Colorado Sex Offender Management Board, CSOMB, 2003; Talbot et al., 2002).

In their writings regarding the accuracy of registered data regarding adolescent sexual offending, Worling and Langstrom (2006) have identified a number of factors that can be adapted and applied in intervening appropriately and effectively when an adolescent has been accused of a sexual offence against a sibling or relative. Specifically, appropriate intervention would require that:

- 1) Victimized individuals are willing to report the offence
- 2) Adults have the ability to correctly perceive and act on information about the victimized individual
- 3) Child protection agencies have the ability to investigate in a timely and appropriate manner
- 4) Police investigate an allegation in a timely manner
- 5) Police notify relevant agencies
- 6) Investigations of both the alleged offending individual and victimized individual(s) occur (as well as family members and potential victims)

In order to effectively fulfill many of these suggested criteria, the roles and responsibilities of those involved at various levels of the system need to be delineated. Having a clear and consensus-built policy or protocol establishes the goals for the system and helps jurisdictions to clearly identify what role each agency will play in addressing and managing cases of sexual offending (CSOM, 2000b, 2008). Determining and implementing the various roles and responsibilities requires ongoing collaboration among those who are responsible for carrying out various parts of the process (CSOM, 2008). Clearly, a coordinated protocol would address issues related to steps to be taken, roles, responsibilities, and collaboration.

COLLABORATION AMONG AGENCIES



Collaboration among agencies is vital when an adolescent has been accused of a sexual offence. In order to implement a multi-system and multi-agency collaboration, it is important to develop functional and working relationships (CSOM, 2000a). According to CSOM, functional relationships will assist to address any misperceptions

or assumptions regarding the roles of other agencies in the process and enable the clear delineation of roles for each provider involved in the process (CSOM, 2000a). To date, agency collaboration may have failed due to a lack of clarity in what others are doing and who is responsible for specific roles, the belief that collaboration may make a job more difficult, a lack of knowledge and training on issues, and the belief that collaboration will not increase efficacy of work (CSOM, 2000a). In addition, when performing a task or role, there may also be a fear of crossing role boundaries (CSOM, 2000a). Therefore, clear guidelines and/or protocols outlining the responsibility and roles of various agencies should eliminate many of the above-mentioned potential detractors from successful collaboration.

Responding to Adolescent Sexual Offending – Recommendations for a Regional Protocol

According to CSOM (2000b), successful collaborative efforts involve the following key factors:

- 1) Effective communication and cooperation among the criminal justice system and professionals
- 2) Assessment of collaborative needs
- 3) Clear definition and delineation of roles
- 4) Efficient and streamlined coordination of agency tasks
- 5) Routine and regular flow of information and data
- 6) Participation and accountability of all parties involved in the process

Therefore, establishing and following guidelines regarding the management of adolescent sexual offending allegations is justified by the expectation that doing so will:

- 1) Enhance efficient handling of all involved
- 2) Ensure consideration of victimized individuals and public safety
- 3) Consider the alleged offending individual's safety
- 4) Improve the overall quality and consistency of response

THE CURRENT PROJECT

This project was initiated with the intention of creating recommendations for the first known Regional Protocol in the Province of Ontario to address the growing incidence of childhood sexual abuse by adolescent perpetrators, both intra- and extrafamilial. The overarching goal of this ongoing project is to coordinate and guide a collaborative and consistent process between Law Enforcement/Police, Youth Justice (i.e., Court System, Youth Probation), Child Welfare Agencies, Children's Mental Health, educators, special interest groups, and clinical experts in child sexual abuse and adolescent sexual offending when intervening in adolescent sexual offending. A primary goal of the current effort is to make recommendations regarding a regional protocol for addressing sexual offending by adolescents, inclusive of sibling-on-sibling abuse, that is grounded in empirically-based best-practices and can be implemented across the continuum of care (i.e., all systems involved).

In addition, a key motivating factor for this effort is the expectation that implementing a well-coordinated regional protocol which validates victimized children and adolescents' needs for both physical and emotional safety, as well as ensures the accountability of adolescents who have sexually offended, will have a profound impact on the delivery of sexual abuse services. This, in turn, should help to decrease the impact of sexual abuse on the victimized children, adolescents, and their families, particularly with respect to the impact that results from system issues.

The specific goals of developing these recommendations are to:

- 1) Coordinate and guide a collaborative and consistent process between Law Enforcement/Police, Youth Justice (i.e., Court System, Youth Probation), Child Welfare Agencies, Children's Mental Health, educators, special interest groups, and clinical experts in child sexual abuse and adolescent sexual offending when intervening in adolescent sexual offending
- 2) Implement clear and consistent best-practice standards for investigating the sexual abuse of children and adolescents when sexual offending by an adolescent has been identified
- 3) Address the removal of an adolescent who has sexually offended from the home for the purposes of assessment and/or treatment

It is expected that the proposed guidelines will:

- 1) Reduce frustration regarding the lack of appropriate or consistent responses to sexual offending by adolescents
- 2) Reduce frustration regarding poor or lack of communication between service providers
- 3) Reduce the short- and long-term impact of poor coordination of services
- 4) Effect more streamlined and collaborative approaches to allegations
- 5) Build competence in addressing safety and support issues for both victimized individuals and the public (CSOM, 2000a)

PURPOSE/USE OF THIS DOCUMENT

This document is intended for use by all professionals, systems, services, and agencies that may become involved when an allegation of a sexual offence has been made against an adolescent. This may include, but is not limited to, school personnel, police services, child protection services, youth justice (e.g., judges, probation services), and children's mental health providers.

It is critical to note that this document is only intended for use with respect to adolescents who are 12-17 at the time of commission of the sexual offence(s) that has been alleged. Under the age of 12, a child who engages in concerning sexual behaviours would not fall under the jurisdiction of the Youth Criminal Justice Act (YCJA, 2002) and would not be chargeable under the Criminal Code of Canada (1985). It is important to consider that, in cases where the child is under the age of 12 at the time of the alleged sexual behaviours, protocol guidelines and recommendations may differ. **This protocol was not developed to address situations in which children under the age of 12 have engaged in concerning sexual behaviours.**

It should also be noted that, in cases where the adolescent who has sexually offended is considerably delayed developmentally, it may be necessary to utilize judgment regarding the appropriateness of pursuing legal sanctions; however, it is important to note that individuals with developmental delays are also at risk of sexual recidivism and the absence of charges in such circumstances can lead to a lack of (or limited) resources being sought for these adolescents. Indeed, the decision to lay charges can be a complicated one and involves various potential risks and benefits.



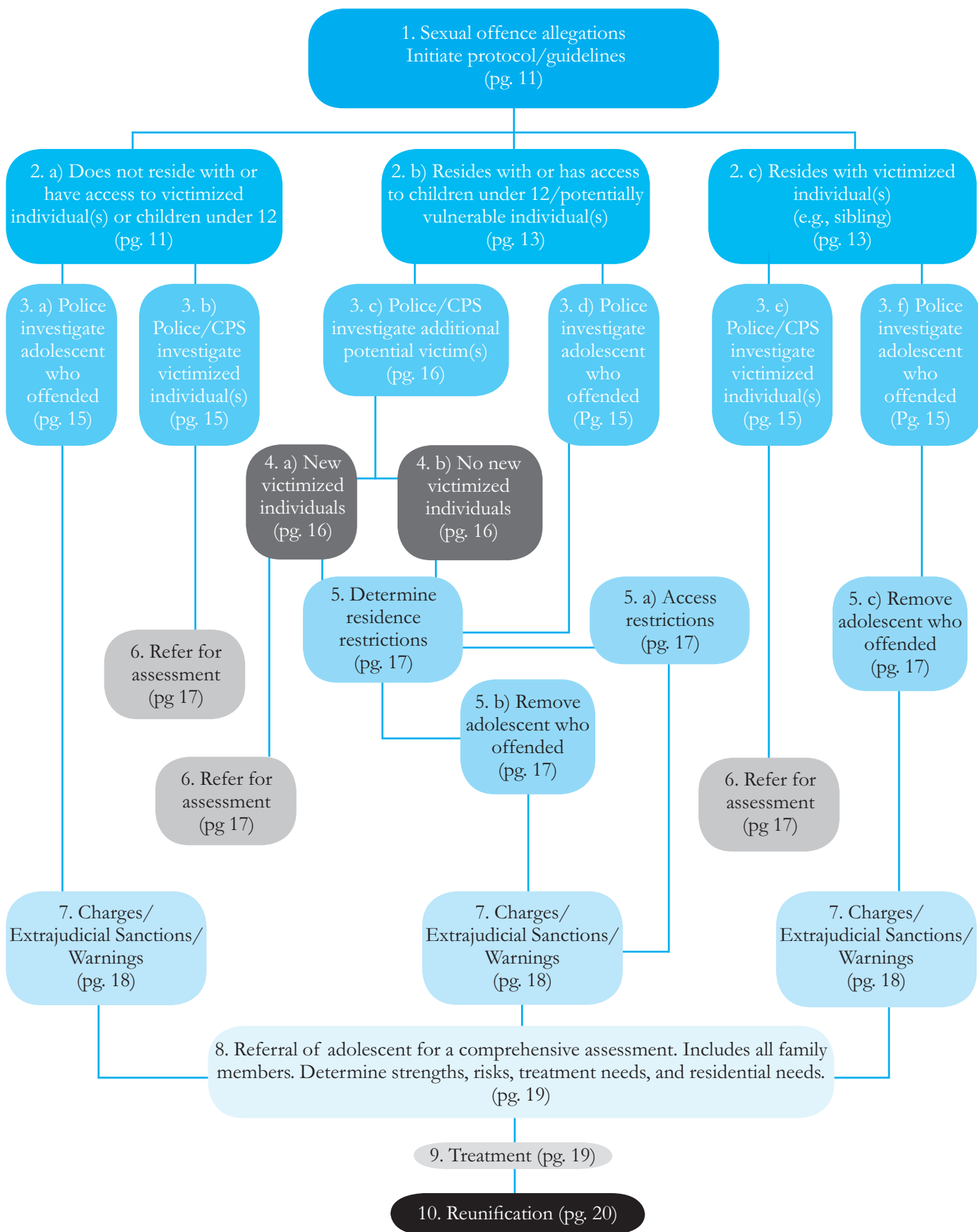
With both cognitively delayed and non-delayed adolescents, in addition to addressing accountability issues, one potential benefit of laying charges against an adolescent who is alleged to have offended sexually is that this often leads to the initiation of resources (e.g., regarding assessment or treatment) that the adolescent (and his/her family) may otherwise resist or that may otherwise be difficult to obtain. Regardless of the ultimate decision that is made regarding charges, it is recommended that investigations be pursued regarding all allegations and all those involved.

It is also important to highlight that this protocol is intended to reflect best-practices and it is recognized that, in some circumstances, some of the recommendations made may be difficult to implement. Certainly, where resources are limited, different and creative responses and solutions may be necessary. Nevertheless, it is hoped that this document will serve as a guide regarding the ideal response. As it is expected that this document will evolve over time, the authors welcome feedback from professionals and agencies regarding its utility, as well as alternative approaches that have been implemented.

ORGANIZATION OF THIS DOCUMENT

The protocol that follows includes a flow chart that is intended to serve as a quick reference for the response process. It should be noted that the numbers indicated in the flow chart correspond with the numbered sections in the document. A glossary of terms is provided at the end of the document.

OVERVIEW OF PROTOCOL



ALLEGATIONS RESIDENCE/ACCESS INVESTIGATION VICTIMIZATION RESIDENCE VICTIM ASSESSMENT CHARGES ASSESSMENT TREATMENT

THE PROTOCOL

1) SEXUAL OFFENCE ALLEGATIONS – INITIATE PROTOCOL/GUIDELINES

An allegation(s) of sexual offending has been made against an adolescent, whether at home, in the community, at school, or any combination of the above. This requires the initiation of an investigation.

INITIATING THE INVESTIGATION:

When a sexual offence by an adolescent has been alleged, it is critical that an investigation be initiated immediately. Regardless of the location of the alleged offence (i.e., school, home, community, etc.), the investigation should be conducted by the appropriate authorities:

- 1) Law Enforcement/Police services – in all cases regardless of the age of the accused adolescent
- 2) Child Protection Services (CPS) – in addition to police services, in cases where the accused is under 16 years of age and/or the victimized individual is under 16 years

Note: If the offence occurs within a school setting, it is highly recommended that school personnel make contact with the appropriate authorities in order to determine the investigation process. An internal investigation and questioning of the accused adolescent or victimized individual(s) by school personnel may influence an official investigation. School personnel should contact police services immediately and, if appropriate, child protection services as well (i.e., if school personnel are aware that the alleged victimized individual(s) is under the age of 16, the accused is under the age of 16, or the accused resides with children under the age of 16, including siblings). If the accused and the alleged victimized individual(s) are over the age of 16, only police services should be contacted. Pending the outcome of their investigation, police services should then determine if child protection services should also be contacted (e.g., victimized individuals under the age of 16 are disclosed; the accused resides with, or functions in a position of power or authority over children; etc.).

2) RESIDENCE OF THE ADOLESCENT/ACCESS TO POTENTIALLY VULNERABLE INDIVIDUALS

The adolescent's access to potentially vulnerable individuals is of particular concern, both at the time of the investigation, as well as throughout the duration of assessment (and, depending on recommendations from assessment, during treatment). At the time of the investigation, it is recommended that the adolescent's access to individuals who may be victimized be addressed immediately, regardless of whether the sexual offending occurred within or outside of the home and toward younger children, peers, or adults. As sexual preference is not necessarily related to prior sexual offence history (Hunter & Lexier, 1998; Thakker et al., 2006), the residence of the adolescent must be addressed regardless of the age of the alleged victimized individual(s), those with whom the adolescent is residing, or to whom the adolescent has access.

The following are of importance:

2. a, b) *Does the adolescent reside with, or have access to, children under the age of 12 or other potentially vulnerable individuals?*
2. c) *Does the adolescent reside with the victim(s)?*

ADOLESCENT'S RESIDENCE – RESTRICTIONS/ REMOVAL

2. a) The adolescent does not reside with, or have access to, children under the age of 12 and/or other potentially vulnerable individuals



Protocol: Do not remove the adolescent

The adolescent can remain in his/her residence as long as child protection determines that this is a safe environment (i.e., the adolescent is not in need of protection). In most cases, adolescents who have sexually offended outside the home (i.e., not against someone with whom they reside) can participate in assessment and treatment while residing with their parents (or current caregivers). It is highly recommended that caregivers be aware of the allegations and the need for supervision during the period of investigation and, if relevant, throughout the duration of a comprehensive sexual-offence-specific assessment and treatment.

Recommendation: During at least the period of investigation and assessment, the adolescent who offended sexually should not have any unsupervised contact with children under the age of 12 or other potentially vulnerable individuals. This supervision should be maintained until feedback is provided from the assessment.

Supervised contact refers to the physical presence, with direct sight of the adolescent (i.e., not in a different room), by an adult who is aware of the allegations of sexual offending and the supervision requirements.

2. b) Adolescent resides with/has access to potential child victims under the age of 12 and/or other potentially vulnerable individuals



Protocol: Temporarily remove the adolescent



Once allegations have been made, until the investigation and, if relevant, a sexual-offence-specific assessment has been completed, the adolescent should not reside with any children under the age of 12 or any other potentially vulnerable individuals.

Recommendation: If removal is necessary, the adolescent who offended sexually, not the children or other potentially vulnerable individuals, should be removed from the residence. In cases where the adolescent is removed, he/she should be placed in a residence in which there are no children under the age of 12 or other potentially vulnerable individuals. As well, the adult(s) in this setting must be made aware of the access

restrictions and supervision needs.

Although the alleged victimized individual(s) may not reside in the home, it is important to ensure that the adolescent is not residing with any possible previously victimized (i.e., by the adolescent) or potentially vulnerable individuals. Child protection should investigate the possibility that children and other potentially vulnerable individuals within the home may have also been victimized. However, as sexual assault is under reported (Smallbone, 2006; van Dijk, Mayhew, & Killias, 1991), it is important to be aware that children and other potentially vulnerable individuals residing with the adolescent may not disclose having experienced sexual abuse, even when asked. As sexual abuse commonly occurs in secrecy and often occurs within the home (Letourneau, 2006), siblings and others within the home might be particularly hesitant to disclose past experiences of sexual abuse by the adolescent.

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The issue of separating the adolescent from potentially vulnerable individuals is not confined only to protecting these individuals, but also involves addressing issues related to risk of sexual reoffending for the adolescent. Researchers suggest that adolescents' sexual interests and arousal patterns are not firmly established (Trivits & Reppucci, 2002), and patterns of offending during adolescence do not, necessarily, represent enduring behavioural tendencies (Thakker et al., 2006). As such, prior sexual assaults against only one type or group of vulnerable individuals (e.g., peer-aged individuals or only males) do not guarantee that the adolescent is not at risk of a sexual reoffence against another type or group of individuals (e.g., children or females).

Temporary removal from the home may also benefit the adolescent as he/she may reside within a family that perpetuates negative attitudes, environments, or socialization that can be detrimental to the adolescent (White et al., 2006). In comparison to individuals who have committed nonsexual and nonviolent offences, sexually offending individuals are reported to have experienced more physical and sexual abuse as well as more violence, instability, and disorganization in their homes (Barbaree & Langton, 2006; Ford & Linney, 1995). Therefore, removing the adolescent will not only reduce risk by eliminating access to potentially vulnerable individuals but, in certain cases, may also remove the adolescent from a negative environment that may perpetuate violence or beliefs supportive of sexual assault.

When the adolescent is not residing with children under the age of 12 or other potentially vulnerable individuals, but has access to such individuals, the appropriateness of the access must be investigated and determined by child protection. In addition, any access to children under the age of 12 or other potentially vulnerable individuals should be directly supervised during the assessment period and pending the recommendations of the assessment (5. a).

Recommendation: *Regardless of the age of the alleged victimized individual(s), the adolescent who offended should not be permitted to reside with any children under the age of 12 or other potentially vulnerable individuals pending the outcome of both the investigation and the recommendations of a comprehensive sexual-offence-specific assessment. When exceedingly long delays are expected with respect to accessing services, strict supervision*

measures should be implemented regarding the adolescent's access to children and other potentially vulnerable individuals against whom he/she has not previously sexually offended (i.e., not known victimized individuals).

2. c) Adolescent resides with victimized individual(s)



Protocol: Temporarily remove the adolescent

The adolescent should immediately be separated from those he/she victimized. If the sexual offending is alleged against an unrelated individual(s), but occurred within a foster home or group home setting, the adolescent should be removed from this setting pending the outcome of the investigation and the recommendations of comprehensive assessments for both the adolescent and the alleged victimized individual(s). If the sexual offending is alleged within the home (i.e., against siblings), best-practices also support separation of the adolescent from his/her siblings (Hodges, 2002). As indicated previously, whenever possible, this should involve removal of the adolescent from the home (i.e., not removing the victimized individuals).

CAUTIONARY NOTE REGARDING SEPARATION/REMOVAL OF THE ADOLESCENT:

Although separation of the adolescent from victimized and potentially vulnerable individuals is recommended, it is important to note that the time from investigation to the end of assessment can be lengthy. While removal from the home is often difficult for all involved, in some situations, a lengthy removal from the home can be particularly deleterious for the adolescent and the family (inclusive of victimized siblings). Therefore, it is strongly recommended that services be initiated as promptly as possible and that, wherever possible, unnecessary lengthy separations be avoided. As resources are often limited, resulting in long waiting lists for services, it is highly recommended that, once

underway, assessments (for all involved) be completed as expeditiously as possible. In addition, whenever feasible, preliminary feedback should be provided by clinicians with respect to contact, residence issues, and the implementation of supervision criteria.

***Recommendation:** Any contact (i.e., direct or indirect) between the adolescent who offended sexually and the victimized individual(s) should be suspended pending the outcome of the assessments and the recommendations of experienced professionals working with the adolescent who offended, the victimized individual(s), the parents/caregivers, and other family members.*

RESIDENTIAL PLACEMENT OF ADOLESCENT



In situations when the adolescent is to be removed from the home, an appropriate placement with kin who will abide by the recommendation of no contact with victimized individuals should be the first option explored. Other options include foster homes and group home settings. However, it is critical to ensure that, in any of the placement options pursued, there are no children under the age of 12 or other potentially vulnerable individuals, and the supervising adults are aware of the supervision requirements for the adolescent. As sexual offending often

involves manipulation, secrecy, and deceit (CSOM, 2000b), those responsible for the adolescent must closely monitor and implement restrictions to reduce the risk of re-offending (Worling & Langstrom, 2006). Visits with non-victimized family members (e.g., non-victimized siblings, parents) should be supported if considered safe for the adolescent (and any non-victimized siblings) by child protection services. It should be noted, however, that siblings who are believed not to have been victimized may, indeed, have been victimized as well, and investigations in this regard should be completed prior to such contact.

VICTIMIZED INDIVIDUAL'S WISHES

Although it may be believed that the physical safety of the victimized individual(s) can be ensured during supervised contact, supervision cannot address the potential emotional or psychological consequences of contact and may not prevent an ongoing emotionally abusive relationship (CAPSAC, nd). In many cases, victimized individual(s) may request to see the adolescent as, among other reasons, they might want to ensure that the offending adolescent is not angry, be forgiven for disclosing, or reduce the anger, sadness, and stress of other family members (CAPSAC, nd). However, regardless of the victimized individual's wishes, it is important that assessments for the victimized individual and the adolescent who offended occur prior to any contact. In addition, it is critical that any contact and/or reunification be guided and timed by experienced treatment providers working with all of the individuals involved and only when all treatment providers are in agreement regarding such contact (CAPSAC, nd). A good reference (Hodges, 2002) in this regard outlines 5 steps to reunification as follows:

- 1) Report the abuse and separate the victimized sibling and offending sibling
- 2) Complete evaluations of family members
- 3) Begin family therapy
- 4) Bring victimized sibling and offending sibling together in family therapy
- 5) Family therapy termination

In addition, the Association for the Treatment of Sexual Abusers (ATSA, 2003) recommends that considerations of family reunification should be given to the wishes of victimized individuals, that contact with children should be addressed as part of a comprehensive risk management plan and linked to the offending individual's risk level and progress in treatment, and that reunification should not be recommended for individuals who deny their offences or are at moderate to high risk for re-offending, as assessed by a competent assessment (i.e., that follows best-practices, for example, as recommended by ATSA).

3) INVESTIGATION

It is highly recommended that trained sexual abuse investigation teams be developed within both police services and child protection. In cases where police services and child protection will both be involved, a joint investigation is recommended as this will improve consistency in investigations, adherence to protocols/guidelines, and determinations (e.g., charges, extrajudicial sanctions, etc.) that are made. In such cases, it would be ideal to develop a joint police-child protection investigation team within the region.

One goal of the investigation for both police services and child protection should be to identify additional potential or undisclosed victimized individuals to whom the adolescent would have immediate access. Addressing the residence of the adolescent is of immediate concern in this regard and should be a priority of the investigation.



3. b, e) Interview of victimized individual(s)

All interviews with victimized individuals should be conducted with considerable priority and concern regarding the victimized individual's emotional and psychological health. Whenever possible, interviews of victimized individuals should not take place at a police station but, rather, at a place considered to be safe and comfortable for this individual.

In addition, police officers should attend in plain clothes in order to decrease fear, anxiety, and the perspective that the victimized child or adolescent has done something wrong. Furthermore, whenever possible, consideration should be given to potential gender issues (e.g., individuals might be more comfortable being interviewed by an officer of the opposite gender to that of their offender; female children might prefer a female officer and male children might prefer a male officer; etc.). Whenever possible, choice should be provided in this regard.

WHO IS INVESTIGATING?

3. a, d, f) Police investigate the adolescent

Regardless of the age of the victimized individual(s) and adolescent, the investigation and interview of the adolescent should be conducted by police services. Again, it is highly recommended that officers trained in adolescent sexual offending and issues related to sexual abuse conduct the investigation. It is critical to ensure that during this process, the rights of the adolescent are upheld (i.e., right to legal counsel). At the same time, child protection workers should interview any known (and potential/suspected) victimized individuals under the age of 16.

It is also critical to consider the victimized individual's need for support while balancing this with the consideration that he/she may be unlikely to disclose information in the presence of specific individuals (e.g., parents, other family members). Privacy for the victim during an interview may be achieved by letting the child/adolescent know where the parent/support person is, taking necessary breaks so the child/adolescent can check in with the support person, providing snacks and/or comfort objects, etc. Ideally, a joint interview by child protection and police services should be conducted in order to prevent the victimized individual from having to endure repeated interviews.

Recommendation: *A specialized team of police officers and child protection workers should be developed and trained with respect to sexual abuse-specific interviewing. These teams should investigate together in cases in which both services will be involved.*

3. c) Police/Child Protection investigate possible additional victims

As noted earlier (see 2. b), offending occurs in secret, often in the home, and when the opportunity is present (Cohen & Fleson, 1979; CSOM, 2000b; White et al., 2006). Therefore, as much as possible/is feasible, there must be investigation of all potential unreported sexual offences against individuals of all ages. For example, if allegations are made with respect to sexual abuse of one sibling, other siblings should be interviewed. Likewise, if allegations of sexual offending against one or more foster siblings or group home residents are made, other foster siblings or group home residents should be interviewed. In addition, any child to whom the adolescent had unsupervised access should be investigated and any identified/confirmed victimized individuals should be referred for a comprehensive assessment (Level 6 of flowchart).

Recommendation: *Specially trained child protection workers and police officers conduct interviews with potentially victimized individuals in order to improve the likelihood of obtaining disclosures from undisclosed victimized individuals.*

With respect to documentation of the investigation, it is recommended that detailed police records and child protection records be maintained. Detailed official documentation regarding the alleged sexual offence(s) (i.e., age and gender of victimized individual(s); location(s); others present; frequency/repetitiveness; acts involved/intrusiveness; threats, coercion, force, or violence involved; how disclosed) is critical for future comprehensive assessments and treatment. Victimized individuals' version of events and impact statements should also be solicited as these can provide critical information for offence-specific assessments if consent is later obtained for release of such documents.

4) VICTIMIZED INDIVIDUAL'S STATUS

4. a) New victimized individuals discovered

When new victimized individuals are discovered, the residence of the adolescent must be re-visited to ensure that the adolescent is not residing with any of the newly discovered victimized individuals. If the adolescent resides with the newly discovered victimized individuals,

it is recommended that the adolescent be removed from the residence (5. b). As indicated previously, the impact of the removal must be considered and unnecessary lengthy separations should be avoided. Prompt initiation of services is recommended.



Recommendation:

All known/disclosed victimized individuals should be referred for a comprehensive trauma-informed assessment.

4. b) No new victimized individuals discovered

In the case that no new victimized individuals are identified, residential criteria for the adolescent are determined based on the existing information (i.e., 2.

a, b, c). Residential restrictions for the adolescent may still exist based on the known victimized individuals and the adolescent's access to these or other potentially vulnerable individuals. If the adolescent is not residing with potentially vulnerable or known victimized individuals, there may be no residential restrictions.

5) ACCESS RESTRICTIONS/ REMOVAL OF ADOLESCENT

Residence of the adolescent for the period of assessment will be dependent upon the information gathered with respect to known and newly disclosed victimized individuals, the adolescent's current living circumstances, and the adolescent's access to potentially vulnerable or victimized individuals.

5. a) In some cases, the adolescent is not residing with victimized individuals, children under the age of 12, or potentially vulnerable individuals; however, he/she has access to such individuals. When this is discovered, determinations must be made regarding the adolescent's access to these individuals.

5. b, c) In all cases where the adolescent is residing with victimized individuals, children under the age of 12, or other potentially vulnerable individuals, it is recommended that the adolescent be separated from these individuals for the period of assessment, pending further recommendations.

Recommendations: *There should be no access to known victimized individuals pending the outcome of the assessment (and, likely, the onset of treatment) of the adolescent who offended sexually and the victimized individuals.*

With respect to the adolescent's access to all other children (not identified as having been victimized), this should be highly supervised during the process of assessment and pending the assessment recommendations.

6) ASSESSMENT OF VICTIMIZED INDIVIDUAL(S)

A referral for a comprehensive trauma-informed assessment is recommended for all individuals who have experienced sexual abuse as these individuals may experience a number of emotional, social, and behavioural consequences. For example, victimized individuals may experience depression, physical complaints, isolation, low self-esteem, and antisocial behaviour and delinquency (for a review, see Mendel, 1995; Finkelhor & Browne, 1986). Furthermore, individuals who have experienced sexual abuse are reported to experience relationship difficulties, sexual problems, issues with sexual orientation, addictions, and sexual aggression (see Mendel, 1995 for a review). Although one focus of the assessment should be on the sexual abuse that was experienced, it is important that other areas of the victimized individual's functioning be assessed as doing so provides considerable information regarding strengths (i.e., potential protective factors) and potential risks.

Specific to siblings who have been victimized, a trauma-informed assessment should also include information related to potential reunification issues. Issues related to victimization are complicated and, therefore, the professional(s) involved in assessment should have specific expertise and considerable experience regarding assessing issues related to victimization and conducting comprehensive assessments in this regard. In cases where the alleged offending adolescent is a family member or sibling, it is imperative that the assessor also be experienced regarding assessing the unique issues involved in intrafamilial sexual abuse and sibling incest, inclusive of issues that are relevant to reunification.



7) CHARGES/EXTRAJUDICIAL SANCTIONS/ WARNINGS

Police determine the appropriateness of charges, extrajudicial sanctions (e.g., diversion), or warnings for the adolescent. In some circumstances, police may determine that a warning/caution is sufficient for the adolescent. Particularly in the case of nonviolent offences or intrafamilial sexual abuse, extrajudicial sanctions may also be effective and sufficient (e.g., mandating participation in assessment and treatment); however, these tend to be more successful if they are implemented post-charge and when the length of time involved is sufficient for appropriate resources to be obtained and interventions to be implemented. Judges and those recommending extrajudicial sanctions should consider that, given the often limited resources, supervision for six months or one year, for example, typically will not be sufficient for the initiation of assessment and completion of treatment, particularly given that the average length of treatment is approximately 17 months (McGrath, Cumming, & Burchard, 2003).

8) REFERRAL OF ADOLESCENT FOR A COMPREHENSIVE ASSESSMENT

The adolescent who is convicted of a sexual offence should be referred for a comprehensive sexual offence-specific assessment to explore treatment issues and issues related to risk of a future sexual offence. In addition to exploring various issues and areas of functioning (see Glossary regarding a comprehensive sexual offence-specific assessment), this assessment should also address risk issues and make use of available risk estimate tools such as the Estimate of Risk of Adolescent Sexual Offence Recidivism, Version 2.0 (ERASOR, 2.0; Worling & Curwen, 2001) and the Juvenile Sex Offender Assessment Protocol-II (JSOAP-II; Prentky & Righthand, 2003).

Typically, it is not recommended that an assessment be completed until a plea has been entered by the adolescent and, ideally, a finding (i.e., of guilt) has been determined by the courts. Not surprisingly, it is difficult for adolescents to participate openly in an assessment if a finding has not yet been determined by the courts, and lawyers often advise the adolescents not to provide detailed information regarding their offences. This is particularly true in cases where the adolescent is pleading “not guilty”.

In the interest of making early sentencing, treatment, and placement recommendations, the sexual offence-



specific assessment should be completed as part of the court process, following a plea or finding of guilt. Under the YCJA (2002), this would entail a Section 34 Assessment to be ordered by the judge. In cases where extrajudicial sanctions are pursued, the adolescent should still be referred for a comprehensive sexual-offence specific assessment. This should be completed by a professional who has experience and expertise regarding sexual-offence specific assessment and risk assessment.

Recommendation: *Whenever possible, it is recommended that a professional with specialized training and expertise complete a Section 34 assessment (i.e., prior to sentencing but subsequent to a plea having been entered or a finding of guilt). The assessor must have familiarity with the Association for the Treatment of Sexual Abusers' (ATSA) guidelines for assessment, as well as risk assessment and available risk assessment tools (e.g., ERASOR 2.0; JSOAP-II). In addition, in cases of intrafamilial sexual offending or sibling incest, it is highly recommended that the assessing professional possess specific experience and expertise in assessing issues related to reunification.*

PARENT/CAREGIVER/FAMILY'S INVOLVEMENT IN ADOLESCENT'S ASSESSMENT

Wherever possible, parents and/or caregivers for the adolescent should be included in the sexual offence-specific assessment. Involving parents and caregivers at the time of assessment increases the likelihood of engaging them successfully throughout treatment. In addition, parents and caregivers can provide considerable information regarding the adolescent's history and functioning in many areas (e.g., developmental, academic, social, emotional, sexual, etc.) which may help to explain the etiology of the sexual offending (CSOMB, 2003). Furthermore, parents and caregivers are often in need of support with respect to the sexual offending that has occurred, and assessing this need early on is important.

In cases of sibling incest, it is also critical for parents and/or caregivers to be involved in the assessment in order to allow the assessor to gather information on, and gain an understanding of, issues related to safety and supervision within the home. This will enhance the assessor's ability to make recommendations regarding potential future contact between the offending adolescent and his/her victimized and non-victimized sibling(s). Involvement of the parents may require encouragement and support from police services, child protection workers, and the assessing professional(s).

The parents'/family's cooperation is also important with respect to informed supervision of the adolescent and his/her progress in assessment and treatment (CSOMB, 2003), as well as issues related to potential risk of sexual reoffending. Non-cooperative family members may negatively impact the adolescent's progress in assessment and treatment, as well as cooperation within a residential placement if one is sought.



NON-VICTIMIZED SIBLINGS

Non-victimized siblings should also be included in assessments to explore issues related to the siblings' safety and to improve an assessor's ability to comment on residence recommendations for the adolescent. In cases where the adolescent has offended solely outside of the home, the professional might determine that (from the perspective of the siblings' safety) the adolescent might be able to reside at home during treatment because the (non-victimized) siblings are sufficiently aware of issues related to privacy, secrets, and boundaries, and are sufficiently able to assert themselves or enlist assistance from their parents. Such information is also important in cases where the adolescent has sexually offended against one or more siblings, but not all siblings. The non-victimized sibling(s) should still participate in the assessment to explore issues related to safety of contact between that sibling and the offending adolescent following the assessment (i.e., it may be appropriate and safe, with supervision, for contact to continue between the offending adolescent and the sibling(s) who was not victimized).

***Recommendation:** Additional family members participate in an assessment as needed or appropriate. Recommendations/requests for involvement of additional family members in assessment are made by experienced clinicians. Contact issues with regards to non-victimized siblings are addressed by clinicians.*

9) REFERRAL FOR TREATMENT

Based on the outcome of the assessments that are completed, recommendations for the adolescent, victimized individual(s), and family might include various combinations of treatment modality (e.g., individual, family, and group therapy). Treatment must be uniquely tailored to the needs of all involved and should address the adolescent's (and other family members') unique strengths, risks, and needs.

Treatment should be delivered by degreed mental health professionals who have the training and experience necessary (as indicated in the ATSA, 2003 guidelines) to provide comprehensive treatment regarding adolescent sexual offending. For those adolescents who have also been victims of trauma, the treating professionals should have experience and training (in accordance with best-practices) in this regard as well (see Saunders, Berliner, & Hanson, 2003).

It is critical to point out that, according to research findings, most adolescents who offend sexually do not continue to offend sexually as adults (Letourneau & Miner, 2005). In addition, specialized offence-specific treatment significantly reduces both sexual and nonsexual reoffending (Reitzel & Carbonell, 2006; Worling & Curwen, 2000). For example, in their 10-year (average 6.23 years) follow-up study of 148 adolescents who had sexually offended, Worling and Curwen (2000) found that 5.17% of those who had participated in specialized treatment reoffended sexually in comparison to 17.8% of those who had not participated in specialized treatment or had dropped out prior to one year of specialized treatment. At 20 years (average 16.23 years), only 9% of the treatment group had been charged with a subsequent sexual offence, in comparison with 21% of those who did not participate in treatment (Worling, Litteljohn, & Bookalam, 2009). In the case of sibling incest, specialized treatment can result in successful repair of the sibling relationship and, in many cases, successful family reunification.

***Recommendation:** Additional family members participate in treatment as needed/appropriate. Recommendations/requests for involvement of additional family members in treatment are made by experienced clinicians and treatment for all family members is provided by clinicians experienced in this regard.*

10) REUNIFICATION



In some circumstances, contact between the adolescent and the victimized individual(s) may be supported at the end of assessment (e.g., the adolescent is estimated to be at a low risk to reoffend sexually and has realistic safety plans, victimized individual(s) is not experiencing a concerning level of trauma/impact from the sexual abuse, parents/adults are aware of issues and able to supervise effectively, etc.). In most circumstances, however, it is recommended that treatment be initiated for all involved prior to contact or reunification, and

that any contact or reunification be timed and guided by the recommendations of the treating professionals who are working with all involved.

In their investigation of clinicians' experiences with reunification of more than 60 sets of siblings following sibling incest, Skau, Barbour, and Falls (2008) found that more than 60% reunified successfully and more than 10% were still in the process of reunification. It should be noted that the intensity and duration of the adolescent's treatment, in general, will depend on the adolescent's progress and participation. In the case of reunification with the victimized individual(s), the intensity and duration of this process will depend, primarily, on the wishes, needs, and progress of the victimized individual(s), inclusive of his/her progress in treatment with an independent therapist. Regardless of the offending adolescent's status in treatment, reunification with the victimized individual(s) should only occur upon the victimized individual's explicit interest and readiness in this regard, as well as the recommendations, support, and involvement of the treating professionals. When conducted by experienced clinicians, sibling and family reunification can be a positive and successful process.

GLOSSARY OF TERMS

ADOLESCENT:

An individual between 12-17 years of age at the time of the sexual offence. That is, an individual who would fall under the jurisdiction of the Youth Criminal Justice Act (YCJA, 2002) in Canada.

COMPREHENSIVE SEXUAL OFFENCE-SPECIFIC ASSESSMENT:

A comprehensive assessment of the adolescent who has sexually offended. This encompasses numerous elements inclusive of, but not limited to, family history and relationships, cognitive functioning, academic functioning, social and recreational functioning, emotional functioning, victimization history, behavioural concerns and nonsexual delinquency, physical and mental health issues, sexual development, sexual behaviour and sexual offending history, sexual interests and attitudes, and amenability to treatment. An estimate of risk of sexual reoffending utilizing the best available protocols/guidelines in this regard is also included, along with comprehensive recommendations (which include specific recommendations regarding contact with children, potentially vulnerable individuals, and, if relevant, known victimized individuals).

COMPREHENSIVE TRAUMA-INFORMED ASSESSMENT:

For the purpose of this document, this is included only where reunification between the offending and victimized individual(s) is a goal. In such cases, the comprehensive trauma-informed assessment encompasses numerous issues inclusive of, but not limited to, family history and relationships, cognitive functioning, academic functioning, social and recreational functioning, emotional functioning, victimization history, behavioural functioning (inclusive of potentially concerning sexual behaviours), physical and mental health issues, and amenability to treatment. Comprehensive recommendations are provided, inclusive of addressing potential contact/reunification with the offending adolescent (or how initiating such contact should be determined, timed, and guided).

EXPERIENCED PROFESSIONAL:

A professional with a post-secondary degree who possesses specialized training and experience in the areas of sexual abuse and sexual offending. Training and experience would include comprehensive assessment and treatment, with knowledge of risk issues, risk assessment, current best-practices, and research findings. Where relevant, this would also include knowledge and experience regarding reunification issues.

POTENTIALLY VULNERABLE INDIVIDUAL:

Any potentially vulnerable individual who may be at risk of sexual victimization. This may include children under the age of 12 or individuals with an intellectual or physical disability that may impact their ability to protect themselves or report victimization.

SECTION 34 ASSESSMENT:

Under the Youth Criminal Justice Act (YCJA, 2002), a Section 34 assessment is an assessment that is ordered by the court and is to be completed by a qualified person who is required to report the results in writing to the court. For sexual offence-specific Section 34 assessments, it is recommended that these are not completed prior to a finding (i.e., of guilt) by the court as the adolescent's ability and willingness to speak openly would be particularly in question at that time. The Section 34 assessment should include issues outlined in the definition of the comprehensive sexual offence-specific assessment, but might also include additional specific recommendations regarding placement and sentencing (e.g., incarceration, probation).

SEXUAL OFFENCE:

For the purpose of this document, refers to any sexual act that is chargeable under the Criminal Code of Canada (1985). This may include contact or non-contact sexual offences.

SUPERVISED CONTACT:

Contact between the adolescent and victimized individual(s) is directly (within constant and direct sight) supervised by an adult who is aware of the sexual offending allegations and specific rules for contact and/or supervision requirements.

UNSUPERVISED CONTACT:

Contact between the adolescent and victimized individual(s) that is not directly supervised or that is supervised by an individual who is not aware of the sexual offending allegations and specific rules for contact and/or supervision requirements.

VICTIMIZED INDIVIDUAL:

An individual of any age who has experienced a contact or non-contact sexual offence by the adolescent.

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ABOUT Us

Established in 1983, The Halton Trauma Centre is committed to addressing childhood interpersonal abuse and violence by servicing children and adolescents who have experienced abuse and trauma (including sibling-on-sibling sexual abuse), children displaying problematic sexualized behaviour, adolescents who have engaged in sexual harm/violence, and their families. The Halton Trauma Centre is the only agency in the region of Halton offering specialized programs to these client groups.

Our multidisciplinary team is comprised of highly skilled clinicians and staff who, in addition to their work with clients, offer regular training, supervision, and consultation to other professionals and community partners. The Halton Trauma Centre also provides student placements and internships for professionals who are interested in developing expertise regarding child abuse, sexualized behaviour, and sexual offending. Our program also conducts public awareness initiatives and research in the area of child abuse and sexual offending to develop and promote best-practice guidelines, public policy, and program and treatment innovations. The Halton Trauma Centre is involved in, and contributes to, trauma-based and sexual-offence-specific research, and has also contributed to a number of national and international conferences.

