

Best Practices in Children's Mental Health:

A Series of Reports Summarizing the Empirical Research on Selected Topics

Report #9 **“Juveniles with Sexual Offending Behaviors”** **December, 2003**

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- Report #1 – October 2001, “Inpatient Treatment for Children and Adolescents”
- Report #2 – November 2001, “Inpatient Treatment for Adolescent Substance Abusers”
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- Report #8 – October 2003, “Best Practices in Therapeutic Foster Care: Review of the Literature and Local Practices in the State of Kansas”
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Juveniles with Sexual Offending Behaviors

Executive Summary

Scope/Overview of Children and Adolescents with Sexual Offending Behaviors

Approximately 10 years ago the National Taskforce on Juvenile Sex Offending was convened to establish a "standard" to "guide practice and program development" (Farris, Gallagher, Nardi, and McHardy, p. 6 1993). The taskforce reviewed all the current empirical literature and state statutes to develop a definition of the problem of juvenile sex offending. The definition is broad and states that there is a "range of sexually abusive behaviors" and variety of children and adolescents who have sexually abusive behaviors (Farris et al., p. 6 1993). The range of abusive behaviors can be conceptualized on a continuum from deviant behaviors termed "nuisance offenses" including "peeping, exhibiting, obscene phone calls, sexual humiliation, and sexual harassment" to middle range sexually abusive behaviors which are more intrusive offenses including some form of inappropriate sexual touching (Farris et al., p. 7 1993). The most severe sexually abusive behaviors involve penetration.

Approximately 20% to 40% of all sex offenses are committed by juveniles (Becker and Kaplan; Cunningham-Rather and Kovoussi, 1986; Brown, Flannagan, and McLeod, 1984; Pithers and Gray, 1998). Male adolescents between the ages of 15-19 are the most documented subtype of juveniles who sexually offend (Farris et al., p. 6 1993). Researchers have speculated that the lack of documented sexual offenses by females is due to the covert nature of the sexually offending behavior, society's disapproval of this behavior in females, and that males tend to externalize aggression (including sexual aggression) more often in general (Righthand and Welch, 2001; Ray and English, 1995). Incidents of sexual offending by children often go unreported and do not get prosecuted so prevalence statistics derived from court records under-estimate the extent of the problem.

The literature notes that of juvenile sexual offenders who receive treatment only 8-14% end up committing another sexual offense; they are more likely to commit another non-sexual offense (Righthand and Welch, 2001). Research is currently being done to assess what factors appear to moderate and mediate juvenile sex offending.

Co-occurrence of Mental Health Symptoms and Serious Emotional Disturbance in the Juvenile Sex Offending Population

Pithers and Gray (1998) noted that 96% of a population of young children with sexual behavior problems met criteria for at least one disorder from the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; American Psychiatric Association, 1994). The most commonly reported diagnosis is conduct disorder across all juveniles who sexually offend (Righthand and Welch, 2001). The diagnosis comprises anywhere

from 80-96% in most empirical studies of juvenile sexual offenders reviewed (Pithers and Gray, 1998; Davis, Liebman, Bean, Schumacher, and Stinger, 1991; Widom and Ames, 1994). The second most common diagnosis is Attention Deficit Disorder (18.5%-40%); and the third most common is oppositional defiant disorder (5.2%-27%) (Pithers and Gray, 1998; Davis et al., 1991). Pithers and Gray (1998) also note that Post Traumatic Stress disorder was given to 17% of the young children studied in their sample. Davis et al., 1991 also noted that 32% of the youth in their study had a co-occurring mood disorder.

There is evidence that adolescents who offend against younger children have more Schizoid, Avoidant, and Dependent symptoms than those who offended against same age peers (Carpenter, Peed and Eastman 1995 cited by Righthand and Welch, 2001). There is also some evidence that juveniles who sexually offend have higher rates of depressive symptoms than are found in the general juvenile population (Becker and Hunter, 1997).

Juvenile Offender Subtypes

In the process of distinguishing the characteristics of juvenile sex offenders, researchers have identified sub-types of the juvenile sex offender population. The most commonly noted sub-types in the literature include; young children, females, developmentally disabled, and adolescent males. Characteristics of these subtypes are discussed in the main body of this report.

From Victims of Child Sexual Abuse to Perpetrators

At least half of children and adolescents with sexual behavior problems in the clinical samples reviewed for this report have themselves been sexually victimized.

The majority of sexually victimized children and adolescents do not go on to perpetrate sexual abuse (Widom, 1995). Any form of child maltreatment results in an increase risk in juvenile and adult criminal behavior and there is a greater association between adult sex crimes and physical abuse (6.2% likelihood) than child sexual abuse (3.9% likelihood) (Widom, 1995). Evidence in resiliency literature suggests that “two-thirds” of any population of “at-risk” children (including victims of abuse and neglect) seem to “survive risk experiences” without major developmental disruptions (Kirby and Fraiser, 1997 p. 14).

Assessment Measures

The Juvenile Sex Offender Assessment Protocol-II (J-SOAP) is the most comprehensive tool identified for use with the male adolescent sex offender. The tool has been “standardized in terms of administration and scoring protocols” however sample sizes are small and normative data needs to be generated (Hunter, 2003, personal communication). The Multidimensional Assessment of Sex and Aggression (MASA) developed by Knight, Prenky, and Cerce (1994) and the Multi-phasic Sex Inventory

(MSI) developed by Milner and Murphy (1995) were originally developed for adults. New versions of these tools exist for use now with juveniles, it is unknown at the time of this review if the tools have been empirically validated.

Empirically Validated Interventions

There is a dearth of well-designed empirical studies of juvenile sexual offender treatment programs. Searching national websites and multiple academic databases yielded no evaluations specifically supporting the use of inpatient programs over community-based approaches or vice versa for children and adolescents who sexually offend.

Community-based outpatient treatment is generally as effective as incarceration in preventing juvenile sexual re-offending (Kahn and Chambers, 1991). One study of a specialized residential treatment for juvenile sexual offenders concluded it was more effective than non-specialized residential treatment (Kimball and Guarino-Ghezzi, 1998). The literature to date relays that treatment completion is associated with lower sexual recidivism rates (Rasmussen, 1999).

The review rendered some information regarding one empirically supported, community-based intervention specifically for juveniles who sexually offend, Multi-Systemic Therapy (MST) (Borduin and Schaeffer, 2001). Multi-systemic therapy is also being piloted in the state of Connecticut to address juvenile sexual offending.

There is also some evidence that outpatient interventions utilizing relapse prevention techniques, expressive therapy, dynamic play and cognitive behavioral therapy are effective interventions for young children with sexual behavior problems (Rasmussen, 1999; Bonner, Walker, and Berliner 2000; Gray and Pithers, 1993).

Two potentially promising programs are Wraparound Milwaukee and one in Norfolk Virginia using "Case Management protocols" (Hunter, 2003, In Press).

National Emphasis on Empirically Based Practice Standards and Dissemination of Effective Model Programs

Organizations such as The Center for Sex Offender Management (CSOM) and The Association for the Treatment of Sexual Abusers (ATSA) have synthesized the most current efforts across the nation to manage juvenile sexual offenders. Both organizations advocate for juvenile specific specialized programming and not the traditional adult models of intervention that have been utilized. ATSA recommends a blend of rehabilitative focus and "juvenile justice sanctions" when appropriate. ATSA also conveys that there is evidence "that juvenile sexual offenders will cease sexual offending behavior by adulthood" and that they are amenable to community based intervention efforts" (<http://www.atsa.com>, retrieved October 10, 2003).

Kansas Situation for the Juvenile Who Sexually Offends

At present, it appears the adjudicated juvenile sexual offenders may be incarcerated in one of three juvenile correctional facilities or diverted to community programs on probation. Prevalence and outcome data on juvenile sexual offenders in the Kansas Juvenile Justice System is not currently available but may be in the near future with the recent implementation of a statewide offense specific data management system. Prevention efforts and specialized treatment for juveniles with sexual offending behaviors may exist in local communities and are known within the juvenile correctional system.

Preventing childhood sexual victimization

A prevention model of intervention encourages key stakeholders to focus on the prevention of the abuse in the first place. The Centers for Disease Control and Prevention (CDC) convened a workgroup of experts in December 1997 that articulated three factors to overcome barriers. These barriers include "support of key leaders, collection of data on the magnitude of the problem, and public education" (McMahon and Puett, p.265, 1999).

Conclusions and Recommendations

Juvenile Sexual Offending can be conceptualized on a continuum from nuisance offenses to more intrusive offenses resulting in penetration. Though there is evidence that a majority of juvenile sexual offenders were themselves victims of sexual abuse, the majority of victims of child sexual abuse do not end up sexually abusing others. Resiliency literature indicates that "two-thirds" of any population of "at-risk" children (including victims of abuse and neglect) seem to "survive risk experiences" without major developmental disruptions (Kirby and Fraiser, 1997 p. 14).

Caution must be used as well with the label "Juvenile Sex Offender" as there is evidence that most juveniles who sexually offend are amenable to treatment with recidivism rates of 8-14% (Righthand and Welch, 2001). There is mild empirical support for community-based interventions such as MST and wraparound. Outpatient clinical interventions incorporating Dynamic Play, Expressive, Relapse Prevention, and Cognitive Behavioral Therapies have also been shown to be effective. Though juvenile sexual offending is a serious problem, service providers and the children themselves benefit from a balanced perspective that conveys the juvenile's strengths and capabilities as well needs regarding sexual offending behavior.

Two national organizations ATSA and CSOM recommend treatment in community based programs that eschew adult sex offender models. The Center for Sex Offender Management has synthesized many of these lessons in a recent publication, *Managing Sex Offenders in the Community: A Handbook to Guide Policymakers and Practitioners through a Planning and Implementation Process* (CSOM, 2002). The handbook provides a framework and 5 basic steps for planning and implementing a comprehensive statewide program for juveniles as well as adult sex offenders.

The material contained in the following report can be used as a starting point to understand the juvenile sex offenders and begin a taskforce in Kansas incorporating perspectives from Juvenile Justice, Public Health, Child Welfare, Education, Mental Health, and experts in the field of sexual abuse.

The impact of sexual abuse is a uniquely personal to its victims. Intervention and prevention efforts targeting those at risk for being victimized and those at risk for re-offending is a proactive approach to what has been defined as a national public health problem. Forthcoming research discussing risk and resiliency in the victim-perpetrator cycle will be a useful tool to stakeholders searching for strategies to prevent sexual abuse.

Juveniles With Sexual Offending Behaviors

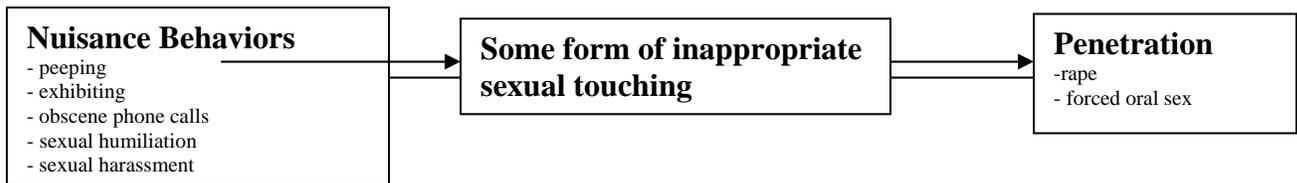
I. Definition of Juvenile Sex Offending

The National Taskforce on Juvenile Sex Offending (NTJSO) has established a definition for juvenile sex offending.

The crime of sexual abuse is a legal construct based on societal values and norms. Sexual abuse includes a range of individuals, and a range of sexually abusive behaviors. Sexual abuse may be perpetrated by anyone of any age or gender. When behavior is sexually abusive, its impact on victims is uniquely personal, but may not differ, on the basis of age or gender of those involved. The laws regarding sexual behavior do not entirely define abuse: some behavior may be prohibited by law but not be abusive, while some abusive behaviors are not covered by law. It is the nature of the relationship, inequality of the participants, presence of exploitation, coercion and control, manipulation, and the abuse of power combined with sexual behavior, which constitutes sexual abuse. Sexually abusive behavior is represented on a continuum of behaviors, some of which may not fall within the court's parameters for prosecution or dependence actions. (Farris et al., p. 6 1993).

This continuum of behaviors includes "nuisance offenses" to more intrusive offenses accompanied by the factors mentioned above. "Nuisance offenses" include "peeping, exhibiting, obscene phone calls, sexual humiliation, and sexual harassment" (Farris et al., p. 7 1993). The term "nuisance" is taken into account by the taskforce in a legal sense. According to the Encarta World Dictionary (2003), a nuisance is an "illegal thing: something not allowed by law because it causes harm or offense, either to people in general (public nuisance) or to a private individual." The middle range sexually abusive behaviors are more intrusive offenses including some form of inappropriate sexual touching. The most severe sexually abusive behaviors involve penetration. Any of the behaviors regardless of their place on the continuum are considered more severe with the presence exploitation, coercion, control, manipulation, humiliation and abuse of power.

Behaviors that warrant a label



Severity Factors - Severity of behaviors increase with presence of 1 or more of these factors

- the nature of the relationship
- inequality of the participants
- presence of exploitation
- manipulation,
- abuse of power
- coercion and control

Though there are variations in the targeted populations defined, most all states and studies examined in this literature review have some elements of the NTJISO's concepts as the purpose of the report was to "set a standard to guide practice and program development" (Farris et al., p. 6).

II. Prevalence

A. The Offenders

"It is estimated that juveniles may account for up to one-fifth of all rapes and approximately one-half of all cases of child molestation committed each year in the United States" (Barbaree, Hudson, & Seto, 1993; Becker, Harris, & Sales, 1993; Sickmund, Snyder, & Poe-Yamagata, 1997 cited by the Center For Sex Offender Management, 2002).

According to the Revised Report from the National Task Force on Juvenile Sexual Offending (1993), juveniles who sexually offend most frequently are between the ages of 15-19 and are male. Figures may underestimate the actual prevalence because juvenile sex offenses are often not reported to authorities (Righthand and Welch, 2001).

Estimates of female juvenile sex offenders in inpatient and outpatient treatment settings range from 3%-5% (Fehrenback, Smith, Monastersky & Deisher, 1986). Lane and Labanov-Rostovsky (1997) cited results of several statewide surveys administered over a 5 year period. Juvenile female sex offenders represented 5% of the arrests in Oregon, 8% in Vermont and 7 % referred to the juvenile court in Utah.

Theorists have speculated that "differences in the socialization process" have resulted in more males who have committed sex offenses (Bourke and Donahue, 1996). The Washington State Department of Social and Rehabilitation Services found that of 200 juveniles identified as sexually aggressive, 18.4% were females (9.3% of were females age 13 and older and 9.1% were females age 12 and under) (Ray and English, 1995). Researchers seem to agree that the lower prevalence rates of female juvenile sex offenders "underestimates the extent of the problem" (Righthand and Welch, 2001). Society may be uncomfortable reporting sex crimes committed by females or admit that girls are capable of committing sex crimes (Charles and McDonald, 1997; Travin, Culen, and Protter, 1990). The sexual abuse committed by young adolescent females may be more difficult to detect due to their frequency of access to young children (babysitting) and the less overt nature of the offenses, females tend to use less force and more use of power in the relationship to encourage compliance (Faller, 1987).

1. Co-occurrence of Serious Emotional Disturbance and Mental Health Symptoms in the Juvenile Sex Offending Population

Only one study found for this report speaks to the prevalence of Juvenile Sex Offenders with SED. Greenbaum, Dedrick, Friedman, Kutash, Lardierie, and Pugh, (1998) summarized a population of SED participant's law enforcement outcomes from six states (Alabama, Mississippi, Florida, Colorado, New Jersey, and Wisconsin). Participants were drawn from publicly funded residential mental health treatment facilities, publicly funded community based mental health programs and community-based special education programs. Thirty five percent of the study participants were adjudicated delinquent or convicted of a crime while 5.3-6.3% had law enforcement contact specifically for sex offenses.

Pithers and Gray (1998) noted that 96% a population of young children (n=127) with sexual behavior problems met criteria for at least one disorder from the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994). The most common diagnosis was conduct disorder (76%), then Attention Deficit/Hyperactivity Disorder (40%), followed by Oppositional Defiant Disorder (27%), and 17% of the sample was diagnosed with Post Traumatic Stress Disorder.

Antisocial behavior and conduct disorder have frequently been observed (Kavoussi, Kaplan and Becker, 1988; Miner, Siekert, and Ackland, 1997 cited by Righthand and Welch, 2001). Of the youth with a diagnosable DSM IV diagnosis, 50-80% of juvenile offenders in the studies reviewed have "conduct" and/or "disruptive disorders" and 10-20% have anxiety and other disorders (Garland, Hough, McCabe, Yeh, and Wood., 2001).

Adolescents who offend against younger children showed higher scores on the Schizoid, Avoidant, and Dependent scales of the Millon Clinical Multiaxial Inventory (MCMI) than those who offended against same age peers (Carpenter, Peed and Eastman 1995 cited by Righthand and Welch, 2001).

Righthand and Welch (2001) indicate Juveniles who have sexually offended "have higher rates of depressive symptoms than are found in the general population of juvenile population."

Two samples of age matched juveniles (one with sexually aggressive behavior and one without) from two residential treatment programs were compared. Bagley and Schewchuk-Dann, as cited by Righthand and Welch (2001) found "higher levels of hyperactivity or restlessness, more depression and anxiety; more histories of firesetting, encopresis, and running away" in the sexually aggressive behavior group.

III. Characteristics of Juveniles Who Commit Sexual Offenses

A. Distinguishing Characteristics

Juvenile sex offenders are likely to commit other types of juvenile offenses prior to and after the referenced sexual offenses. The findings on current literature agree that sexual offending behavior of juveniles should be viewed as part of a larger pattern of acting out behavior (Martin and Kline-Pruett, 1998; Righthand and Welch, 2001). Weinrott (1998) found (n= 80) that the majority of juveniles who disclosed engaging in sexually assaultive behavior had previously committed a non-sexual offense. Martin and Kline-Pruett (1988) reviewed several citations (Becker, 1986; Aljazireh, 1977) noting 40%-60% of juvenile sexual offenders have a history of prior non-sexual delinquent behavior.

Martin and Kline-Pruett (1998) have also identified some additional distinguishing characteristics among JSOs:

- JSOs tend to be socially isolated; “shy, timid and withdrawn compared to other delinquents”
- juvenile child molesters are even more withdrawn and have more social problems
- family dysfunction (intense conflict between parents, violence at home, physical abuse) is common.
- the most reliable predictor of severity and type of re-offense to be committed is the previous pattern of offending.

B. History of Sexual Victimization

Studies of various subtypes of juveniles with sexual offending behavior problems described later in this paper, indicate that at least 75% of the study populations experienced sexual victimization. (Hunter, Figueredo, Malamuth, and Becker, 2003; Pithers and Gray, 1998; Matthews, Hunter, and Vuz, 1997). This finding parallels Righthand and Welch's (2001) summary that sexual victimization has been found in “50-75 percent in prepubescent male samples.” Studies samples show that female juveniles who have sexually offended tend to be victimized at a higher rate than their male counterparts (Ray and English, 1995; Mathews, Hunter and Vuz, 1997). Martin and Kline Pruett (1998) indicate that “while percents across studies vary, there are numerous results indicating that molesters are sexually victimized to a greater extent than are other sex offenders and delinquents.”

C. Continuance of the Victim-Offender Cycle

Although most offenders were once victims, most victims do not become offenders. Widom (1995) studied 908 individuals who had experienced physical abuse, sexual abuse, or neglect from age 11 into adulthood along with a comparison group consisting of children who had not been maltreated. A key finding was that “a vast

majority of childhood sexual abuse victims are not arrested for sex crimes or any other crimes as adults” (Widom, 1995 p. 2). Any form of child maltreatment results in an increase risk in juvenile and adult criminal behavior and there is a greater association between adult sex crimes and physical abuse (6.2% likelihood) than child sexual abuse (3.9% likelihood). The differences among the groups in likelihood for arrest for one particular sex crime, prostitution, were significant. Though arrests for this crime were rare (3.3%), child sexual abuse victims had a 27.7 times higher chance than the control group for being arrested for prostitution as an adult (Widom, 1995).

The Center for Sex Offender Management cites research conducted by Hunter and Figueredo (1999) many adolescents who commit sexual offenses do have histories of being abused, but this does not mean that the majority of these youth grow up to become adult sex offenders. Recent research suggests that the age of onset and number of incidents of abuse, the period of time elapsing between the abuse and its first report, perceptions of how the family responded to the disclosure of abuse, and exposure to domestic violence all are relevant to why some sexually abused youth go on to sexually perpetrate while others do not (Hunter and Figueredo, 1999 as cited by CSOM, 2000).

Evidence in resiliency literature suggests that “two-thirds” of any population of “at-risk” children (including victims of abuse and neglect) seem to “survive risk experiences” without major developmental disruptions (Kirby and Fraiser, 1997 p. 14).

In addition some research has been conducted assessing particular factors associated with resiliency in the victim-offender cycle with victims of childhood sexual abuse. Lambie, Seymore, and Adams (2002) conducted a retrospective study of two groups of childhood sexual abuse victims in a community sample. One group was called the resilient group (they did not go on to perpetrate child sexual abuse) and the other an offender group (they did go on to perpetrate child sexual abuse). The researchers collected demographic variables, administered a measure used in Canada to assess prevalence and impact of child sexual abuse, and a measure to assess family and social environment to categorize and assess qualitative themes from both groups. All measures were self-report.

Results of the analysis concluded that there were significant differences between the subjects in their experience of child sexual abuse, age (resilient group was younger), education level, social relationships, and perceived emotional support. The following table summarizes the differences between the offender and the resilient group.

Differences in Victim-Offender Group and Resilient Group	
Victim-Offender Group (n= 41)	Resilient Group (n= 47)
Experiences of Sexual Abuse	
- Did not report greater sexual arousal and pleasure during abuse experience - Did report fantasizing and masturbating after the abuse	- Experienced more emotional comfort with the abuse (providing friendship, being kind, and providing gifts) associated with their abuse -
Education Level	
- Lower level of education (Group had more subjects with elementary school education only)	- Higher Level of education (Group had more subjects degrees and diploma level qualifications)
Social Relationships and perceived emotional support	
-More frequently reported an adverse home environment acted as an obstacle to receiving emotional support	- Subjects had a wider range of social contacts and frequency of contacts - Subject perceived that they received support from a wider variety of sources

Note. From "Resiliency in the Victim-Offender Cycle," by I. Lambie, F. Seymore and P. Adams, 2002, *Sexual Abuse: A Journal of Research and Treatment*, 14, p.31-48. Copyright 2002 by Plenum Publishing Corporation.

The researchers summarized that "certain factors can be identified that if present increase the likelihood a male victim of child sexual abuse will sexually offend" (Lambie, et al., 2002 p 43).

Some studies have noted that there is a greater impact of sexual abuse when there is a "close relationship" between the victim and perpetrator, a higher frequency of abuse, timeframe of the abuse, and if the abuse involved force (Kendall-Tackett, Williams, and Finkelhor, 1993; Beitchman, Zucker, Hood, da Costa, and Akman, 1991). The impact has been associated with outcomes such as higher depressive symptoms, substance abuse and other mental disorders. The distinction should be made that these factors may not be associated with a CSA victim's propensity to perpetrate (Lambie, et al., 2002).

D. Victim and Relationship Characteristics

Righthand and Welch (2001) summarized that the victims targeted most frequently were "female children" with "male victims" making up about "25% of some samples." The average age of victims is under the age of 7, according to the Uniform Data Collection System of the National Adolescent Perpetrator Network (Farris et al., p. 7 1993). The victims in the sexually exploitive relationships "tended to be much younger than the perpetrator, usually relatives or acquaintances," and "babysitting often provides" the opportunity to offend (Righthand and Welch, 2001).

E. Use of Aggression

Though juveniles have been shown to be less violent than adults, Righthand and Welch (2001) summarized that studies indicate they may use "intimidation, threats of violence, physical force, or extreme violence." In one study (n=91) 40% of the offenses examined were accompanied by aggression (Miner, Siekert, and Ackland, 1997). Juveniles who offended against adults tended to use more force than those who offended against younger children or same age victims.

F. Recidivism

Research summarizing recidivism after juveniles have been referred for treatment indicates that there are low rates (8-14%) of sexual recidivism (Kahn and Chambers, 1991; Miner, et al, 1997; Rasmussen, 1999; Schram, Milloy, and Rowe, 1991; Sipe, Jensen, and Everett, 1998; Righthand and Welch, 2001). Differing definitions of and methodologies used to assess recidivism may also account for the differences in these recorded recidivism rates. In addition the longer term follow-up studies assessing recidivism post-treatment, intervention, or discharge tend to show higher rates of recidivism. Rassmasun's (1999) five year observational study (n=170) reports a 14.1 percent recidivism rate after the commitment of the first sex offense and referral to some sort of treatment, while Kahn and Chamber's (1991) 20 month follow-up study (n=221) documents a 8% recidivism rate post treatment.

A meta-analysis on the effectiveness psychological treatment for sex offenders (four of which included treatment for adolescent sex offenders), treated and untreated, found that the sexual recidivism rate was lower for specialized treatment groups (12.3%) than comparison usual services or non-specialized treatment groups (16.8%) (Hanson, Gordon, Harris, Marques, Murphy, Quinsey and Seto, 2002).

IV. Subtypes of Juvenile Sex Offenders

Four of the most commonly noted special populations of young sex offenders selected for inclusion in this literature review are young children, juveniles with developmental disabilities or mental retardation, male adolescents, and females.

A. Young Children

Pithers, Gray, Busconi, & Houchens (1998) was the first study to develop "empirically derived" subtypes of young children with sexual offending behaviors. The sample included 127 children ages 6-12 who had sexual behavior problems.

The "problematic" behaviors that were included were "repetitive, unresponsive to adult intervention and supervision, equivalent to adult criminal violations, pervasive, occurring over time and in different environments, and diverse (consisting of a variety of developmentally unexpected sexual acts)" (p.386).

Five subtypes were identified: “sexually aggressive, non-symptomatic, highly traumatized, abuse reactive, and rule breaker.” The factors that distinguish these subtypes are as follows:

1. Sexually aggressive children tended to have the highest rates of conduct disorder diagnosis. These children were more likely to penetrate victims and were victims themselves.
2. The non-symptomatic children were, as the classification name implies within the normal range on most test measures. They typically did not have a psychiatric diagnosis, evidenced low levels of aggression in their sexual behaviors and had the fewest victims. These children were more likely than other children to have extended family members who had perpetrated sexual abuse.
3. Both the highly traumatized children and the abuse reactive children typically were among the youngest and had the highest average number of victims. These two groups of children also had been victimized the most (greatest number of sexual and physical abuse perpetrators).
4. The highly traumatized children had the highest incidence of psychiatric diagnosis and posttraumatic stress disorders. Their parents were most likely than other parents to report feeling less attached to their children.
5. The abuse reactive children had the shortest time between their own personal victimization experiences and the onset of their abuse against others. They experienced a high level of maltreatment and had a high number of sexual abuse perpetrators. This group had a high incidence of oppositional defiant disorders. Occasionally aggression accompanied their offenses.
6. The rule-breaking group included a higher number of girls and had a greater lag time between their own victimization experiences and the onset of their abuse against others. These children had higher levels of sexualized and aggressive behaviors and also were more likely to act out in nonsexual ways. They had the highest number of sexual abusers within their extended families.

The most severe younger children who sexually abuse across all five subtypes were those children who were abused by more perpetrators and had impaired attachments with their parents. These children had a greater number of victims.

B. Juveniles with Developmental Disabilities and Mental Retardation

Though there are few studies conducted to date on this particular group, one citation (Gilby, Wolf, & Boldberg, 1989) gives the results of a survey that was conducted to gather some preliminary data on the “extent and types of sexual problems among groups of mentally retarded and intellectually normal adolescents.” The authors concluded that mentally retarded adolescents are dealing with sexuality and are just as likely to show sexual problems as their normal intellect counterparts do. The closer adolescent sexual behaviors are observed the more problems are found. The authors also point out that mentally retarded adolescents with sexual problems are typically closely observed in structured residential or community based programs, therefore upon admission the sexual behavior problems are usually known. Conversely, normal intellect

adolescents are not observed closely until they enter some kind of treatment or have charges pending for a sexual offense of some sort. This phenomena may account for the seemingly over-representation of MR adolescents with sexual problems.

According to the survey, mentally retarded adolescents with sexual behavior problems are more likely to show inappropriate, non-assault sexual behavior (public masturbation, exhibitionism). When looking at the MR adolescents in the sample, the authors note that there is much less consensual sexually deviant behavior in the outpatient sample. Consensual behavior increased with the inpatient sample and the authors speculate this is due to more opportunity.

In treatment this subtype of juvenile sex offender may present with organicity, affective disorders, psychotic thought processes, gender identity and self-esteem issues. Mental status exams are crucial when providing mental health treatment to this specific population. Clinicians should note that mentally retarded offenders might have difficulty recalling sexual events or responding to standard paper and pencil tests and remain sensitive to this. When making a diagnosis, clinicians need to be aware that the mentally retarded individual should first receive the MR diagnosis on Axis I. Sexual offenses and inappropriate sexual behaviors should not be regarded as a primary diagnosis (Hingsburger, 1988).

C. Male Adolescents

Hunter, Figueredo, Malamuth and Becker (2003) conducted a study across multiple public and private sites from across the United States (n= 157). They found that there are differences in males who offend against younger children and males who offend against adolescent females.

Males who offend against young children “were more likely to: be related to their victims; commit offenses in the victims home; have a prior arrest history; show greater deficits in psychosocial functioning; be less aggressive, know their victims, and were less likely to be under the influence of alcohol” (p 40). Close to half of all the males in this subtype met assessment criterion for intervention for depression and anxiety.

Males who offended against adolescent females “were more likely to: use force and a higher level of force; use a weapon; and be under the influence of alcohol or drugs at the time of offense.”

D. Females

Ray and English (1995) looked at social services statewide data on children who were identified as “sexually aggressive.” Overall they found that girls tended to be younger than boys. Girls were less likely to rape (defined as forced oral or genital penetration) their victims. Ninety four percent of the girls (85% of the boys) were victims of sexual abuse and more the girls (94% verses 86%) had experienced multiple forms of abuse. Girls were more likely to be truant, steal, and have temper tantrums than

the boys in this sample. Girls were equipped with more social skills and empathy than boys in this sample. A striking contrast the authors found in this study was that “although approximately one-third of all the juveniles studied were legally charged with an offense, only 2 girls (as contrasted with 93 boys) were charged” (Ray and English, 1995). This phenomenon may be due to the society's unwillingness to confess that females commit sex offenses. More girls in the sample also received assessment and treatment for their previous victimization. This finding may also indicate that sex offenses females commit or would have committed as a result of their own victimization are more often prevented.

Several studies point to socially accepted daycare arrangements (Bumby and Bumby, 1997; Fehrenback and Manastersky, 1997; Johnson and Shrier, 1987; Hunter, Lexier, Goodwin, Browne and Dennis, 1993) in which females engage in sexually abusive behaviors. Female juvenile sex offenders like their male counterparts across all studies reviewed experienced academic difficulties, expulsions, and difficulties with peers. Studies have also indicated that female sex offenders tend to have experienced a higher rate of sexual abuse or victimization themselves (Bumby and Bumby, 1997; Hunter et al., 1993; Ray and English, 1995; Mathews, Hunter, and Vuz, 1997).

V. Legal Context

A. Federal Mandates

Federal and state legislation has a direct impact on the how adjudicated juvenile sex offenders are managed in the communities in which they live. The registration of sexual offenders began in 1994 with the enactment of the Violent Crime Control and Reinforcement Act. The law was amended in 1996 with the passing of “Megan's Law.” The amendment required state and local law enforcement agencies to release information on individuals registered under the 1994 law deemed to be necessary for the maintenance of public safety. The Pam Lyncher Sexual Offender Tracking and Identification Act of 1996 set criteria for mandatory lifetime sex offender registration, penalties for failure to register and a requirement that sex offenders notify the FBI of changes in address (Hunter and Lexier, 1998).

B. Kansas State System for the Management of Juvenile Sex Offenders

Kansas Statute 22-4901-22-4910 states that if a juvenile is convicted in juvenile court for the same crime that if committed as an adult would constitute a sexually violent crime, they must register with the county sheriff, within 10 days of being in that residing county. If attending school or an educational institution outside the county of residence, the juvenile sexual offender must register with the sheriff of that county within 10 days of commencement of the school term. The juvenile must also register with the sheriff upon 10 days of commencement of employment if the worksite is not in the offender's county of residence. The information about the juvenile offender's county of residence is then forwarded to the Kansas Bureau of Investigation where it is published on the Registered

Offender Search Website at https://www.accesskansas.org/apps/kbiro_search.html. (retrieved May 5, 2003).

As part of the Juvenile Justice Reform Act, the legislature instituted a Placement Matrix that the Kansas Juvenile Justice Authority (JJA) utilizes to identify appropriate placement for all juvenile offenders that come into custody. According to the matrix, "rape, aggravated indecent liberties, and aggravated sodomy" are acts referred to as "Serious I and violent II offender types." Sentences for these offenses range from 18-36 months or until 22 1/2 years of age (Juvenile Justice Authority Agency's FY2002 Annual Report). Prevalence and outcome data on juvenile sexual offenders in the Kansas Juvenile Justice System is not currently available but may be in the near future with the recent implementation of a statewide offense specific data management system (Personal Communication with Kansas Juvenile Justice Authority Public Information Officer, Nov., 11, 2003).

VI. Theories: Explaining and Understanding Juvenile Sexual Offenders

A. Psychodynamic

Theorist Carl P. Malquist conveys that an individual's sexually deviant interests can be traced to the persistence beyond childhood of earlier forms of sexuality as preferred expressions of sexual gratification. The individuals under functioning superego and lack of security has its roots in early childhood. Furthermore the sexual offender is seriously developmentally delayed. Malquist gives more description to the male adolescent sexual offender saying that they are "socially incompetent" have a poor self image and therefore avoid female and same age peers. The male adolescents in his theory will then gravitate toward sexual gratification they can control or are less threatened by (Martin and Kline-Pruett, 1998).

B. Socio-Ecological Theory

Brofenbrenner (1979) conveyed that youth and their families are interconnected with schools, work places, peers and their communities. The relationships with these systems have "dynamic and reciprocal influences on the behavior" of youth and families. Behavior is maintained by stress within and between transactions in these systems (Borduin & Shaeffer, 2001). Multi-systemic Therapy (MST) is based on this theory and targets interventions in the home, schools and communities to address behavior where it occurs striving to address the identified stressors. MST attempts to empower parents to gain the skill and resourcefulness needed to address the needs of their adolescent. MST also draws from techniques developed out of strategic family therapy, structural family therapy, behavior parent training and cognitive-behavioral therapy (Swenson, Henggeler, Schoenwald, Kaufman, & Randall, 1998).

C. Cognitive Behavioral Theory

Cognitive models of psychological functioning point to the sexual offending behavior as the result of a false “perception” or “cognitive distortion” on the part of the offender. In this model the theorist speculates that sexual offenders think that the victim is reciprocating his/her sexual interest. These distortions of reality are rationalizations for the behavior. The rationalizations allow for continuance of the sexual offending behavior without guilt (Martin and Kline-Pruett, 1998).

D. Social Learning Theory

Social learning theory suggests that the offender learns the behavior through modeling or through the association of deviant thoughts with a reinforcer. The sexual abuse is a “set of events” the offender has been through before and they are “re-enacting” this event with themselves in the role of the perpetrator. “This model considers sexual behavior as a habitual response that is compulsive, heavily patterned, and ritualized, which in turn makes it difficult to distinguish.” Control becomes the focus of treatment and helping the juvenile sex offender “gain personal control over their responses to stimulating events” (Martin and Kline-Pruett, 1998). Social Learning theory feeds what Weinrott (1998) calls the “Sexual Assault Cycle” that is addressed in many treatments provided to the adult sex offender population.

E. Relapse Prevention Theory

Relapse prevention theory has roots in cognitive behavioral and social learning theories (Marlatt & Gordon, 1985). Relapse prevention theory has been used for over a decade in the substance abuse field to treat addictive behaviors (Christo, 1996). According to this framework, there are certain factors (thoughts, feelings, events, and environmental circumstances) associated with an increased risk of sexual offending. Coping skills can be learned to assist individuals to manage their responses to these factors.

VII. Assessments: Best Practices

A. Individualized and Comprehensive

With respect to the heterogeneous nature of juveniles who have sexually offended, comprehensive assessments are needed to facilitate individualized treatment and intervention strategies. Righthand and Welch (2001) recommend an assessment of each juvenile's needs (psychological, social, cognitive, and medical), family relationships, risk factors, and risk management possibilities from multiple sources. Morenz and Becker (1995) noted that parents or guardians of juveniles should be involved in the assessment and in the treatment process. Victim statements, juvenile court records, mental health reports, and school records can reveal valuable information about the JSOs functioning. Kraemer, Spielman, and Salisbury (1995) suggested that assessments should address the juvenile's beliefs regarding the sex-offending behaviors;

issues of aggression, impulsivity, withdrawal, and depression; attitudes toward treatment; potential barriers to treatment; and approaches most likely to be effective.

B. Measurement Tools for Assessment

1. Juvenile Sex Offender Assessment Protocol-II –(J-SOAP II) (Prentky and Righthand, 2002) is the most comprehensive systematic review of risk factors that have been identified in the professional literature as being associated with sexual and criminal offending. The tool is designed to be used on males ranging from ages 12-18 as part of a comprehensive assessment guiding treatment. The scale is still in experimental phases to improve reliability and strengthen predictive validity but shows promise (Prentky and Righthand, 2002). The tool has 2 sections that assess static and dynamic risk. Indices cover sexual drive and preoccupations, impulsive antisocial behavior, intervention readiness items, and community stability and adjustment. The latest revision of J-SOAP II Manual is available for use and can be downloaded at the Center for Sex Offender Management at <http://www.csom.org/pubs/jsoap.pdf>. Retrieved July 5, 2003.

2. The Multi-phasic Sex Inventory (MSI) was developed originally for adults, but there is a juvenile version of the MSI. The MSI is a 300-item questionnaire specifically designed to assess denial, minimization, cognitive distortions and treatment motivation among sexual offenders. The scoring of the questionnaire is not obvious or apparent, and the test is designed to minimize the offender's ability to fake "good" responses. Reliability and validity on the revision for juveniles are not established. In their discussion of the adult MSI, Milner and Murphy (1995) discussed the issue of limited validity data but stated that in spite of this important weakness, the MSI may have clinical utility for descriptive purposes in known offender groups. Milner and Murphy (1995) did not discuss the juvenile MSI.

3. The Multidimensional Assessment of Sex and Aggression (MASA), developed by Dr. Ray Knight, Dr. Robert Prentky, David Cerce, and Alison Martino, is a computerized, self-report inventory that covers multiple domains (Knight and Cerce, 1999; Knight, Prentky, and Cerce, 1994; Prentky and Edmunds, 1997). A juvenile version is currently being validated as cited by Righthand and Welch, 2001. The questionnaire asks about attitudes and behaviors in many areas of an individual's life, including childhood experiences, family and social relationships, school and work experiences, alcohol and drug use, and sexual and aggressive behavior and fantasies. The tool includes items that have been linked with various classifications of offenders and with recidivism and includes "sophisticated" methods for assessing response biases, random responding, and dissimulation (Righthand and Welch, 2001).

4. The Child Sexual Behavior Inventory-3 (CBSI-3) (Friedrich, Beilke, and Purcell, 1989) is "the most widely used measure for assessing sexual behavior problems in children ages 6-12" (Rasmussen, 1999).

"The CSBI is a 35-item instrument completed by a parent or caregiver to determine the presence and intensity of a range of sexual behaviors in children

ages 2 to 12 over a six-month period. The instrument assesses the child's sexual behaviors on a continuum ranging from mild to aggressive and provides separate clinical scores based on the child's age and gender. This instrument is the only checklist created to specifically assess sexual behavior problems in children ages 6 to 12. Studies conducted by Friedrich et al. (1991) have indicated that sexually abused children differ from non-abused children on critical items as well as on the total sexual behavior score, with sexually abused children showing significantly higher scores" (Bonner, Walker, and Berliner, 2000).

C. The Mental Health System's Role in Assessment

The National Mental Health Association advocates for "comprehensive diagnostic and treatment services in the juvenile corrections system" conveying that they "are an indispensable early intervention tool" (<http://www.nmha.org/position/ps030198.cfm>, retrieved October 15, 2003). Other citations note that effective interventions for JSOs are provided by a marriage of mental health and juvenile corrections intervention efforts to address the balance of assisting youth to establish internal and external control over their sexually abusive behaviors (Martin and Kline-Pruett, 1998; Righthand and Welch, 2001). The mental health system may lend its expertise to the Juvenile Justice System providing consultation and training in assessment to address the mental health needs of the juvenile with sexual behavior problems.

As noted above in the prevalence of mental health diagnosis section, as many as 50% to 96% of juvenile's with sexual behavior problems in clinical samples have met criteria for at least one DSM IV diagnosis (Righthand and Welch, 2001; Pithers and Gray, 1998). There is evidence of Schizoid, Avoidant, and Dependent symptoms in offenders of younger children (Carpenter et al, 1995). Some empirically based assessment tools, repeatedly recommended in the literature, that may be utilized to assess the presence of mental health diagnosis and symptoms are listed below.

D. Empirically Based Assessment Tools to Assess Mental Health Diagnosis and Symptoms

1. The Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A). The MMPI-A has been described as the psychological test most widely used with juvenile sex offenders (Bourke and Donohue, 1996). Because of the heterogeneity of juveniles who have committed sex offenses, there is no MMPI sex offender profile that distinguishes these juveniles from others (Bourke and Donohue, 1996; Dougher, 1995). The MMPI-A's strengths include its validity scales, which help the evaluator assess a juvenile's attitude and approach to the evaluation. The MMPI-A also may be useful for gaining insight into a juvenile's personality and for assessing possible other psychopathology (Bourke and Donohue, 1996; Dougher, 1995).

2. Child Behavior Checklist (CBCL) (Achenbach, McCaughney, and Howell, 1987) is a familiar tool utilized in the Kansas Community Mental Health system. The CBCL "obtains reports from parents, other close relatives, and/or guardians regarding

children's competencies and behavioral/emotional problems. Parents provide information for 20 competence items covering their child's activities, social relations, and school performance. The CBCL/6-18 has 118 items that describe specific behavioral and emotional problems, plus two open-ended items for reporting additional problems. Parents rate their child for how true each item is now or within the past 6 months using the following scale: 0 = not true (as far as you know); 1 = somewhat or sometimes true; 2 = very true or often true." (<http://www.aseba.org/PRODUCTS/cbcl6-18.html>, retrieved May 20, 2003).

3. Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, McKrew, Cytryn, Stern and Klein, 1987) is a rating scale, which assesses a youth's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems. The CAFAS is also utilized in the Kansas Community Mental Health system.

E. The Family Environment

The family is another critical dimension to assess when serving the JSO in their community. The Family Environment Scale (FES) (Moos and Moos, 1986) was developed to measure social and environmental characteristics of families. The scale is based on a three-dimensional conceptualization of families. Additionally, three separate forms of the FES are available that correspondingly measure different aspects of these dimensions. The Real Form (Form R) measures people's perceptions of their actual family environments, the Ideal Form (Form I) rewords items to assess individuals' perceptions of their ideal family environment, and the Expectations Form (Form E) instructs respondents to indicate what they expect a family environment will be like under, for example, anticipated family changes. Data on Real Form suggest that the scales are measuring relatively distinct characteristics of family environment and with reasonable consistency. Test-retest reliabilities for the Form R subscales for 2-month, 3-month, and 12-month intervals range from .52 to .91. These estimates suggest that the scale is reasonably stable across these time intervals. The face and content validity of the instrument are supported by clear statements about family situations that relate to subscale domains. Evidence of construct validity is presented in the manual through comparative descriptions of distressed and normal family samples; comparisons of parent responses with those of their adolescent children; descriptions of responses by families with two to six or more members; and descriptions of families with a single parent, of minority families, and of older families. Additional validity evidence is provided in the manual through summaries or references to approximately 150 additional research studies. This measure would be useful in a program that evaluates family involvement in the JSOs treatment.

VIII. National Organization Efforts to Address Juvenile Sexual Offending

In the mid 80's the experts in the field advocated that juvenile sex offenders are unique and needed "offenses specific treatment" (Obrien, 1985). This awareness has resulted in formulation of juvenile specific initiatives among national organizations such

as the Center for Sex Offender Management and the Association for the Treatment of Sexual Abusers.

A. Center for Sex Offender Management (CSOM)

“Established in June 1997, the Center for Sex Offender Management's (CSOM) goal is to enhance public safety by preventing further victimization through improving the management of adult and juvenile sex offenders who are in the community. The Center for Sex Offender Management is sponsored by the [Office of Justice Programs](#), U.S. Department of Justice, in collaboration with the [National Institute of Corrections](#), [State Justice Institute](#), and the [American Probation and Parole Association](#). CSOM is administered through a cooperative agreement between OJP and the [Center for Effective Public Policy](#)” (<http://www.csom.org/>, retrieved October 31, 2003).

The Center for Sex Offender Management (2003) acknowledges that the, “the number of programs providing treatment services to juvenile sex abusers more than doubled between 1986 and 1992, and continues to climb” (<http://www.csom.org/whatsnew/2000%5Fv1%5Fn1.html#Promising%20Interventions%20with%20Youth%20who%20Sexually>, retrieved July 5, 2003).

CSOM is optimistic that this growth reflects “society’s interest” in “early intervention.” Righthand and Welch (2001) identify that the “growth of interventions” for juveniles with sexual offending behavior has progressed without the knowledge of how to “identify at risk youth, the causes of the behavior, and the most appropriate treatment for the juvenile sex offender.” It was not until the last decade, with the establishment of national organizations such as the National Association for the Treatment of Sexual Abuse, and the Center for Sex Offender Management that more centralized data on program effectiveness and standards of practice for juvenile sexual offenders are being formulated.

B. Association for the Treatment of Sexual Abusers (ATSA)

“Incorporated in 1984, the Association for the Treatment of Sexual Abusers is a non-profit, interdisciplinary organization. ATSA was founded to foster research, facilitate information exchange, further professional education and provide for the advancement of professional standards and practices in the field of sex offender evaluation and treatment” (<http://www.atsa.com>, retrieved October 10, 2003).

ATSA provides practice standards and guidelines (2001 revised in 2003) and a code of ethics (first published in 1993 revised 1997) for the treatment of sexual abusers for it’s members. The ethics and standards are a “synthesis of the professional literature” (Practice Standards and Guidelines for Members of ATSA, 2003).

The ATSA Standards and Guidelines have been organized in five domains; “training and qualifications, professional conduct, evaluation, intervention, and risk

management in the community” (Practice Standards and Guidelines for Members of ATSA, 2003). The appendices address “phallometry, polygraphy, viewing time, medications, selection of individual or group therapy, and psychological tests” (Practice Standards and Guidelines for Members of ATSA, 2003). It appears that the standards and guidelines are intended to be utilized for all ages of sexual abusers. If current research or the professional literature mentions special considerations for children and adolescents, these considerations are noted in the document.

For example, “phallometric testing has primarily been used with adults ...some practitioners have expressed concerns about the potentially harmful effects of exposing adolescents to deviant sexual content in the context of phallometric testing (ATSA Practice Standards and Guidelines, 2003).

The standards and guidelines are available for order via ATSA's website (<http://www.atsa.com>) and provide a starting place for the care and treatment of children and adolescents who sexually abuse.

In addition to the Practice Standards and Guidelines, ATSA developed a public policy position paper, in March of 2001, on “The Effective Legal Management of Juvenile Sexual Offenders.” This paper highlights the serious problem of juvenile sexual offending while encouraging a “balance” of a “rehabilitative focus” that enforces “criminal justice sanctions” when possible. The document explains that there are “important distinctions between juvenile and adult sexual offenders” as well as the heterogeneous nature of the juvenile sexual offender. ATSA states, “Recent prospective and clinical outcome studies suggest that many juveniles who sexually abuse will cease this behavior by the time they reach adulthood, especially if they are provided with specialized treatment and supervision.” ATSA encourages “treatment efforts that engage families, parents, and caregivers.”

ATSA makes 5 specific recommendations for legal management of juvenile sexual offenders:

1. High quality, juvenile specific, community based treatment be mandated for juvenile sexual offenders whenever possible.
2. The Association for the Treatment of Sexual Abusers believes that juveniles should be subject to community notification procedures in only the most extreme cases and instead that enhanced community monitoring and supervision should be provided to ensure public safety.
3. The Association for the Treatment of Sexual Abusers encourages the prosecution and adjudication of adolescent sexual offenders in the juvenile courts. At the same time, ATSA supports and encourages continued adherence to the Juvenile Justice system's long standing commitment to a rehabilitative focus with juvenile sexual offenders.
4. The Association for the Treatment of Sexual Abusers supports the development of primary* (i.e., community focused) and secondary* (i.e., focused toward "at-risk"

juveniles) prevention efforts as a potentially effective means of reducing risk factors that may foster the development of sexual offending in juveniles.

5. The Association for the Treatment of Sexual Abusers encourages continued research on the etiology, assessment, prevention and treatment of juvenile sexual offending.

The complete position paper is included as an appendix of this review and can also be downloaded at ATSA's website (<http://www.atsa.com/pubPPapers.html>, retrieved October 31, 2003).

IX. Empirical Evaluations of Treatment: What Doesn't Work? What Does Work?

A. Traditional Approaches

In spite of the rapid growth of programs specifically designed for juvenile sex offenders, evaluation of these specialized approaches has been limited. Many of these unstudied programs are inpatient/residential and focus on learning about the long-time established "sexual assault cycle" (Righthand and Welch, 2001) which has been used for years with the adult sex offender population. The concern when this theory is applied toward JSOs is it fails to encompass "naive experimenters, those who desist from their abusive behavior, those who perpetrate sex offenses as part of a group, and those whose sexual behavior may be a result of significant psychopathology or deviant sexual arousal" (Righthand and Welch, 2001). Chafin and Bonner (1998) warn against the allegiance those in the treatment field have pledged to the acceptable and effective approaches for the treatment of JSOs that have no empirical evidence to support them.

The undocumented assumptions and the myths about adult treatment models include;

"sex offender-specific treatment is the only acceptable and effective approach and that all teens and children who have performed inappropriate sexual behaviors must receive it; that a history of personal victimization is usually present, is a direct cause of abusive sexual behaviors, and must be a focus of treatment; that denial must be broken; that hard, in-your-face confrontation is synonymous with good therapy; that treatment must be long term and involve highly restrictive conditions; that deviant arousal, deviant fantasies, grooming [of victims] and deceit are intrinsic features; that parents and families of offenders are generally dysfunctional; that long-term residential placement is commonly required; that behaviors always involve an offense cycle or pattern that must be identified; that these teenagers and their parents must face the fact that they have a compulsive, incurable, life-long disorder; and that these youngsters are such dangerous predatory criminals that neighborhoods must be notified of their presence." (p.314)

Critiques of programs that utilize these strategies are that juveniles may confess to deviant sexual behaviors so that they may be discharged from the treatment and that

comparison treatment groups are needed to establish whether treatments that adhere to these philosophies are in fact effective (Righthand and Welch, 2001).

B. What Does Work? What is Generally Known about effectiveness of existing clinical interventions?

Kahn and Chambers (1991) conducted a retrospective study of case data to assess re-offense risk in a 20-month post-treatment period. The juvenile sexual offenders ranged from ages 8-18. Over 50% of the juveniles had a previous nonsexual criminal history. The researchers reviewed records from juveniles participating in one of ten programs in Washington. The programs were "seven juvenile court sponsored outpatient projects, one university-based program, and two institution-based correctional treatment programs" (Kahn and Chamber, p. 334 1991). The interventions incorporated many different treatment approaches. The researchers (1991) found that community-based outpatient treatment generally was as effective as incarceration in preventing juvenile sexual re-offending. Though the sexual re-offense risk was low (7.5%), nearly half of the participants had another criminal offense. Another key finding was that of the participants who were diverted (a small number that the authors don't give but they do say the finding was significant at $p < .015$) from formal adjudication and received treatment, all re-offended criminally. Though these were not sexual re-offenses, this finding supports adjudication to decrease general criminal re-offending.

Rassmassun (1999) conducted a longitudinal study on youth referred to the Utah Juvenile Court/Division of Youth Corrections ($n=170$) in three urban counties in 1989. They followed the participants over a 5-year period. They studied independent variables associated with recidivism one of which was clinical intervention. Participants were counted as having clinical intervention in community based, residential, inpatient, or out of home care of any time for the sexual offending behavior. Though, the measure of recidivism (another documented sexual offense) was conservative, they recorded a 14% rate after the first adjudication and referral to treatment (though not all referrals completed treatment). The study found that youth who did not complete treatment were 49% more likely to sexually recidivate than other youth.

A nationwide survey of programs on current practices in assessing, treating and managing sex abusers concluded that "no best practice standard" has been developed concerning what percentage of programs should be located in the community. The field "widely accepts that a range of service options across a continuum of care is needed." Given the research on the relationship between program setting and program effectiveness, placement of sexual abusers in the least restrictive setting in which their risk can be effectively managed is an important disposition consideration" (McGrath, Cumming and Burchard, p. 17 2003).

C. Empirical Evaluations of Specialized Programs for Juveniles Who Sexually Offend

1. Outpatient Interventions

a. Multi-Systemic Therapy (MST)

An evaluation was conducted on Multi-systemic therapy (MST) specifically designed for the juvenile sex offender population. A multi-agent, multimethod assessment battery was utilized to assess theory driven interventions in 48 juvenile sex offenders who were randomly assigned to an MST group and a usual services group. Usual services consisted of "outpatient therapy (utilizing an eclectic blend of psychodynamic, humanistic, and behavioral approaches)" (Borduin and Schaeffer, 2001).

The MST youth and their families showed improvement on a range of self-reported behavioral outcomes: less self reported criminal offending, improved peer relations, improved family interactions, better grades in school, and decreased symptoms in parents. The MST youth also spent less time (75) days in out of home placements. An eight-year follow-up with these youth also revealed that the MST youth were less likely to have sexual re-offenses (12.5% vs. 41.7%) and non sexual re-offenses (29.2% vs. 62.5%).

Hanson et al., (2002) cites in a meta-analysis of the empirical studies evaluating the effectiveness of psychological treatment for sex offenders (adult and youth) MST was cited as the only treatment with a "strong research design" to be effective with adolescent sex offenders.

b. Expressive Therapy and Relapse Prevention Techniques

Pithers et al. (1998) conducted a comparative study "identifying five subtypes of children with sexual behavior problems: sexually aggressive, non-symptomatic, highly traumatized, abusive reactive, and rule breaker." The study showed some differences in how children in different subtypes were influenced by various types of treatment.

Children and their families (n=127) were assigned to one of two treatment conditions at intake. One treatment was a revised form of relapse prevention, which included "an external supervision and advocacy dimension called the prevention team." The prevention team included the child, the child's caregiver, their treatment providers and treatment groups and selected advocates within the child's and caregivers world who were educated in respectful methods of providing re-enforcement for the family's abuse prevention lifestyle (Pithers et al., 1998). The other group treatment "involved expressive therapy, reportedly recommended by some national experts as the treatment of choice for children with behavioral problems" (Pithers et al., 1998). Both treatments involved 1.5 hour long parallel child and parent groups. Children's groups were conducted separately for children ages 6-9 and ages 10-12. Parents were involved in

concurrent group interventions. The Child Sexual Behavior Inventory-3 (CSBI-3) was used to assess clinical outcome.

Results indicated that children in most of the subtypes evidenced similar degrees of change regardless of treatment modality. The highly traumatized children, however, benefited significantly more from modified relapse prevention than from expressive therapy. In fact, highly traumatized children who were in expressive therapy actually evidenced a slight increase in sexualized behavior.

More than half of the highly traumatized children evidenced significant reductions in problematic sexual behavior after the first 16 weeks of treatment. In contrast, only 7 percent of the sexually aggressive children demonstrated significant decreases in their sexual behavior problems. (Pithers et al., 1998 as cited by Righthand and Welch, 2001).

The findings from this study also indicate that relapse prevention and expressive therapy were equally effective with all subtypes except highly traumatized children, who benefited more from relapse prevention. Neither intervention appeared to be very effective with the sexually aggressive subtype.

More empirically based studies exploring the commonly used modalities with subtypes of young children with sexual behavior problems are needed to assess what specific modalities are useful.

c. Cognitive Behavioral Therapy and Dynamic Play Therapy

Bonner, Walker, and Berlinger (2000) recruited children from the ages of 6-12 with sexual behavior problems from the Oklahoma and Washington State Departments of Human Services, law enforcement, physicians, foster parents, school personnel, other mental health professionals, and parents. The researchers studied the efficacy of cognitive behavioral and dynamic play interventions for participants who attended at least 9 of the 12 treatment sessions offered (n=69). They concluded that both were equally effective in improving clinical scores and in recidivism rates. Interventions were delivered in one hour group sessions for children and one hour group sessions for adults on a weekly basis for 12 weeks. Interventions were provided by a male and female doctoral level psychology student or post-doctoral psychologists. The same male/female pair conducted the children's and parent's groups, i.e., two therapists conducted the Cognitive Behavioral Therapy groups and two different therapists conducted the Dynamic Play Therapy groups.

Cognitive Behavioral Therapy is a form of psychotherapy that emphasizes the important role of thinking in how we feel and what we do. Cognitive-behavioral techniques teach that when our brains are healthy, it is our thinking that causes us to feel and act the way we do. Unwanted feelings and behaviors are the result of thinking that causes feelings and behaviors. Children learn how to replace this thinking with thoughts that lead to more desirable reactions (Bonner et al., 2000).

Dynamic Play Therapy also referred to as expressive therapy (Pithers et al. 1998) involves encouraging parents and children to engage in mutual expressive activities. Movement, “dramatic games, art activities, sound-and music-making, and video-making” are used to help parents and children experience more creativity and flexible expressiveness in their daily life, and to develop meaningful metaphors that reflect difficult issues (particularly those concerning intimacy and attachment) and emotions in their relationships. Dynamic Play Therapy differs from other approaches in two significant dimensions: a much enlarged use of physical engagement for both parents and children; and an emphasis on spontaneous creativity in moment-to-moment playful expression (Bonner et al, 2000).

The Child Sexual Behavior Inventory (CBSI-2) (Friedrich, Beilke, & Purcell, 1989) and the Child Behavior Checklist (CBCL) (Achenbach, 1991) were administered at the beginning of treatment and at the end of treatment. “There was a significant differences between children’s pre-test and post-test scores on the CBCL ” ($p<.001$) (Bonner et al, 2000 p 6). Specifically, the CBCL scores were significantly different from pre-test to post-test on the internalizing, externalizing, withdrawn, anxious-depressed, thought problems, delinquent behavior, aggressive behavior, sex problems, social competence, and activities competence sub-scales. The CBSI-2 scores were statistically significant from pre-test to post-test ($p<.001$). The researchers found no significant differences in scores between the CBT and DPT groups.

Recidivism rates were explored at 2 years following intervention for 29% ($n=20$) of the participants. “Subsequent inappropriate or aggressive sexual behavior” was observed in 15% of the CBT group and 17% in the DPT group (Bonner et al., 2000).

Hanson et al., (2002, pg 189) found in a meta-analysis (consisting mostly of interventions of adult evaluations) of effective treatment programs that “some form of cognitive-behavioral treatment” has been shown to be effective with adult sex offenders. More studies assessing these interventions with random assignment and larger sample sizes with children and adolescents will clarify if cognitive-behavioral treatments are an evidenced based practice for the juvenile sex offender.

2. Residential Programs with specialized treatment for juvenile sex offenders

Kimball and Guarino-Ghezzi (1998) conducted an evaluation of the efficacy of treatment of juvenile sexual offenders for the Division of Youth Services in the state of Massachusetts. A specialized treatment program achieved better community outcomes and recidivism rates than a “usual” treatment group.

The specialized treatment programs were residential in nature and consisted of relapse prevention in which youth engaged in 6-7 hours of group therapy using peer group confrontation to address, denial, victim impact, motives and antecedent events to the offending behavior for at least a year. The comparison group usual services consisted of 2 hours a day group therapy, sex education, life skills training, substance abuse intervention for 6-8 months in a residential type setting.

The treatment group consisted of 44 adjudicated juvenile sex offenders and the comparison group 31 adjudicated juvenile sex offenders. Random assignment was not possible. Placement was determined by administrators at DYS and had more to do with the “administrative expediency” (Kimbal and Guarino-Ghezzi, 1998) rather than level of need. Demographic backgrounds of offense history were similar.

Community transitions outcomes show that the specialized treatment group succeeded in their aftercare placements at a significantly higher rate ($p < .05$) than the non-treatment group (70.6% versus 41.2%). Success was not defined by the authors. They also report additional sex offender treatment during community transition “seemed to be beneficial” (Kimbal and Guarino-Ghezzi 1998. p.51).

Recidivism rates for both treatment groups were measured 12 months post treatment. Recidivism was defined as an arraignment of any kind. The recidivism rate for the specialized treatment group was 30.3% for any offense and 0% for sexual offenses. The recidivism rates for usual the usual services group was 48% for any offense and 4% for a sex offenses. These recidivism rates are higher overall rates than the community sample studies.

Kramer et al. (1998) explored the specific variable associated with treatment failure with a juvenile sex offending population served in a residential program. The sample included 78 youth ages 12-17 who had sexually abused children at least 3 years younger than themselves. The intervention involved 10 specific treatment goals focusing on an autobiographical statement, victimization of others, assault cycle, deviant thinking, victim reconciliation, relapse prevention, three by threes (facts, thoughts, and feelings before, during, and after his acting-out behavior), healthy functioning, control, revenge, anger and power (CRAP) issues and victim empathy (Kramer et al., 1998).

Fifty three percent successfully completed the program. Successful completion was defined as achieving sexuality-specific goals (see 10 goal topics described above) to the satisfaction of a multi-disciplinary team. There were 47% who were not successful due to “decampment,” decision to end treatment by staff for failure to meet goals or because the participant was harmful to himself or others. Another sample was collected (n=35) and 57% successfully completed and 42.9% did not.

The information obtained from the battery of tests administered upon entry into the program showed that older age (Mean = 14.25) and impulsivity were the only two variables associated with treatment failure. The Jessness Inventory (Jessness, 1966, 1991 cited by Kramer et al., 1998) was chosen as it has been used for classification and treatment purposes and to predict delinquency and monitor a juvenile's psychological change over time.

Sexual behavior specific indicators obtained from the MSI-J-R (Multiphasic Sex Inventory Juvenile Version Revised) yielded no statistically significant associations that would predict treatment non-completion.

Some authors have noted that Juvenile Sexual Offenders placed in more restrictive settings are more chronic and severe. This may be the reason that they tend to have higher recidivism rates (Rasmussen, 1999). A previous literature review on Group Care for Children and Adolescents summarizes empirical literature that indicates “violent, severe, chronic offenders experience significantly better outcomes in family foster care than those placed in group care” (Barfield and Petr, p 4, 2002). The family foster care model for juvenile sex offenders is described in the promising practices section of this review.

C. Recidivism as an outcome measure for treatment effectiveness

Righthand and Welch, (2001) summarized that “most outcome studies have used recidivism rates to assess treatment effectiveness.” Research regarding recidivism on the adult sex offender population indicates that a clear “distinction” about what constitutes recidivism is critical to gain accurate information. The National Crime Victimization Surveys (Bureau of Justice Statistics) conducted in 1994, 1995, and 1998 indicate that only 32 percent (one out of three) of sexual assaults against persons 12 or older are reported to law enforcement (CSOM, 2001). If researchers are relying on public record, they will miss the underreported incidents of sexual offenses. There are different levels of severity researchers must take into account when utilizing recidivism as an outcome measure for program evaluation (Rasmusun, 1999). Controlled, longitudinal program evaluations looking at specific aspects of the re-offending behavior (outside of documented public records) will be useful in getting an accurate representation of JSOs who re-offend.

X. Promising approaches

A. Multi-Treatment Foster Care (MTFC)

One evaluation of multi-dimensional foster care (MTFC), which is similar to MST only youth are placed in a foster home to receive treatment instead of their family home, included some juvenile sexual offenders who were randomly assigned to regular “community based group care settings” and MTFC. Juveniles had less justice system referrals and returned home to relatives more often than those in group care settings (Chamberlain & Reid, 1998). MTFC was a better predictor of reduced offense rates than other well-know predictors.

B. Wraparound Milwaukee

The program began as a multi-system collaborative pilot project supported by a grant form the Substance Abuse and Mental Health Services Administration. The program has served juvenile sex offenders referred to them by the court system since 1995. The average daily enrollment is 560 youth. At any given point, 65-70 of these youth are adjudicated juvenile sex offenders. These adjudicated juveniles are served in Wraparound Milwaukee as a “court ordered condition of probation” (Hunter, Gilbertson, Vedros, and Morton, 2003, In press).

Care coordinators are educated at the bachelor's level and are "intensively trained and certified in the wraparound process by Wraparound Milwaukee." The care coordinators maintain no more than eight families on their caseload at a time. Care coordinators do not provide treatment they broker services that match the identified needs and risks identified by the child and family team. The teams for the juvenile sex offenders include the probation or parole officers and professionals who are providing specialized support services. The teams develop a broad treatment plan that reflects the needs across multiple domains in the youth and families' lives. Special care is taken with enrolled juvenile sex offenders. The teams carefully plan "individualized strategies" to establish "public safety," hold participants "accountable," and "strengthen relevant youth and family competencies." (Hunter, et al., 2003, In Press).

Preliminary program outcome data shows system change (reallocation of monies to community services as opposed to residential programs) and financial gains per juvenile treated (overall cost per child, per month for the care dropped by 18% between 2000 and 2002). Hunter et al., (2003 in press) attribute this change to "broader implementation and offense-specific and holistic assessment, the development of viable community resources, and the corresponding decreased reliance upon residential treatment as the sole means for treatment."

Individual participant outcomes on recidivism were measured to evaluate program effectiveness. Recidivism included any arrest and/or adjudication after the initial arrest and/or adjudication. Recidivism outcomes show promise. A sample of 202 youth were examined beginning in January 2000. The average length of enrollment for these juveniles with sexual behavior problems in the program was 16.5 months. Adjudicated sexual recidivism (n=202) during enrollment was 8%. One year after enrollment (N=100) the recidivism was 2% (Hunter et al., 2003, in press). Dressen (2002) documented that at a five-year follow-up on 1996 program referrals indicated that the sexual recidivism rate was 15.5%. Longer-term examination of recidivism is currently underway and will be compared to the rates Dressen noted in the 1996 sample to assess system changes in Milwaukee.

A limitation of this evaluation may be the way in which recidivism is tracked as some sexually assaultive behavior may occur after enrollment but may not be reported or warrant an arrest or adjudication. As noted in the previous section individual follow-up interviews with service personnel, participants and caretakers may provide a more accurate picture of sexually assaultive behavior post-treatment (CSOM, 2001). Also the follow-up sample does not include 102 participants being tracked in the January 2000 original sample.

C. Norfolk, Virginia

Hunter, 2002 describes a comprehensive plan for some "case management protocols" for providing services to juvenile sex offenders in the community. The information in the report was developed for the Virginia Department of Juvenile Justice

by the "Community-Based Sex Offender Management Advisory Committee." The advisory committee included a broad range of systems representatives. The guidelines were developed based on clinical and legal experience handling juvenile and adult sexual offenders and had not been validated through research. The model has three main foci of intervention: 1) to maintain public safety; 2) to hold offenders accountable; and 3) to present offenders with the opportunity to receive specialized treatment.

The program targets two populations, males 12-20; 1) placed on probation, supervised and treated in the community and; 2) returning to the community following treatment in a residential or institutional setting.

A psychosexual risk assessment is conducted by a certified sex therapist to determine needs. In addition a "formal risk, needs, personality and family functioning measures are utilized to gather information. It is unknown from the publication reviewed what these measures are of if they have been empirically validated.

The interventions blend social logical theory with other sex offender specific interventions. Interventions include groups for juveniles and families, individual therapy, in home services. The sex offender specific interventions include sexual offender treatment group which focuses on changing cycles of behavior, enhancing empathy, awareness of victim impact, controlling sexual arousal, teaching relapse prevention, conflict resolution, and impulse control. Role-play, therapeutic assignments, and group process are utilized to intervene in the group sessions. Probation and Parole officers along with treatment providers utilize a relapse prevention framework as they strive to build "collaborative networks with discharging" youth (Hunter, Gilbertson, Vedros and Morton, 2003 in Press).

Measurement strategies were not listed explicitly in the citation, however, it appears the evaluators surveyed youth and program staff.

The program served 25 youth in the first year of operation. Young males in the program ranged from 12 to 19 years of age. When a youth received services in the community as opposed to group homes and other residential placements the cost would be \$50-60,000 less per year per youth.

Individual Outcomes

- The majority of youth admitted to the program acknowledged all or some part of the sexual offenses of which they were convicted (87.5%) and took total or partial responsibility for the behavior (82.6%).
- As expected, denial was higher in probation than post-institutional treatment, parole cases. Slightly more than one-half of youth on probation acknowledged "everything" that they had been accused of, in contrast to three-quarters of those on parole.
- As expected, the youth's level of compliance with legal and clinical directives appeared to be linked to level of family support and parental compliance.

- Consistent with past research (Hunter & Figueredo, 1999), acknowledgement of the sexual offense and acceptance of responsibility for the offending behavior appeared to be associated with compliance with legal and treatment program requirements and positive program outcomes.
- The majority of youth were still in treatment at the time of follow-up; slightly over 16% had successfully completed the program.
- No youth committed a new sexual offense from the point of enrollment in the program to follow-up (range 1-8 months); 20% committed a new non-sexual offense.

A qualitative study of the success of the program was conducted by interviewing key court and community stakeholders. Results showed a consensus regarding achievement of the following program goals:

- Improved collaboration between clinical and legal communities;
- Improved community supervision and surveillance strategies;
- Improved decision-making;
- More focused and strategic use of in home services and mentoring;
- Increased community knowledge of juvenile sex offender issues;
- Increased community knowledge of victims of sexual offenses;
- Increased specialization and skills by probation/parole staff;
- Vastly improved psychosexual evaluation process; and
Improved treatment practices, interventions, and ongoing assessment.

Limitations of this study include the lack of a control group and the small sample size (25 youth). Comparisons of the programs individual and program level outcomes in years to come will yield more useful information about the program's usefulness.

D. Federally Funded Demonstration Projects

The Center for Sex Offender Management Office of Justice Programs U.S. Department of Justice has awarded over \$10.05 million to demonstration projects since 1999. Of the 72 grantees, 24 describe specific initiatives to enhance the management of juvenile sex offenders. Themes and concepts from the other states grant proposals include; establishing planning/advising committees to devise an approach, identifying gaps in the systems serving the juvenile sex offenders, collaboration across systems, community based treatments, establishing victim advocacy groups, family involvement in treatment, and standard assessment and treatment processes. In 2002 Kansas was one of 11 states to receive a grant, but, efforts to find if juveniles were involved in the planning

of this grant were unsuccessful. Summaries of the rest of the demonstration projects can be located on the Department of Justice website at <http://www.csom.org/vawo/vawo.html> (retrieved July 1, 2003). The following three paragraphs illustrate some innovative strategies implemented with CSOM funding.

1. Delaware County, Ohio

Through this grant, Delaware County, Ohio sought to expand and enhance existing treatment and supervision services for approximately 40 juvenile sex offenders currently on probation supervision. The Delaware County Court proposes working with young juvenile sex offenders (7-12 year olds) as well. Most offenders remain in the community; only 4-8 offenders actually served sentences in state institutions annually. Many other offenders receive jail as part of their community probation sentences. The county has a history of collaboration and effective juvenile sex offender management within their community. They propose using grant funds to hire a full time grant coordinator and coordinate existing resources and supervisions, an intensive probation counselor, a part time victim advocate, and a research coordinator. One of the primary outcomes of the grant is the implementation of at least five treatment foster care homes for juvenile sex offenders.

2. The State of Connecticut

Connecticut used its grant to support a juvenile sex offender management initiative in Willimantic, Connecticut. Willimantic is a small, low-income city surrounded by largely rural townships. The population of Willimantic stands at 22,857. The goals of the grant are to strengthen existing multi-agency collaborative efforts in an effort to better supervise, manage, and treat juvenile sex offenders; to standardize juvenile sex offender evaluations; and to establish local, community-based juvenile sex offender treatment services. The project will also encourage strengthened partnerships between the court and family service and child protection agencies, and will move to implement the recommendations of a long-standing policy advisory committee that has been working to develop comprehensive policies for the management of juvenile sex offenders in the community.

In addition to the CSOM grant, Connecticut's Department of Children and Families (DCF) has drafted a request for proposal to fund experienced existing MST program providers to serve males and females up to 16 years of age who are "DCF committed youth adjudicated for charges of sex offense and/or related charges and are on parole" (http://www.state.ct.us/dcf/RFP/RFP_Index.htm, retrieved October 31, 2003). According to the Connecticut General Statutes, the Connecticut Department of Children and Families is required by law to manage and treat children and youth who are "mentally ill, substance abusing, emotionally disturbed, delinquent, abused, neglected or children and youth voluntarily admitted to the department for any kind of services" (http://www.state.ct.us/dcf/RFP/RFP_Index.htm, retrieved October 31, 2003).

The goal of the RFP is to reduce the length of stay in residential treatment facilities, reduce recidivism, and enhance the behavioral health services for these youth. The RFP states that a 3 person JSO MST team would support 6-8 families per year by providing intensive services for 1 year. The recipients of the RFP are required to track project data as well as contact MST trainers at the Connecticut Center for Effective Practice (CCEP) and "MST Juvenile Sex Offender Treatment Researcher Charles Bourduin Ph.D at the University of Missouri" (http://www.state.ct.us/dcf/RFP/RFP_Index.htm, retrieved October 31, 2003). Data regarding program effectiveness is not available at this time (personal communication with Borduin, Nov., 11, 2003).

E. Promising Theoretical Treatment Approaches

Araji (1997) looks at 10 treatment practices and interventions for children with sexual behavior problems in her book, none of which have been empirically validated. The programs emphasized personal abuse histories as a target of intervention and incorporate developmentally sensitive interventions addressing the sexual assault cycle and relapse prevention models. Individual, group and pair therapies were noted. Pair therapy is when two children are seen in therapy together. Developmental issues also come into play when treating young children as for instance a 3 year old will perceive a sexual act very differently than a 7 year old. All treatments that Araji reviewed involved parents or caretakers in various ways (training in parent and child attachment, supervision, trauma resolution) Araji also notes "the importance of developing individualized treatment plans" (p. 184). "Although a variety of interventions may be required, ranging from community-based approaches to residential care, helping families to create safe, predictable, and growth promoting relationships among family members is key to helping the sexually reactive and sexually aggressive child" (p. 187).

XI. Kansas Situation for the Juvenile With Sexual Offending Behaviors

A. Management of the Adjudicated Juvenile Sexual Offender

The 2002 statistics in the Juvenile Justice Authority (JJA) Annual Report did not delineate the number of sex offenses committed by juveniles. As explained above, sex offenses that warrant a juvenile coming into custody include "rape, aggravated indecent liberties, and aggravated sodomy" and are acts referred to as "Serious I and violent II offender types." These sex offenses are placed under the umbrella of crimes against persons in the juvenile correctional system. Regardless of a first time offense, the juvenile is incarcerated anywhere from 18-36 months or 22 1/2 years of age in a juvenile correctional facility or placed on diversion in community treatment alternatives that vary according to the region of the state. Incarcerated juvenile sexual offenders are then transferred to Beloit (if female), Atchison, or Larned. In these facilities the juvenile may receive some offense specific treatment. In the Topeka Juvenile Correctional Facility (TJCF) for instance, "classified sexual offenders" are required to attend a class entitled "Family Planning and Parenting." They also receive some "substance abuse programming" and "individual sex offender counseling." (Winds of Change, 2002).

Crimes against persons constituted 64% at Topeka Juvenile Correctional Facility (TJCF), 60% at Beloit Juvenile Correctional Facility (BJCF, the facility for females) and 8% at Larned Juvenile Correctional Facility (LJCF). In the current Juvenile Justice system, a first time juvenile sexual offender could be incarcerated with a first degree murder juvenile offender. There is no data available to the public that denotes how many of these crimes against persons were a sexual offense at the present time. These statistics may bring up concerns when we take into account the empirically validated theory that "exposure of less antisocial youth to more characterologically disturbed youth may produce enduring negative treatment effects" (Dishon et al., 1999). The Juvenile Justice Authority in Kansas has recently launched (as of July 2003) a juvenile justice information system that will be able to track offense specific adjudications in their care as well as adjudications that were deferred to the community. This data will be useful to assess the prevalence of juvenile sex offending in Kansas.

According to the public information officer with the Kansas Juvenile Justice Authority, if the juvenile is not committed to a correctional facility for an adjudicated sex offense they may be placed on diversion. Depending on the area of the state in which the juvenile is from, they are referred to the care of a community case management agency or a Juvenile Intensive Supervision and Probations Services Agency. These agencies are responsible for identifying and coordinating appropriate treatments to address the sexual offending behavior. The juvenile justice authority at the state level relies on local probation officers and case-managers coordinating care to access specialized treatment services. Data is not available at the present time to assess offense specific adjudications or sexual recidivism of juveniles in the Kansas JJA community-based diversion programs. In approximately 4 years this data will be available.

Colorado's diversion programs show promise. Recidivism outcomes in the 1998 to 1999 fiscal year in Colorado for JSOs in diversion indicate that 83% of the sample ended the program without re-offending or failing to comply with the program (Campbell and Lerew, 2002). The researchers conducted a review of Colorado's diversion program to assess the demographic constructs of the juvenile sex offenders in diversion. They found that of the 112 juveniles, most were male (96.4%), between the ages of (14-15), and Caucasian (63.4%). The interventions most JSOs in diversion received were "some form of diagnostic intake and case management." The more serious sexual offenders were most frequently "assigned to" vocational and employment type programs or any other type of intervention including diagnostic interventions. The study did not report the average length of time in which the JSOs were in diversion. In addition the researchers found that approximately half (56) of the juveniles placed in diversion were adjudicated. Only 30% of the sample had a prior arrest of any kind indicating that most juveniles in diversion (70%) were first time offenders. Demographic statistics on juvenile sexual offenders in diversion programs in Kansas would be useful to stakeholders planning for the needs of this population. It may be as in the case of Colorado's diversion program, that the diversion programs in Kansas are somewhat effective in meeting the ultimate outcome of preventing recidivism.

B. Prevention Efforts, Management of the Non-Adjudicated Juvenile With Sexual Behavior Problems

Juveniles who have sexual behavior problems are usually served within the system (education, mental health, social welfare) they come into contact with first. General assessment and identification materials discussed in the report would be useful to frontline workers who work directly with children and families, so that appropriate referrals can be made or expert consultants may be contacted to address the needs of the juvenile who commits sex offenses.

The current system of care at the state level for non-adjudicated at risk juvenile sexual offenders is poorly coordinated if almost non-existent in the state of Kansas. To receive any kind of sexual offender specific services from the Juvenile Justice Authority a juvenile must be charged and convicted of a sexual act. Prevention dollars granted out by JJA are managed at the local level and are utilized for a broad range of services and initiatives. Juvenile Justice prevention dollars that have been able to address at risk juvenile sexual offenders are not clearly delineated.

The service system for non-adjudicated juveniles sex offenders is further complicated when treatment modalities require the potential offender accept a label of a juvenile sex offender or be adjudicated before they can gain access to treatment. This model of intervention is shaped after interventions targeting the adult sex offender and the literature search conducted for this review yielded no empirically validated programs utilizing this approach with juveniles.

There may be local community initiatives in Kansas that meet the needs of children and adolescents with sexual behavior problems. A survey conducted by the Safer Society Foundation in 2002 (McGrath, Cumming, and Burchard, 2003) has identified some programs in Kansas for male and female adolescents and children. Kansas has 5 community programs for adolescents and 2 for children, and 4 residential programs for adolescents. The state of Kansas would benefit from a survey finding these programs and initiatives that are effectively serving juveniles who have sexual behavior problems. These programs should be empirically evaluated to assess effectiveness and information on these best practice models in the state should be disseminated to other communities struggling to meet the needs of this juvenile with sexual behavior problems.

The Effective Legal Management of Juvenile Sexual Offenders

Adopted by the ATSA Executive Board of Directors on March 11, 2000

Juvenile Sexual Offending Represents A Serious National Concern Which May Be Best Addressed By a Balanced Approach Involving A Strong Rehabilitative Focus, As Well As Criminal Justice Sanctions When Warranted

The Association for the Treatment of Sexual Abusers (ATSA) believes that juvenile sexual offending represents a significant problem and merits careful legal and professional attention. Current estimates suggest that juveniles account for approximately 20% of the individuals charged for a sexual assault in the United States and Canada (Barbaree, Hudson, & Seto, 1993; Federal Bureau of Investigation, 1993; Statistics Canada, 1997; Weinrott, 1996). Furthermore, retrospective studies of adult sexual offenders indicate that juvenile sexual offending may, under certain circumstances, indicate more chronic patterns of sexual aggression (Kaufman, Holmberg, Orts., McCrady, Rotzien, Daleiden & Hilliker, 1998; Marshall, Barbaree & Eccles, 1991). ATSA believes that effective public policy requires the careful balancing of criminal justice sanctions which are designed both to enhance public safety and to punish criminal acts, with providing interventions. Youthful offenders who appear amenable to rehabilitation should receive those interventions. ATSA's support of rehabilitative programs is consistent with both the juvenile justice policy in a number of countries (e.g., United States, Canada) as well as the emerging research related to juvenile sexual offending.

Juvenile Sexual Offenders Differ From Their Adult Counterparts in Important Ways and Are Likely to Benefit From High Quality Treatment Efforts

Recent research suggests that there are important distinctions between juvenile and adult sexual offenders, as well as the finding that not all juvenile sexual offenders are the same. There is little evidence to support the assumption that the majority of juvenile sexual offenders are destined to become adult sexual offenders. Moreover, the significantly lower frequency of more extreme forms of sexual aggression, fantasy, and compulsivity among juveniles than among adults suggests that many juveniles have sexual behavior problems that may be more amenable to intervention.

In fact, recent prospective and clinical outcome studies suggest that many juveniles who sexually abuse will cease this behavior by the time they reach adulthood, especially if they are provided with specialized treatment and supervision. Research also indicates that juvenile offenders may be more responsive to treatment than their adult counterparts due to their emerging development. Juvenile treatment efforts may benefit as well, from the involvement of parents, caregivers, and family members, who are rarely participants in

Appendix A (continued)

adult offender treatment. These studies, in addition to clinical observation, support the growing optimism that many juvenile sexual offenders can be successfully treated.

Recommendations:

1. The Association for the Treatment of Sexual Abusers suggests that high quality, juvenile specific, community based treatment be mandated for juvenile sexual offenders whenever possible.

ATSA questions the appropriateness of imposing adult sentences for the majority of the juvenile sexual offenders. Incarcerating juveniles in adult correctional settings may restrict their access to treatment, expose them to the potentially detrimental influences of anti-social adult role models, as well as create management and safety issues. ATSA believes that most juvenile sexual offenders can be safely and effectively managed in the community if they receive specialized treatment and court supervision. Such treatment should be based upon a comprehensive assessment that allows for the tailoring and titration of interventions based upon the risks presented by the juvenile offender. It is important to recognize that community-based treatment also offers opportunities for family involvement in the treatment process as well as reintegration into productive community roles (e.g., student, employee, family member). We also recognize that some juveniles require treatment in a structured, secure residential program due to the severity of their psychosexual and psychiatric problems. ATSA recommends that sanctions which best serve the long-term interests of the community and the juvenile be considered and that those who make the final decisions have access to a broad range of potential sanctions and placement options.

2. The Association for the Treatment of Sexual Abusers believes that juveniles should be subject to community notification procedures in only the most extreme cases and instead that enhanced community monitoring and supervision should be provided to ensure public safety.

ATSA believes that juveniles should be subject to community notification procedures in only the most extreme cases. The wide variation in how communities interpret and implement notification laws is problematic, especially with juvenile sexual offenders. In some states notification is restricted to the immediate area in which the adolescent resides, ignoring their ability to move beyond these limited geographic boundaries. In other areas, the implementation of community notification varies from jurisdiction to jurisdiction with some more restrictive in their commitment to implementing notification than others. Despite the questionable public safety benefits of community notification with juveniles, it is likely to stigmatize the adolescent, fostering peer rejection, isolation, increased anger, and consequences for the juvenile's family members. Until research has demonstrated the protective efficacy of notification with juveniles and explored the impact of notification on the youth, their families and the community, notification--if imposed at all for juveniles--should be done conscientiously, cautiously, and selectively.

Appendix A (continued)

3. The Association for the Treatment of Sexual Abusers encourages the prosecution and adjudication of adolescent sexual offenders in the juvenile courts. At the same time, ATSA supports and encourages continued adherence to the Juvenile Justice system's long standing commitment to a rehabilitative focus with juvenile sexual offenders.

We believe that juveniles should be held legally accountable for their behavior. Such accountability is necessary to assist the offender in taking responsibility for their offending behavior, to ensure compliance with therapeutic requirements, and to address the needs of the victim. As part of the adjudication process, it is recommended that juvenile sex offenders be evaluated by clinicians with specialized training in working with this population. Such evaluations should determine if the juvenile is amenable to treatment and to assist the court in identifying the most appropriate type and level of care. Treatment should be a court ordered requirement for each juvenile offender and should also be provided by clinicians who have specialized training and experience with this population. Evidence suggests that the vast majority of juvenile sexual offenders respond well to treatment and do not recidivate. Most juvenile sexual offenders can be safely and effectively treated in the community, if they are provided with specialized treatment and on-going court supervision.

4. The Association for the Treatment of Sexual Abusers supports the development of primary* (i.e., community focused) and secondary* (i.e., focused toward "at-risk" juveniles) prevention efforts as a potentially effective means of reducing risk factors that may foster the development of sexual offending in juveniles.

Recent research suggests the potential for identifying risk factors related to child sexual abuse and the promise of utilizing such information to enhance the efficacy of national and community based prevention initiatives. Efforts to conceptualize child sexual abuse as a community health problem and to apply the Public Health Model (McMahon & Puett, 1999) to its prevention represent critical steps toward more effective prevention initiatives. ATSA will continue to advocate for increased prevention funding for intervention as well as research in this area.

5. The Association for the Treatment of Sexual Abusers encourages continued research on the etiology, assessment, prevention and treatment of juvenile sexual offending.

We particularly support research efforts directed at creating a juvenile sex offender typology and linking offender classification with risk assessment. Such research will contribute to an improved understanding of effective prevention and management strategies for addressing juveniles who engage in sexual aggression and provide needed guidance in determining the most appropriate clinical and legal dispositions for individual offenders.

Appendix A (continued)

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