

Preventing Youth Sexual Violence and Abuse: Problems and Solutions in the Australian Context

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Young people under 18 years of age are responsible for a significant proportion of officially recorded sexual offences worldwide, including in Australia. In this article we examine the wider problem of youth sexual violence and abuse, and propose solutions for the Australian context. We describe an ecological, field-based clinical forensic practice model developed in Queensland, and show how engagement with youth sexual offenders within their natural social ecologies has led to the discovery of specific endemic problems that would normally remain hidden or beyond the reach of conventional clinical services. Drawing on public health and crime prevention concepts and methods, we present a comprehensive framework for organising prevention strategies and describe how this framework has guided our approach to developing place-based prevention strategies at two sites. We conclude by outlining the changes we see as necessary for forensic psychology practitioners to engage in a wider crime prevention agenda.

Key words: crime prevention; indigenous offenders; sexual offenders; youth offenders.

What is already known on this topic

- 1 Sexual violence and abuse poses serious threats to health and well-being, particularly for women and children.
- 2 Youth under 18 years of age are responsible for a significant proportion of known sexual offences.
- 3 Australia's culturally diverse and geographically dispersed population presents serious challenges for enabling equitable access to services, including clinical forensic services.

What this paper adds

- 1 Field-based practice preserves ecological validity of psychological assessments and interventions in ways that centralised service delivery cannot.
- 2 Social ecological assessment and case formulation allows for wider crime problems to be identified, beyond those concerning individual referred clients.
- 3 The article includes suggestions for how clinical forensic psychologists may engage in a wider crime prevention agenda.

Adolescents are responsible for committing a substantial proportion of known sexual offences. In an early review, Davis and Leitenberg (1987) concluded that at least 20% of all sexual offences involve adolescents as the identified offender, with estimates ranging as high as 50% for offences involving children as victims. In the USA, youth under 18 years of age have consistently been found to account for 18–20% of arrestees for forcible rape and other sexual offences (e.g., U.S. Department of Justice, 2008). In Queensland, youth under 18 years were the identified perpetrators in 25% of all sexual offences reported to the police in the year 2010–2011 (Queensland Police Service, 2011).

In response to a growing awareness about the involvement of young people in sexual violence and abuse (SVA), most Australian jurisdictions now provide specialised services aimed primarily at reducing sexual recidivism among referred youth. These programs vary in their referral sources, theoretical

approaches and practice models, but most were established and continue to operate as centralised services, requiring referred youth to travel to capital cities or other major urban centres to participate in assessment and treatment. The content and format of programs for these youth were originally modelled on those designed for adult sexual offenders, and intensive, long-term, group-based, individual-level treatment thus became the accepted practice standard (American Academy of Child and Adolescent Psychiatry, 2000). It was not until the late 1990s that the logic and efficacy of using adult treatment models for youth sexual offenders came to be seriously questioned (Chaffin & Bonner, 1998; Letourneau & Miner, 2005). Many programs now give more emphasis to the developmental context of the youth and their problem behaviour, although many have also retained aspects of adult-type interventions. For example, although there has been an increased effort to engage with referred youth's families, many programs in Australia and elsewhere continue to focus their assessments and interventions more or less exclusively on individual-level problems, and interventions themselves are still commonly delivered in a group-based format in a centrally located clinic setting (O'Brien, 2010).

In the present article we describe the development of an ecological, field-based, statewide service for youth who have committed sexual offences, and outline how our clinical practice

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has been extended to place-based primary and secondary prevention of youth SVA at two sites—a remote Aboriginal community, and a regional suburban setting. We begin by describing the main challenges of providing clinical forensic services to a heterogeneous, geographically dispersed and culturally diverse client group. We then outline a comprehensive prevention framework, and locate our clinical service within this framework. Next, we present two case studies illustrating how engaging with referred youth within their natural social ecologies has led to the discovery of endemic problems at specific locations, and describe how we are approaching the new challenge of developing strategies to prevent other young people at these locations from becoming perpetrators or victims of SVA. We conclude with suggestions for how clinical forensic psychology might contribute to a wider crime prevention agenda.

Clinical Challenges and Solutions

In this section we briefly outline some of the characteristics of youth sexual offenders, highlighting the diversity of these youth and the implications of this for clinical practice. We also consider some of the features of the Australian context and their relevance to clinical program development, focusing particularly on some of the geographical challenges and cultural considerations with respect especially to the Australian Indigenous population.

Population Heterogeneity

Early clinical conceptions of youth SVA were strongly influenced by reports that adult sexual offenders typically begin offending as adolescents (e.g., Abel et al., 1987). The implication was that adolescents who committed sexual offences were at an early stage of a persistent, life-long sexual offending “career” (Abel, Osborn, & Twigg, 1993). As research on adult sexual offending began to mature and research on youth sexual offenders themselves developed, it became apparent that these early conceptions were misleading. It now seems clear that only a minority of adult sexual offenders begin sexual offending as adolescents, and that most youth sexual offending does not persist into adulthood (Smallbone & Cale, in press). Nevertheless many youth sexual offenders remain at significant risk of committing further sexual offences during adolescence, and some are at risk of persisting into adulthood (Nisbet, Wilson, & Smallbone, 2004).

It has long been recognised that youth who commit sexual offences are a very heterogeneous population (Bourke & Donohue, 1996; Knight & Prentky, 1993), with wide variations in their personal characteristics, offending behaviour, and their home and community environments. Apart from their offending itself, by far the most commonly observed characteristic of youth sexual offenders is male gender. Victim characteristics vary widely. In our own service, victim ages range from 2 to 80 years, but are concentrated in pre-adolescence (Mean = 11.3 years; Median = 9 years). For this offender cohort, 80% of victims were female (Smallbone, Crissman, & Rayment-McHugh, 2009). As is also the case with adult sexual offenders, victims are typically well known to the offender,

although offences against strangers do occur. Youth SVA seems to often occur against the backdrop of other irresponsible and antisocial behaviour, with identified offenders as much as eight to ten times more likely to be re-arrested for a nonsexual offence than for a new sexual offence (Nisbet et al., 2004; Worling & Langstrom, 2006).

Researchers have attempted to reduce this observed heterogeneity by identifying more homogenous subgroups of youth sexual offenders. Various schemes have been proposed, based on offender (e.g., Almond, Cantor, & Salfati, 2006; Worling, 2001), offence (e.g., Nisbet, Smallbone, & Wortley, 2010), and victim characteristics (e.g., Hunter, Figueredo, Malamuth, & Becker, 2003; Worling, 1995). For example, Almond et al. (2006) found empirical support for three distinct backgrounds among these youth (abused, delinquent, or impaired), suggesting that different life experiences and psychological processes may contribute to their offending behaviour. Significant variations are nevertheless found even within such subgroups. Clinical (and other) responses must therefore be responsive to the remarkable heterogeneity within this youth offender population.

Geographical Challenges

With approximately 22 million people dispersed across an area of 7.7 million km², Australia’s demography presents serious challenges for enabling equitable access to a range of services, including clinical forensic services. Although the majority of the Australian population resides in major urban centres, small regional and remote communities are scattered across vast distances. Particularly because of their seemingly intractable overrepresentation in the criminal justice and child protection systems, the geographical distribution of Indigenous people poses special challenges for the delivery of clinical forensic services.

While only 12% of non-Indigenous Australians live outside the major cities or inner regional districts, 23% of Indigenous Australians live in outer regional districts and an additional 27% in remote or very remote areas (Human Rights and Equal Opportunity Commission, 2006). Some non-urban Aboriginal people live in camps on the fringes of regional towns, while others live in scattered settlements that may be a day’s drive along a rough, unsealed road to the nearest town or other settlement (Memmott & Moran, 2001). Of the 1,291 separate Aboriginal communities that have been identified, almost three quarters have populations of less than 50 inhabitants, although settlements with populations of more than 200 account for 70% of all settlement dwellers. In ordinary circumstances, reaching these settlements can be difficult and time-consuming, but seasonal variations can also close road (and sometimes air) access and create uncomfortable working conditions, particularly in central desert and northern tropical locations.

Cultural Considerations

Australia is one of the most ethnically diverse countries in the world, with more than 200 cultural and linguistic groups

identified (Commonwealth of Australia, 2007). Almost one in four of the Australian population was born overseas (Commonwealth of Australia, 2008), including about 14% who were born in a non-English-speaking country (Australian Institute of Health and Welfare, 2008). Among the 370 referrals received by our own service since 2001, we have identified 16 separate ethnic or racial groups, occasionally requiring us to call upon the assistance of external translation and cultural consultation services. Typically, we see only a few youth from any particular ethnic minority group. By far the greatest number of minority-group clients has been Indigenous youth, who have comprised 34% of all referrals to date.

Numerous National and State inquiries (Aboriginal and Torres Strait Island Task Force on Violence, 1999; NSW Aboriginal Child Sexual Assault Taskforce, 2006; Wild & Anderson, 2007) have reported an alarmingly high incidence and prevalence of SVA within regional and remote Indigenous communities. Available data indicate that Indigenous children are three times more likely to be a victim of sexual abuse than non-Indigenous children. These reports have also observed that, due to the particular barriers to reporting of sexual abuse by Indigenous people, it is likely that the true rate of overrepresentation may be much higher (NSW Aboriginal Child Sexual Assault Taskforce, 2006). Despite these high prevalence rates, major inquiries have noted that specialist intervention services have not been consistently available to youth in remote locations (e.g., NSW Aboriginal Child Sexual Assault Taskforce, 2006), and this remains one of the critical challenges in the field.

Reports typically point to different environmental and other contextual factors, rather than to increased levels of individual psychopathology, as the key explanation for the higher prevalence of SVA in some regional and remote locations. Identified contributing factors include the breakdown of Aboriginal culture and customary Lore; increased vulnerabilities of women and children, often associated with familial violence and neglect; substance abuse; lack of education and work skills; early exposure of children to sexual activity; and a deep reluctance to report abuse (Wild & Anderson, 2007). Queensland correctional data are consistent with this, suggesting that SVA among Indigenous offenders is associated with a more general pattern of antisocial behaviour reflective of the social ecological context, rather than a specific problem associated with higher rates of individual sexual deviance (Smallbone & Wortley, 2000). Understanding the ecological context of SVA, rather than adopting an exclusively individual-level conceptualisation, has been cited by numerous observers as critical for successful outcomes for Indigenous offenders (O'Brien, 2008; Westerman, 2010).

On a practice level, there are additional unique challenges for psychologists in addressing SVA with Indigenous clients. These include the historical experiences of engagement with statutory services; wide diversity in culture, context, and language; the role of cultural Lore and traditional punishment; differences in cultural understanding and beliefs about family and gender; profound social disadvantage and associated problems experienced in some communities; and the paucity of research informing practice with this population (Dudgeon, Garvey, & Pickett, 2000).

A Field-Based, Collaborative Practice Model

Griffith Youth Forensic Service (GYFS) provides specialist assessment and treatment services on a Queensland-wide basis (an area of approximately 1.8 million km²) for young people adjudicated for sexual offences. GYFS day-to-day practice draws from a wide empirical and conceptual base, particularly evolutionary theory and neurobiology; developmental criminology; developmental, social, and clinical psychology; environmental criminology; and social ecological approaches, as well of course as evidence specifically concerning adolescent sexual offending. We see evidence concerning the effectiveness of various treatments with youth sexual offenders as part of this broader evidence base, rather than as a reason to try to replicate a clinical model developed elsewhere. We have been progressively developing our own theoretical model that aims to integrate individual, ecological, and situational levels of explanation (Smallbone & Cale, in press; Smallbone, Marshall, & Wortley, 2008a; Wortley & Smallbone, 2006).

In response to the challenges outlined above, GYFS has developed a field-based, collaborative practice model (see Smallbone et al., 2008a, 2009; Smallbone, Rayment-McHugh, Crissman, & Shumack, 2008b). The model is characterised by three core elements: field-based practice; individualised, multisystemic assessment and intervention; and collaborative partnerships. The field-based model allows the provision of specialist services in metropolitan, regional, rural, and remote locations (including remote Indigenous communities) from a base in Brisbane. The aim is to provide equitable access to specialist services regardless of client location. Rather than requiring clients and their families to travel to a central location in order to access services, clinical staff travel to the client to conduct assessments and provide specialist treatment services. Depending on location, this may involve multi-day or week-long community visits, often with telephone or email contact during intervening periods.

Working in the field allows for direct observation of the contextual factors that may contribute to SVA and other problem behaviour, and thus preserves the ecological validity of assessment in ways that interviewing an individual offender in a clinic room (often many kilometres away from the client's community) cannot. Field-based practice also allows interventions to be delivered in the same environment in which risk and protective factors give effect, thus ensuring ecological validity of the interventions as well. It also promotes client comfort and support, which may in turn increase levels of engagement and participation. Whereas centralised group-based programs often have very high attrition rates, attrition for GYFS clients is virtually zero (Smallbone et al., 2009).

The heterogeneity of the client population noted above requires assessment and intervention services to be designed on a case-by-case basis, rather than according to a prescriptive program or manual. In our case a multisystemic case formulation is developed, which in turn informs the development of an individualised treatment and risk management plan. Interventions directly target identified individual-, family-, peer-, school-, and community-level factors, focusing on both problems and strengths (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). Because many youth sexual offenders

present with significant antisocial behaviour problems, we avoid bringing clients together in groups. Efforts are instead directed towards increasing the frequency and quality of contact with prosocial peers, insofar as it is safe to do so.

Because it is not possible to sustain direct involvement in interventions in difficult-to-access locations, GYFS practice model relies on the identification and recruitment of a team of local collaborative partners, including professionals, para-professionals, non-professionals, and family members, to assist in the development and delivery of interventions. The collaborative approach draws on a broad range of skills and knowledge within the natural and professional ecology to enhance interventions, increase cultural and ecological validity, and promote continuity of service delivery between GYFS visits. Collaborative partners may include statutory youth justice or child protection officers, mental health practitioners, teachers, youth workers, alternative care providers, community elders, and other key community stakeholders, and are identified on a case-by-case basis (see Smallbone et al., 2008b). To ensure culturally appropriate and respectful practice with Indigenous clients and communities, clinical practice occurs in collaboration with a local cultural consultant, also identified and recruited on a case-by-case basis (Vicary & Bishop, 2005).

GYFS clinical assessments involve three separate areas of investigation: the offence itself; the offender; and the offender's social ecology. Offence-focused assessment involves a systematic micro-level analysis of what happened, where, when, and how it happened, and who was involved; the relationship between the offender and the victim, with a particular focus on their interaction immediately prior to the offence(s) in question; the whereabouts and actions of potential capable guardians at the time of the offence; and the responses of the offender and various third parties to the offending incident(s). Offender-focused assessment more conventionally explores who the individual youth offender is, their history, and how they came to be the way they were at the time of the offence. Common aspects of offender-focused assessment include: developmental, family, educational, and medical history; social and interpersonal skills; emotional and behavioural regulation, problem solving, and perspective taking skills; and sexual knowledge, experiences, interests, and behaviour. Ecological assessment aims to identify risk and protective factors across family, peer, school, neighbourhood, and community levels.

Assessment data are drawn initially from referral documents (e.g., police briefs, victim statements, child protection histories, previous reports), following which interviews are undertaken with the young person, family members, and other key stakeholders as appropriate (e.g., care providers, school personnel, police, detention centre staff, community justice group members). Psychometric (e.g., Child Behavior Checklist, Achenbach & Rescorla, 2001; Millon Adolescent Clinical Inventory, Millon, 1993) and structured risk assessment (e.g., Juvenile Sex Offender Assessment Protocol II, Prentky & Righthand, 2003) are typically undertaken, although because of the diversity of the client population, decisions about the usefulness and appropriateness of various tests are made on a case-by-case basis. Observational assessment is also often undertaken of the neighbourhood or community (including, where appropriate, the crime scene itself), focusing on the physical environment,

routine activities, guardianship, and potential opportunity structures for further offending. An environmental audit is also undertaken to identify local resources.

These assessments are used to develop a theory-informed case formulation. Each formulation aims to explain why the offence(s) occurred, based on the interactions of biological, developmental, ecological, and situational factors (Smallbone & Cale, in press; Smallbone et al., 2008a). Formulations in turn inform individually tailored treatment goals, with goal attainment scaling used to monitor treatment progress. Individual treatment targets could include safety planning, behavioural and emotional regulation, empathy training, relationship skill building and attachment, correcting cognitive distortions, and education about appropriate sexual behaviour. Family treatment targets could include building family capacity for guardianship, strengthening family relationships, and developing capacity for risk management. Systemic treatment targets might include building connections to family and community, enhancing available support, facilitating educational or employment opportunities, improving peer relationships, and increasing opportunities for the youth to engage in pro-social recreational activities. Treatment goals and intervention approaches are continuously reviewed and where appropriate revised.

A Comprehensive Prevention Framework

Clinical forensic psychology services are traditionally concerned with assessment and treatment of adjudicated offenders, usually in conjunction with other criminal justice interventions involving police, the courts, and corrections. Preventing recidivism among known offenders is an important aspect of crime prevention, but such interventions alone cannot solve crime problems. Rather, clinical forensic services should be part of a much wider crime prevention agenda. In this section we outline a comprehensive framework for preventing youth SVA. The framework draws particularly from public health and crime prevention concepts and methods.

Public Health Model

The public health model distinguishes three levels of prevention. *Primary (or universal) prevention* targets whole populations or specific places and aims to prevent a given problem from developing or occurring in the first place. Applied to youth SVA, primary prevention would have two main aims: (1) to prevent potential victims from being exposed to SVA in the first place; and (2) to prevent potential offenders from committing a first sexual offence. The advantage of primary prevention is obviously that problems may be prevented before they might otherwise occur. This is highly desirable in principle because the aftermath of SVA can be exceedingly costly in personal, social, and monetary terms. A disadvantage is that primary prevention can be very inefficient, especially when it is used to address relatively infrequent or low-prevalence problems such as SVA, and especially when risk factors are poorly defined or understood.

Secondary (or selected) prevention targets at-risk individuals, groups, or places, and aims to prevent or slow the transition from risk to manifest problem. Secondary prevention of youth

SVA would target children and youth at risk of committing SVA offences, persons (particularly women and children) identified as being at risk of SVA victimisation, or settings where significant risks for SVA have been identified. A key advantage of secondary prevention is that it promises a far greater efficiency than would be possible with primary/universal prevention. However, identifying at-risk individuals, groups, or places involves making judgements about who (or where) is at risk and who/where is not. Because such judgements are inevitably imperfect, secondary prevention introduces two types of error to the prevention task, particularly for person-focused prevention: false positive error, where individuals are identified as at risk but who would not, in fact, go on to offend or be victimised; and false negative error, where individuals are judged not to be at risk but who do, in fact, go on to develop the targeted problem. At best, false positive error results in an inefficient allocation of prevention resources; at worst, it can be harmful in itself by unnecessarily and mistakenly labelling people as at risk or drawing them into intrusive and possibly even harmful interventions. Because secondary prevention targets specific groups or individuals who are thought to be at risk, secondary interventions are often more intensive and intrusive than primary/universal interventions. It is important therefore that secondary strategies be designed to anticipate and control for negative impacts on unintended targets (i.e., false positive cases).

Tertiary (or indicated) prevention targets those individuals or places identified as having already developed a given problem, and aims to ameliorate associated harms and prevent further recurrences of the problem. For youth SVA offenders, tertiary prevention essentially involves efforts to prevent further sexual and other offending. For victims, tertiary prevention aims principally to prevent any further incidents of sexual victimisation. For places, it aims to change criminogenic features of specific settings where SVA offending has occurred. Tertiary prevention in some respects offers the greatest efficiency of the three prevention levels because it targets the fewest number of people/ places and because it is easier to identify a problem once it exists. However, because it applies only after the fact, it also has the highest social and personal (and probably also monetary) costs. As with secondary prevention, tertiary interventions also introduce error because they are based on predictions or assumptions about future outcomes. Because of the high level of concern attached to these potential outcomes, a higher threshold for false positive error is typically tolerated for tertiary interventions. That is to say, policy-makers and practitioners will often be more concerned to avoid missing intended targets, and less concerned about over-including non-intended targets.

We need not be distracted by how we might precisely define these three prevention levels. In fact, we prefer to conceptualise the model in terms of a continuum along which various prevention strategies might be located, rather than as a categorical scheme. The significance of the public health model is that it provides a conceptual framework within which it is possible to envisage a wide range of potential preventive interventions, including the compelling possibility that youth SVA might be prevented before it would otherwise occur. A key limitation of the public health model is that it does not identify specific prevention targets or methods. For this we need to turn to developments in crime prevention.

Crime Prevention

Tonry and Farrington (1995) outlined four distinct approaches to crime prevention, each of which is supported by its own conceptual foundations, empirical base, and practice experience: developmental prevention; situational prevention; community prevention; and criminal justice interventions.

Developmental crime prevention is based on established theories of human development and on extensive evidence linking adverse developmental circumstances to later involvement in delinquency and crime. Developmental prevention aims to reduce individual criminal propensities from emerging in the first place by reducing the prevalence of individuals' exposure to adverse developmental circumstances or by minimising harmful outcomes for those who are exposed. The main sources for identifying developmental risk factors have been numerous large-scale prospective longitudinal studies (e.g., Cambridge Study in Delinquent Development, Farrington, 1994; Dunedin Multidisciplinary Health and Development Study, Moffitt, 1990; Pittsburgh Youth Study, Loeber, Van Kammen, & Fletcher, 1996), as well as prevention trials showing that targeting developmental risk factors can produce significant reductions in later delinquency and other problem outcomes (e.g., Elmira Prenatal/Early Infancy Project, Olds, 2002; High/Scope Perry Pre-School Project, Schweinhart, Barnes, & Weikhart, 1993; Montreal Prevention Project, Tremblay, Pagani-Kurtz, Masse, & Vitaro, 1995). Developmental risk factors have been identified at all levels of the individual's natural social ecology: individual-level (e.g., impulsivity; poor concentration); family-level (e.g., high conflict; low supervision); peer-level (e.g., attachments to antisocial peers); school-level (e.g., low achievement; dropout); and neighbourhood-level factors (e.g., neighbourhood violence; availability of weapons).

Prospective studies have generally not reported outcomes separately for SVA, although retrospective studies of youth sexual offenders indicate that very similar developmental risk factors are associated with both sexual and nonsexual offending. A recent meta-analysis of retrospective studies suggests that, in addition to these generic risk factors, sexual abuse and "atypical sexual interests" may be uniquely associated with youth SVA (Seto & Lalumiere, 2010). Developmental crime prevention has been focused exclusively on potential offenders, but the same principles may also be applied to reducing risks among potential victims.

Situational crime prevention shifts the focus of crime prevention efforts from reducing criminality among individuals to preventing the crime event itself. This approach is based largely on rational choice (Cornish & Clarke, 1986, 2008) and routine activities theories (Cohen & Felson, 1979). Application of situational prevention involves a careful analysis of the situational characteristics of the (potential) crime setting, and the development and implementation of environmental counter strategies. There is a substantial and growing body of evidence that situational interventions can be highly effective in reducing specific crimes in specific contexts (Clarke, 1997). Wortley and Smallbone (2006; see also Smallbone et al., 2008a) have outlined how situational approaches may be applied specifically to preventing sexual abuse. Situational techniques are usually organised according to five principles: increasing the effort of

offending; increasing the risks of offending; reducing the rewards from offending; removing excuses for offending; and reducing provocations to offend. Essentially situational prevention targets the opportunity structures and precipitating conditions for specific crimes.

Situational interventions are very complementary to developmental interventions. Like other human behaviour, SVA is best understood as the product of a person–situation interaction (Mischel, 1968): developmental prevention targets the “person” side of this equation by reducing individual criminal propensities, while situational prevention targets the “situation” side by reducing criminogenic aspects of specific settings. Whereas developmental strategies are generally a long-term option, sometimes taking years to produce desired outcomes, situational strategies aim to have an immediate effect.

Community crime prevention involves establishing community partnerships to systematically identify local crime problems and devising local solutions to these problems (Hawkins et al., 1992). Typically, a local committee is established to undertake a crime audit and to oversee the implementation and evaluation of local crime prevention activities, with funding and other resources generally provided by a central government agency. Community projects may draw from a wide range of proven or promising prevention strategies, including developmental, situational, and criminal justice strategies. While community development approaches are thus pragmatic and eclectic, key features are the active participation of local communities, and employing a systematic, evidence-based approach to identifying and responding to specific, local crime problems. Smallbone et al. (2008a) pointed out that in normal circumstances, community action is much more likely to be sparked by immediate, visible, external threats such as outbreaks of vandalism, street violence, or residential burglaries, than by concerns about SVA. Community prevention approaches to SVA are likely to be limited to rare cases where an unusually high prevalence of the problem has been identified, including some remote Aboriginal communities (Aboriginal and Torres Strait Island Task Force on Violence, 1999; Wild & Anderson, 2007) and perhaps some specific urban, suburban, or organisational settings.

The fourth element of Tonry and Farrington’s (1995) crime prevention model is *criminal justice interventions*. These include the day-to-day activities of police and other statutory authorities, the courts and various diversionary programs, and adult corrections and youth justice agencies. Criminal justice interventions thus encompass the detection and investigation of

SVA, specific and general deterrence strategies, the general and selective incapacitation of SVA offenders, and the treatment of youth sexual offenders.

A Comprehensive Prevention Framework

Smallbone et al. (2008a) adapted the crime prevention model described by Tonry and Farrington (1995) and integrated this with the public health model to propose a comprehensive framework for preventing sexual abuse. We further adapt this framework here to propose a comprehensive model for preventing youth SVA. The model involves four key targets—(1) offenders (or potential offenders); (2) victims (or potential victims); (3) situations or specific settings in which SVA has occurred or is likely to occur; and (4) communities—across three prevention levels (primary, secondary, and tertiary prevention). The model is depicted in Table 1, together with some examples of the kinds of prevention strategies that might be used to target the various aspects of the problem. The model is intended to serve as a heuristic device, and we acknowledge some conceptual overlaps and slippage between categories. We consider below how this model may be applied to two settings where we have observed endemic problems with youth SVA, but first we describe how and why these sites were identified.

Clinical Services and Prevention

Typically forensic practitioners have been funded, employed, and trained specifically to provide assessment and treatment with identified offenders. The identified client may be referred directly by the courts, or by a party to a legal proceeding, for this specific, limited purpose. Along with a host of criminal justice system activities, forensic psychology services are thus typically confined to tertiary-level, offender-focused interventions (see Table 1). They are an important component of the broader prevention framework, and are in fact the area of prevention that attracts the most attention and resources. In this context, forensic psychologists may not have thought far beyond individual-level risk prediction and recidivism to how the offending behaviour may have been prevented in the first place, yet most would surely agree this is preferable to waiting until the offence has been committed (and the victim victimised).

However, through their training and experience, forensic psychologists may acquire a deep knowledge of the systemic factors that contribute to SVA and other crime problems, and may even

Table 1 A Comprehensive Framework for Preventing Youth Sexual Violence and Abuse

Targets	Primary prevention	Secondary prevention	Tertiary prevention
Offenders	<ul style="list-style-type: none"> • General deterrence • Developmental prevention 	<ul style="list-style-type: none"> • Interventions with at-risk children and adolescents 	<ul style="list-style-type: none"> • Early detection • Treatment
Victims	<ul style="list-style-type: none"> • Personal safety training • Resilience building 	<ul style="list-style-type: none"> • Resilience building with at-risk children and youth 	<ul style="list-style-type: none"> • Ameliorating harms • Preventing re-victimisation
Situations	<ul style="list-style-type: none"> • Opportunity reduction • Extended guardianship 	<ul style="list-style-type: none"> • Situational interventions in at-risk places 	<ul style="list-style-type: none"> • Safety plans • Organisational interventions
Communities	<ul style="list-style-type: none"> • Community education • Community capacity building 	<ul style="list-style-type: none"> • Responsible bystander training • Enabling guardianship 	<ul style="list-style-type: none"> • Interventions with “problem” families, peers, organisations, and communities

have a responsibility to address some of these assessed systemic factors as they relate to an identified client. In this context, the treating forensic practitioner is perhaps uniquely placed to extend interventions to other tertiary-level responses (e.g., situational or community-level interventions, see Table 1), or indeed beyond a tertiary level and to contribute directly to primary and secondary prevention. Ecological assessments can provide a depth of information about factors that may thus not only prevent further offending by a known offender, but if addressed may also prevent others from engaging in SVA in the first place.

As with other aspects of treatment, community-level interventions may also be individualised and informed by assessments on a case-by-case, community-by-community basis. Situational prevention activities provide the most immediate, concrete, and practical approach to both individual and community-wide intervention. These might include increasing guardianship and supervision, increasing safety in public locations, reducing opportunities, managing the precipitating conditions of specific behaviours, and activity scheduling to avoid high-risk periods or locations. Other prevention interventions may aim for longer term outcomes. These could include developmental prevention (e.g., improving parental and peer attachments; improving educational outcomes; improving parenting skills), and community development activities (e.g., awareness raising and capacity building workshops mapping existing services and identifying service gaps; developing a community prevention reference group; public education about safety and appropriate sexual behaviour).

Case Studies

GYFS clinical assessments typically identify a range of systemic factors, and for the most part these are more or less contained within the individual's family or peer systems. However, from time to time, these assessments identify wider systemic and situational problems affecting youth other than GYFS individual clinical clients, indicating that further SVA is likely to occur unless these wider problems are better understood and addressed. In some cases, it is clear that other young people, including younger generations of children, will also be at risk of SVA offending or victimisation now or in later stages of their development.

The need for primary and secondary prevention activities becomes increasingly clear in this context. Forensic practitioners working with identified offenders can inform initial prevention efforts by identifying key areas of focus or contributing directly to designing and implementing prevention strategies. We describe below two case studies where GYFS clinical assessments and community engagement have led to a wider involvement in SVA prevention.

Case 1: Aboriginal Community

Some years ago, we received referrals concerning a number of youth living in a small remote Indigenous community in Far North Queensland. The logistics of working with youth in this location were complex and required approximately six-weekly, weeklong visits over a period of several years. A minimum of two staff worked together.

We will use the example of one youth to illustrate the process of assessment and treatment. In this case, assessment interviews were undertaken with the young person and his grandmother, the community justice group coordinator, and with statutory child protection and youth justice staff who had a history working with this family. Observational assessment was undertaken within the community, including of the setting in which a number of offence incidents had occurred (a disused house). Engagement with residents indicated other specific places of interest, most notably places where groups of youth would spend time away from adult supervision. Analyses focused on family, peer and community guardianship, and youth routine activities.

Treatment in this case was primarily undertaken outdoors at the local riverfront. The young person was engaged individually, utilising a combination of narrative therapy and cognitive behavioural approaches. Pictures and role plays were used to overcome literacy and language barriers. A male respected community member was engaged to assist with language, review treatment themes between GYFS visits, and to engage with the youth around "men's business" aspects of treatment. Individual treatment focused on developing skills for behavioural restraint, education about appropriate sexual behaviour, building healthy relationship skills, challenging cognitions associated with sexual offending behaviour, and safety planning.

In this case more time was spent in engagement with the family than with the youth himself. In fact, a total of eight different extended family members were engaged in the treatment process. Family interventions primarily focused on building capacity for guardianship, building positive parenting skills and skills in supporting the young person to stay safe, risk management (including identifying situations which presented a higher risk and developing strategies to address these), and strengthening family relationships. Systemic interventions included linking the client with employment opportunities, reducing the frequency of interactions with antisocial peers, and building prosocial relationships in the community.

Initial assessments with all six referred youth identified numerous systemic problems contributing to SVA behaviour (see Table 2, left column). Particularly given that criminogenic factors were readily located at various systemic levels, it was immediately clear that, even if systemic interventions were successful with individual clients (none, as far as we are aware, have committed further sexual offences, although some have been in trouble for other serious offences), these referred youth would soon be replaced by other children and youth who were continuing to be exposed to very similar family, peer, organisational, and community risk factors.

Based on community development crime prevention methods, GYFS practitioners established local partnerships to identify problems and develop local solutions. This has included engaging and collaborating with key community stakeholders to discuss issues regarding community safety generally, SVA specifically, and possible approaches to prevention. Formal workshops were convened to map existing local services and to identify key service gaps. Smallbone et al.'s (2008a) 12-point prevention model (see Table 1) was used to guide these discussions and inform mapping exercises.

Table 2 Examples of Systemic Risk Factors Contributing to SVA at Sites 1 and 2

Systemic level	Case study 1 (remote community)	Case study 2 (regional suburban precinct)
Individual	Self-regulation problems; low educational achievement; low aspirations	Antisocial attitudes and behaviour; attitudes supportive of sexual entitlement and coercive sexual practices
Situational	Various opportunity structures (e.g., unsupervised night-time "loitering") and precipitating conditions (e.g., jealousy; teasing; intoxication)	Poor residential design; use of public spaces for illicit activities, including SVA; limited guardianship
Family	Family violence; limited supervision; impaired guardianship	Absence of supervision or guidance
Peer	Peer normalisation of early/aggressive sexual activity; antisocial peers	Peer normalisation of abusive sexual behaviour, antisocial peers, gang membership
Organisational	School disengagement; risks during organised recreational activities	School disengagement; low achievement
Community	Community violence; breakdown in community norms concerning responsible social and sexual behaviour	High crime rates; substance use; public fights and assaults; barriers to effective community guardianship

Situational interventions were begun early to increase guardianship by family members and to reduce opportunities for SVA. Place managers were targeted through training workshops, direct assistance, behavioural modelling, and skill building. Increased supervision of children and youth was arranged before, during, and after community events, lighting was increased at night-time events, and for referred youth activity, scheduling (formal, supervised pro-social recreational activities) was focused on periods of increased risk.

Plans for increased public education about safety and appropriate sexual behaviour were discussed with local community leaders. Ideas have been generated (e.g., radio segments in local language, community drama with safety focus, locally designed brochures), though these are yet to be fully implemented.

Case 2: Regional Suburban Precinct

GYFS received a referral for one male youth who had committed multiple rape offences, in company, against a female youth, at night, in a public park, in a suburban precinct in a regional city. In this case assessment, interviews were undertaken with the young person and his biological parents. Observational assessments were also undertaken both at night and during the day, to gain a better understanding of youth routine activities in this neighbourhood, the offence location and the extent of available guardianship, and aspects of the physical environment that may increase risk.

Individual treatment was conducted in the local youth justice service offices, utilising primarily cognitive behavioural strategies. Treatment sessions focused on safety planning, challenging distortions and antisocial attitudes, and interrupting routine activities linked to the offending behaviour. To facilitate familial and systemic treatment interventions, large family meetings were held with many members of the extended family, in order to identify roles and responsibilities within the kinship network for various aspects of the young person's support and intervention needs. This allowed us to tailor interventions with the family to their agreed roles. For example, intervention with the primary carer focused on psychoeducation about risks, boundary setting in the home, and the implementation of safety rules.

Work with an identified aunt focused on challenging concerning gendered attitudes and providing appropriate messages about women, supporting the young person's adherence to safety rules, and increasing support available to the young person and primary carer. A member of the extended family also agreed to speak directly to the young person about appropriate sexual behaviour, with support and guidance from GYFS. All family treatment sessions were undertaken in their respective homes.

On a systemic level, intervention aimed to weaken connections to an antisocial peer group, build links with pro-social peers and activities, and re-engage the young person with educational systems. Community-level interventions are ongoing and are aimed at addressing environmental risks, building community guardianship, and disrupting youth antisocial activities in the area.

As with the previous case study, initial clinical assessment again identified a range of systemic factors that had likely contributed to the offences in question (see Table 2, right column), and that if left unchecked would both increase risks of reoffending for the referred youth and continue to cause further SVA involving other youth.

According to a local council report (uncited here, 2010), the precinct itself is characterised by low socioeconomic status; a high concentration of public housing and low-income households; high unemployment; high crime rates; and an extensive Indigenous population. Early engagement with a broad range of local professionals and service providers (e.g., police, youth justice and child safety personnel; community centre) indicated widespread serious concerns about youth activities associated with the referred case. The main concerns involved illegal sexual and other activity involving youths, including as groups, and particularly sexual assaults of girls and young women at night in public spaces. These concerns are reflected in official Queensland police data showing increased reports of violent offences and sexual assaults on 15–19-year-old females, and increased group offences by youths, in this and adjoining precincts.

Engagement with central government agencies revealed high-level long-standing concerns about these problems. Indeed, the precinct has been the target of numerous crime prevention programs, including a community and urban

renewal program, a council-led community safety project, and an ongoing community participation program. Although these programs have identified numerous crime prevention and community well-being goals, they have not focused specifically on the prevention of SVA in this community, with the exception of increasing lighting in one identified park. A systemic, evidence-based approach to the problem based on prevention concepts and methods such as those outlined above has not previously been attempted.

Our prevention work at this site is much less advanced than the work in the remote community. We note it here in part to illustrate that the prevention concepts and methods we have outlined have potential application in diverse settings. We are presently involved in a research project that aims to more systematically investigate contributing factors to SVA at these two sites, and to use this analysis as a basis for devising, implementing, and evaluating locally tailored prevention strategies.

Conclusions

Forensic psychology practitioners have little involvement in crime prevention beyond dealing with offender-centred, individual-level problems in centralised clinic settings. Arguing that forensic psychologists should engage with a wider crime prevention agenda is not to diminish the importance of assessment and treatment with known offenders. To the contrary, we ourselves place a high value on such work. Rather, we envision something of a new frontier for forensic psychology practice that includes, but is not limited to, traditional offender-centred work. We conclude with some suggestions about how this vision might be realised.

First, we urge clinical forensic practitioners to embrace an ecological conceptual and practice framework. Quite apart from any wider contribution that might be made, such a framework, we believe, constitutes sound clinical theory and practice. It is consistent with long-standing and current thinking in developmental criminology (e.g., Farrington, 2005; Loeber & Farrington, 1998), clinical approaches to youth crime and violence (e.g., Henggeler et al., 1998), and child maltreatment prevention (Belsky, 1980; World Health Organisation, 2006). Such a framework allows clinical forensic assessments and interventions to understand and address problem behaviour in its ecological and situational context, and from there it is possible to identify a range of contributing factors both internal and external to the offender. The importance of this becomes especially clear in cases where offenders live in, or on their release from prison or hospital return to, highly criminogenic environments. Without systemic and situational interventions, the traditional individual-level treatment goal essentially involves making the individual offender somehow less susceptible to the criminogenic effects of their living environment. An ecological-situational approach recognises that changing aspects of the immediate environment itself is often key to changing individual behaviour. We think this applies just as much to adult offenders as it does to youth offenders.

Second, we urge practitioners to get out of the clinic and into the field. We appreciate the financial and logistical problems that may be associated with this, especially in cases where the client lives at some distance from the practitioner's usual place

of work. However, having clients travel to a central location simply shifts the financial and other impost to the client, and in the wider scheme of things may therefore be a false economy. The advantages of observing the offender's usual living environment are perhaps self-evident, since it is here—not in the practitioner's office—where risk of further offending exists. At the very least, engaging with family members and others by telephone is likely to contribute valuable information to the assessment task, but this is still no substitute for direct observation and engagement. There are obviously practical limitations to this, especially for private practitioners who may be more financially and professionally dependent on providing a restricted level of service. However, a shift in practice standards may be required to change expectations among referring agencies about what constitutes best practice.

Finally, we believe forensic psychology practitioners are well placed to contribute to a wider crime prevention agenda. One way to do this is for practitioners to be more active in disseminating knowledge about the individual, ecological, and situational factors that contribute to various crime problems. This could occur informally, for example, by engaging with front-line agencies that are directly engaged with problem communities, or more formally by engaging with central government agencies about wider problems that may come to light when dealing with individual cases. In our experience at least, such problems are often contained within immediate individual and family systems, in which case they can be managed effectively within the scope of standard clinical interventions. However, from time to time, as we hope to have shown in this article, ecological assessment of individual cases uncovers much wider problems affecting people other than the offender and his immediate family. Engaging with these wider problems is perhaps a role that forensic psychology is yet to grow into.

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