



Sex Offense-Specific Treatment & Discharge Outcomes for Juveniles

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Abstract

When it comes to making decisions involving juvenile sex offenders, responsible stakeholders (e.g., supervising agencies, social service agencies, child protective services) look to treatment outcomes to assist them in the decision-making process. In the absence of standardized programs or a clear understanding of treatment objectives and their desired outcomes, these stakeholders may experience confusion regarding how progress or lack of progress should factor into their decisions. This paper is a companion to a similar paper outlining treatment outcomes for adult sex offenders engaged in sex offense-specific treatment. As with its companion, this paper will provide information and guidance in the hopes that a better understanding of treatment outcomes will lead to better decisions involving juvenile sex offenders, their families, and the public at large. It is not intended to address the treatment needs of sexually reactive children who are typically below the age of 12.

According to the Center for Sex Offender Management (CSOM), approximately 18% of arrests for sexual offenses involve juveniles under the age of 18, 90% of which are boys. Research and theories regarding the nature and etiology of sexual offense behavior suggest that juvenile sex offenders differ in many respects from adult offenders. Even among juvenile offenders, there are meaningful differences between pre-adolescent offense behavior and adolescent offense behavior. These differences suggest the need to understand the effects of brain development, childhood sexual abuse and other adverse childhood experiences in the etiology of sexually reactive behavior. Additionally, examining the role of the family, the social environment, and media contribute to an enhanced understanding of juvenile sexual offending. While it is beyond the scope of this paper to address the myriad factors differentiating youth offenders from one another, it is worth noting the substantial research base that has shown that juvenile sex offenders have lower recidivism rates than adult offenders and that, in general, they benefit more from treatment than adult offenders. For this reason, it is widely accepted that sex offense-specific treatment is an important intervention in the prevention of future re-offense.

As with the provision of sex offense-specific treatment with adults, it is strongly recommended that practitioners be specialized in the treatment of juvenile offenders.¹ Specialized treatment for youth with sexually abusive behaviors (excluding sexually reactive youth) typically includes a continuum

¹ The Oregon Sex Offender Treatment Board regulates all providers who obtain certification to provide sex offense-specific treatment. At the time of this writing, it is not prohibited to provide sex offense-specific treatment without SOTB certification. For more information go to <http://www.oregon.gov/OHLA/SOTB/Pages/index.aspx>

of services selected for a particular youth based on several concerns, including, community safety, victim(s) safety, the youth's assessed treatment needs, as well as, any additional factors that support the reduction of the risk for re-offense. Sex offense-specific treatment for juvenile sex offenders and youth with sexually abusive behaviors, first and foremost, promotes accountability. Treatment methods and intervention strategies follow an individual youth's treatment plan developed through a process of assessment and evaluation. Based upon results from these processes, a treatment plan is developed that sets forth the goals and treatment modalities. These include, but are not limited to psycho-education, skills training, group sessions, individual therapy, and multi-family group meetings (unless contraindicated).

In keeping with the "Risk-Needs-Responsivity" principles from the field of criminal psychology (Andrews & Bonta, 2005), treatment and supervision of juvenile sex offenders ideally considers the relative risk an offender poses (i.e., low, moderate, high), their criminogenic² needs, and the unique client-specific characteristics they possess that may potentially interfere with being able to make use of or benefit from treatment interventions. Some examples include language barriers or intellectual and/or developmental disability. Once criminogenic risks and needs are properly assessed and identified, treatment interventions target those risks and needs, in the hopes that to do so reduces an offender's risk to reoffend. Common treatment goals include, but are not limited to, learning and using healthy coping skills (e.g., anger management, frustration tolerance, problem-solving); fostering pro-social peer relationships; enhancing family relationships; sex education; and learning to manage sexual behavior. As noted above, 90% of juvenile sex offenses are committed by adolescent males, thus, interventions aimed at the development of healthy masculinity are ideally embedded in treatment.

To achieve these goals, treatment interventions typically use a cognitive-behavioral approach, which focuses on the process of identifying and then altering faulty thinking and maladaptive behaviors. Commonly, treatment focuses on the development of a comprehensive understanding of the situational, emotional, and behavioral antecedents of sexual offense behavior, in many cases, leading to the development of a Reoffense Prevention Plan. Adjunctive therapies may focus on family dynamics through the use of family therapy, as well as, psycho-education for parents in order to help to improve their parenting skills. It has long-been observed that for juveniles who have engaged in sexually abusive behavior, the more their families are involved in the treatment process, the shorter the duration of treatment.

Many treatment programs are structured according to stages or phases of growth/progress, beginning with an assessment phase, an orientation to treatment phase, a treatment intensive phase, and aftercare or a maintenance phase. The duration of treatment varies but typically lasts between 1 and 5 years, depending on client motivation, as well as other variables affecting treatment prognosis (e.g.,

² The word "criminogenic" refers specifically to risks and needs associated with criminal conduct, not risk or needs associated with issues unrelated to criminality.

level of risk and needs). The goals of each phase are routinely assessed. As the individual youth successfully completes the assigned task of each phase, he or she progresses to the next phase. Assigned tasks vary among programs, however, it is not uncommon for programs to require, for example, the presentation of an autobiography, a sex history, no-send clarification letters to victims and other affected parties, and the completion of a relapse prevention plan. Youths address sexual self-management, deviant arousal, and healthy sexuality utilizing age-appropriate methods and/or other behavioral strategies as appropriate. Many treatment programs require passage of polygraph examinations during the course of treatment. This ensures both accountability on the part of the juvenile and allows treatment planning to address the full range of offense behavior.

In preparation for aftercare, individuals may develop plans for continuing with education, job training and/or employment, or moving toward independent living (as appropriate). Finally, the goals of aftercare are related to the ongoing maintenance of an individualized aftercare plan that may include acquiring independent living skills, obtaining housing and/or employment, getting a GED or pursuing other educational goals, and mental health aftercare, including medication management.

The desired outcomes of sex offense-specific treatment for juveniles are most effective when matched to the developmental stage and functional abilities of the individual. Younger, lower functioning or developmentally delayed juveniles cannot be expected to have the same competencies as older, higher functioning juveniles. In such cases, evidence that the juvenile is aware of risks and is able to manage them may be demonstrated by his/her willingness to ask for help when needed, avoid risky situations, cooperate with adult caregivers, and comply with rules. Aftercare and long-term reoffense prevention for juveniles who are still highly dependent or cannot reasonably master relevant outcomes will require commitment from their support systems. For juvenile sex offenders functioning without cognitive impairment, desired outcomes are expected to their capacities. In these youth, positive indicators of change that are thought to reduce the risk to reoffend include a youth's ability to: consistently recognize and interrupt patterns of thought and/or behaviors associated with his/her abusive behavior; consistently demonstrate the ability to label feelings accurately, express emotions appropriately, and show empathic responses to self and others; demonstrate functional coping patterns under conditions of stress; make accurate attributions; avoid blaming external forces and take responsibility for their own behavior; demonstrate the ability to manage frustration, anger, boredom without reverting to past maladaptive thinking and/or behaviors; and work to improve overall health, strengths, and skills necessary for successful functioning.

Outcomes indicative of a juvenile sex offender's increased overall health are many and varied. They include the youth's ability to successfully foster pro-social relationships skills and demonstrate an ability to establish closeness and trust; accurately assess trustworthiness in others and show healthy sexual attitudes such as gender equality, respect for boundaries, and safe behaviors. The youth conveys a positive self-image and an ability to be separate, independent, and competent to the extent possible given his age and maturity. He resolves conflicts and make decisions thoughtfully;

demonstrates assertive, tolerant, forgiving, and cooperative attitudes toward others; negotiates and compromises when conflicts arise; relaxes, plays and celebrates positive experiences; plans for and participates in structured pro-social activities; maintains a healthy social support system; delays gratification, perseveres in pursuit of goals, respects reasonable authority and limits; thinks and communicates effectively; and possesses a healthy sense of purpose and future.

Treatment with juvenile sex offenders whose victims are siblings poses certain additional challenges in managing the needs of the victim, the family, and the offender. Expectations of family reunification are dependent on the careful balancing of those needs. For juvenile offenders who pose a low to moderate risk, treatment is focused on reconciliation among family members through a process involving accountability and victim empathy. The “clarification” process leads to reconciliation that, under optimal conditions, leads to family reunification.

Successful completion or discharge from treatment usually refers to the cessation of mandated sex offense-specific treatment due to the termination of juvenile justice supervision. It may not be an indication of the end of the juvenile’s management needs or imply the elimination of risk to the community. Decision-makers who comprise the juvenile offender’s team (e.g., probation officer, treatment provider, DD case manager) carefully consider victim and community safety before making a determination of treatment discharge. Successful completion of sex offense-specific treatment requires compliance with treatment conditions and supervision; completion of tasks and goals identified in the treatment plan; and a demonstrated integration of skills and learning into daily practice. In exceptional cases where some of the above-stated requirements for successful completion are not met but the youth is nonetheless terminated from treatment, all those involved in the treatment and supervision of the youth document the reasons for the termination, for example, because the individual has achieved maximum benefit from treatment or has been deemed not amenable to treatment.

Sex offense-specific treatment for juvenile sex offenders and youth with sexually abusive behavior is dynamic and ever-changing. As research on this specialty population progresses, it can be expected to guide improvements in better assessing juvenile offender risk, programming, treatment interventions, and aftercare. Interested individuals are encouraged to refer to the following resources for additional information about juvenile sex offense-specific treatment:

The Oregon Adolescent Sex Offending Treatment Network at www.oasotn.org

The Association for the Treatment of Sexual Abusers at www.atsa.com

Sex Offender Treatment Board at www.oregon.gov/OHLA/SOTB/Pages/index.aspx

The Center for Sex Offender Management at www.csom.org