JUVENILE SEXUAL OFFENDER TREATMENT EVALUATION

FINAL RESEARCH REPORT

Prepared for:

Governor's Juvenile Justice Advisory Committee
State of Washington

Prepared by:

Donna D. Schram
Urban Policy Research

Wendy E. Rowe
Rowe and Associates

December, 1987

ACKNOWLEDGMENTS

This study could not have been accomplished without the assistance of many, many people. The research team is particularly grateful to the project directors and staff of the juvenile sexual offender treatment programs and the members of the research advisory committee. Without the cooperation, guidance and assistance of these dedicated professionals, the study could not have been completed. Gratitude is also extended to the many juvenile parole counselors, probation counselors, and staff of the Division of Juvenile Rehabilitation and the Office of the Administrator for the Courts who assisted us in locating and collecting data.

To all of these helpful and delightful people -- a very sincere thank you.

EXECUTIVE SUMMARY

This report concludes a two year study of juvenile sexual offenders who participated in offense-specific treatment at any of ten project sites between March 1, 1984 and October 31, 1984. This research was funded by the Governor's Juvenile Justice Advisory Committee to describe the services provided to juvenile sexual offenders in each of the projects examined and to assess the effectiveness of different modes of treatment in terms of reoffense behavior.

The major tasks undertaken during the first year of the research consisted of a survey and description of the ten juvenile sexual offender projects selected for inclusion in the study. Two projects were located in state operated juvenile institutions (Maple Lane School and Echo Glen Children's Center) and relied on group and/or individual therapy as the primary treatment modality. The remaining eight programs were based in communities and were administered by local juvenile courts or the University of Washington. These programs utilized a variety of treatment approaches, although family-centered therapy and group therapy were the forms most often favored.

Research tasks undertaken in the second year focused on the collection and analysis of case-level and criminal history data for each of the juveniles included in the study sample. Using these data, it was possible to describe, or profile, the "typical" juvenile sexual offender who participated in treatment. In general, the offender was a white male in his early teens who lived with his mother. Although he was enrolled in school at the time of the sexual offense(s), he exhibited behavior problems in the classroom and often suffered from a learning disability. He was likely to have been sexually abused by a non-related male and to have been physically abused by his father or stepfather. A history of violence between his parents was common. He sexually offended against a female child who was known to him and used threats of force or coercion to obtain compliance with his sexual demands. The sexual offense involved touching the genitalia of his victim(s), and frequently involved penetration of the vagina or anus, fellatio, cunnilingus, or masturbation.

The "typical" juvenile offender pled or was found guilty as charged and was incarcerated in a local detention facility or state institution. He was required to undergo sex offender specific treatment in a community program or at an institution. Although he admitted his offense(s), he blamed its occurrence on the victim or someone/something other than himself. He was a "loner" who was isolated from his peers and had never experienced an age appropriate sexual relationship.

Treatment for the "typical" juvenile sexual offender consisted of individual therapy in combination with some other mode, such as group or family therapy. Although he usually participated in his treatment sessions and showed insight into his offending behavior, he expressed no remorse for his act(s) or empathy for his victim(s). He terminated treatment when it was no longer required, despite his need for follow-up treatment or support and his assessed risk of reoffending.

Analysis of the criminal history data revealed that slightly less than one-half of the juveniles recidivated; that is, they were convicted of at least one subsequent offense during the period of follow-up. The most common form of recidivism consisted of convictions for new misdemeanor or felony offenses. Sexual recidivism was rare: only 7.5 percent of the juveniles were convicted of new sexual offenses.

Answers to several important research questions required analyses of the relationships between recidivism and three key treatment variables, namely location of treatment, type of treatment, and quantity of treatment. None of these treatment variables was associated with overall recidivism or with sexual recidivism. Although juveniles treated in institutional programs were more likely to reoffend than youth treated in community programs, the differences were not statistically significant. Similarly, no significant differences in recidivism were found as a function of the four primary types of treatment provided, or as a result of the number of treatment sessions attended.

Sexual recidivists were distinguishable on the basis of several characteristics. For example, youth who blamed their victims for the sexual offenses, or who verbally threatened their victims, or who forced their victims to masturbate them were more likely to reoffend sexually. In contrast, youth who denied their instant sexual offenses were significantly less likely to be convicted of new sexual offenses. Therapists were very accurate at identifying those youth who were at low risk to reoffend sexually. No juveniles who were assessed as capable of monitoring themselves were convicted of new sexual offenses.

A different set of variables characterized the overall recidivists. These youth were distinguished on the basis of their overall youthfulness, reported behavior problems in school, and histories of truancy and sexual abuse. Recidivists were less likely than non-reoffenders to use verbal coercion in the commission of their instant sexual offenses. Finally, youth were more likely to reoffend if their sexual offense referrals were diverted from the formal adjudication process. Overall recidivism was significantly lower among youth who had pled to, or were found guilty of, their instant offenses.

TABLE OF CONTENTS

APPENDICES

(Juvenile Sexual Offender Treatment Project Descriptions)

CHAPTER I

BACKGROUND AND OVERVIEW

This report summarizes the efforts and presents the products of a two year research project funded by the Washington State Governor's Juvenile Justice Advisory Committee, and is entitled "Juvenile Sexual Offender Treatment Evaluation". The project examines juvenile sexual offender treatment programs implemented in two state institutions and eight communities dispersed throughout the state.

This study focuses on treatment processes and outcomes and has three general research objectives:

1. To describe the services provided to juvenile sexual offenders, from initial referral to termination, in each project examined;

2. To collect client information from individual projects and "pool" or collapse it on the basis of the primary approaches utilized in the treatment of juvenile sexual offenders; and

3. To assess the effectiveness of different treatment modalities or approaches used to treat juvenile sexual offenders.

The information and findings presented herein are intended to address each of these major objectives.

BACKGROUND

Interest in the adolescent sexual offender has been fueled by research which indicates that juveniles are responsible for a significant proportion of all sex crimes committed against children and, to a lesser extent, against adult victims. In the

past, many of these offenses were not taken seriously by criminal justice authorities. Juveniles accused of such offenses were not charged at all, or were charged with non-sexual crimes, such as simple assault (Groth, 1977; Reiss, 1960).

Although the precise incidence of adolescent sexual offense behavior is not known, estimates have been reported from several sources. According to Deisher (1982), 42 to 56 percent of the child victims seen by three sexual assault centers were molested by offenders under the age of 18 years. Statistics on the involvement of juveniles in forcible rapes are equally impressive. In 1980, for example, official arrest statistics indicated 50 arrests for forcible rape per year per 100,000 adolescent males (Uniform Crime Reports, 1980). However, victim reports published in the National Crime Survey for this same period suggest that the actual incidence of forcible rape by adolescents is many times the arrest rate. According to this survey, juveniles were responsible for 21 percent of the forcible rapes in 1979, indicating a rate of 200 rapes per 100,000 adolescent males.

Ageton (1983) conducted an extensive study of the incidence of sexual assault using a national probability sample of male adolescents aged 13-19 years. Sexual assault was defined as all forcible contact with the sexual parts of the body, including rape, incest, sodomy, and fondling. Exhibitionism, peeping, and any other "hands off" sexual behavior was excluded. Based upon the responses obtained from the sample, Ageton found that, each

year, between 195,000 to 450,000 adolescents committed sexual assaults involving force. Frequencies of this magnitude translated to a rate of 5,000 to 16,000 sexual assaults per 100,000 adolescent males.

Onset of Sexual Offense Behavior

Studies of adult offenders indicate that many begin their sex offending careers as adolescents. In a survey of adult males convicted of sexual offenses, Groth, Longo and McFaden (1982) found that these adult offenders committed their first sexual offenses at a modal age of 16 years. Furthermore, two-thirds of the rapists and two-fifths of the child molesters had at least one prior conviction. The actual incidence of prior sexual offenses was much higher than the number of convictions indicated: offenders admitted committing two to five times as many sex crimes as those for which they were apprehended.

Groth, et al. (1981, 1982) examined the self-reported offense histories of convicted rapists and child molesters and found that 47 percent had committed their first sexual offense between the ages of 8 and 18 years. As many as 35 percent of these offenders reported progressing from compulsive masturbatory activity, repetitive exhibitionism and/or persistent voyeurism to the behavior for which they were convicted as adults. Once the offense behaviors were established, they showed remarkable continuity over time. Groth (1977) found that the sexual offenses committed by adults were often identical to those committed by them earlier as adolescents.

Persistence of Sexual Offense Behavior

Studies of self-reported sexual crimes and recidivism among adult offenders have found that certain types of offenses are likely to persist over long periods of time and involve a large number of victims. Quinsey (1981) and others have reported that sex crimes such as exhibitionism and voyeurism were particularly likely to be repeated and to have commenced as early as seven or eight years of age.

Similarly, Abel (1987) recently released the findings of an eight year national study of child molesters. The 403 offenders included in the study molested more than 67,000 children for an average of 166 victims per molester. When Abel examined only the more serious ("hands on") offenses, he found that 63 percent of the children who were sexually assaulted were little boys. Molesters who assaulted boys reported an average of 282 victims compared to an average of 23 victims among men who assaulted girls. These findings point to the repetitive, compulsive nature of some types of sexual offenses and, according to Abel, suggest the need to intervene before offense patterns are firmly established.

Characteristics of Juvenile Sexual Offenders

Ageton (1983) has conducted the only large scale study of sexual offense behavior among the general adolescent population. She examined a group of 1,725 adolescents selected from a "multi-stage, cluster-sample" of 8,000 households throughout the United States. Self-reported sex offender and victim experiences

were collected from a group of adolescents over a five year period. Among this group of adolescents, 50 percent reported one or more sexual offenses. A comparison of the characteristics of adolescent offenders and non-offenders indicated the following:

1. No significant differences between groups on the basis of race, social class, age or place of residence.

2. Offenders were significantly more estranged in all settings, including home, school and social situations involving peers.

3. Offenders were more likely to believe that achievement or attainment of control and power required the use of unconventional or illegitimate means.

4. Offenders displayed significantly more commitment and exposure to delinquent peers and received less disapproval from peers for delinquent and sexually aggressive behavior.

Ageton also found the attitudes of juvenile offenders to be significant. Almost one-half of the respondents who self-reported a sexual assault had told their close friends about the event. In most instances, their friends approved of their sexually aggressive behavior. When describing their feelings about the event, only 14 percent reported any sense of guilt.

While Ageton's research indicates that adolescent sexual offenders can be distinguished from non-offenders, other research suggests that juvenile sexual offenders can be differentiated from one another on the basis of their personal characteristics, victims of choice, and amount of violence/aggression used in the course of their offenses. Several typologies of juvenile sex

offenders have been proposed, all of which are remarkably similar.

Groth (1979), for example, distinguishes between three types of adolescent offenders. The first consists of young, unsophisticated, passive juveniles who generally just look at or fondle younger children. Exhibitionism is common among this group. The second type are those who offend against peers and are more focused on dominance and violence. The sex offenses committed by these adolescents are generally more aggressive. The third type of offender selects older, female victims. Adolescents in this group are often very disturbed, sadistic and violent. Alcohol and drug use are commonly associated with the offenses.

Deisher, et al. (1982) also differentiate among three types of male adolescent sex offenders seen most often for evaluation and treatment. The first, and most common, of these types consists of youth referred for indecent liberties (sexual molestation) involving young child victims. Offenders in this category demonstrate poor social skills, isolation from peers, and low self esteem. A significant proportion of these offenders are likely to have been sexually abused themselves. The second group of juvenile offenders are referred for sexual assault or indecent liberties with a peer or an adult. These youth often demonstrate little concern for their victims, use force or a weapon in the commission of their crimes, are quite disturbed, and resist treatment. The final group of offenders are frequently referred for non-contact offenses, such as peeping and

exhibitionism. These offenders are believed to experience serious emotional problems and feelings of inadequacy.

Wenet and Clark (1981) also describe two types of sex offenders differentiated on the basis of offense behavior and personal/historical characteristics. The first type is the adolescent child molester. This offender is generally extremely passive and feels powerless and inadequate. He has been chronically isolated as a child and has never had friends his own age. He tends to play with young children and is often chosen as a babysitter for them. The offending behavior itself has less to do with sexual arousal than with acting out frustrations and anger associated with home and school where he feels tense and out of control. The second type of offender is the adolescent rapist. This offender superficially appears to function quite well. He is not necessarily a loner, since he may have a peer group and be involved in an age-appropriate heterosexual relationship. This adolescent demonstrates little empathy for his victim(s) and abdicates responsibility for the sexual offending behavior. According to the authors, the youth who fits this type has often been raped himself and his acts are revenge motivated.

Historical Experiences and Family Backgrounds

Despite the noted differences between and among "types" of adolescent sexual offenders, research has identified a number of common elements in the backgrounds of many of these juveniles. The first of these, and perhaps the most frequently noted, is a

history of childhood sexual victimization. Researchers have reported that as many as 50 to 87 percent of all adolescent offenders were sexually abused as children (Deisher, et al., 1984; Knapp, 1983). Further, when sexual abuse of siblings, relatives and parents was considered, nearly all juvenile sexual offenders came from families in which physical and sexual abuse or sexually inappropriate behaviors were common (Smith and Monastersky, 1984). Other dysfunctional elements frequently found in these families have included marital discord, alcoholism, drug abuse, absent or emotionally distant fathers, and overly rigid family expectations (Rowe, 1983; Deisher, et al., 1982; Sonderman, 1984; and Smith and Monastersky, 1984).

Most of the theories of the genesis of sexual offense behavior have been derived from studies of the behavior and attitudes of adult rapists and pedophiles. For example, some theorists have postulated that sexual offenders are motivated out of rage, anger and the desire for retaliation (Fortune, 1983). Others have posited that sexual offense behavior is a manifestation of poor socialization or the product of sociopathology or an anti-social personality.

Perhaps the best known, and most eclectic, of these theories is the social learning model proposed by Becker and Abel (1984). According to this theory, the acquisition and maintenance of deviant sexual arousal occurs as a result of a number of direct experiences or observations. First, individuals may either observe aggressive behavior within the family, peer group, or

through characters represented in the media, or experience it directly as victims of the physical or sexual aggression of others (Abel, 1983). These exposures may predispose individuals to model the aggressive behaviors. Second, these observations or experiences may be recalled during masturbation-orgasm activities. The pairing or bonding of these deviant fantasies with sexual excitement is postulated to give the fantasies greater erotic power (Abel, 1975). Over time, a persistent deviant sexual arousal pattern develops. According to Abel and his colleagues, most adult sexual offenders attempt to control their urges, but the deviant fantasies continue. Control breaks down and they eventually act on the urges. "After committing the sexually aggressive behaviors, most offenders...feel uncomfortable or guilty and thereby gain some control over their urges. As time passes, their sexual urges again increase and the cycle begins anew." (Abel, 1984).

Social learning theory has been incorporated into most current thought about the causes of sexual offending behavior among adolescents. The strong evidence of sexual abuse, exploitation and dominance among family members of adolescent offenders suggests the importance of experiencing and modeling aggressive or deviant behavior. According to the proponents of this theory, youth who have been poorly socialized or raised in homes without good role models for functional social and assertive behavior are likely to experience difficulties relating to peers. The resultant isolation and rejection may lead

adolescents to socialize with young children and eroticize their interest in them, or to use force to obtain sexual interactions with otherwise unobtainable peer partners.

Adherents of the social learning model believe that what the offender says to himself about his behavior is critical to the development of deviant sexual interest. According to Becker and Abel (1984):

> (b)efore the offender translates his fantasies into acts, he anticipates that positive consequences will result from his behavior and that negative consequences to himself or his victim will be minor. These cognitive distortions are a result of limited sexual knowledge, a lack of empathy for the victim, a limited understanding of sexual values and faulty perceptions about his own experiences as a victim. If the sexual offender engages in a deviant sexual act and there are no negative consequences for that behavior, the behavior is then rewarded and the offender is motivated to commit further offenses.

Treatment Approaches

Mental health professionals have increasingly emphasized the need to treat sexual offenders while they are young and before patterns of sexually offending behavior have been firmly established. The first step in this process is accurate assessment of the need for intervention.

Groth, et al. (1981) believe that the clinical assessment process must differentiate among three types of sexual behavior:

1. Normative sexual activity that is situationally determined;

2. Inappropriate solitary sexual activity that is non-aggressive in nature; and

3. Sexually assaultive or coercive behavior that poses some risk of harm to another person.

Only those youth whose sexual behavior falls within items 2 and 3 above are appropriate candidates for treatment.

Treatment can be provided in either a residential (institutional) or out-patient (community) setting. While there may be many common denominators or treatment in each of these settings, there are also major differences. Treatment in a residential or institutional setting is often more intensive. Treatment sessions often occur more frequently or over a longer period of time. In contrast, out-patient treatment sessions are usually scheduled on a weekly basis and usually cease after six to twelve months.

The degree of family involvement in treatment is often dictated by the setting of treatment or the willingness of family members to participate. Community-based models often place a high emphasis on treating the entire family (family systems approach), rather than the individual juvenile sexual offender. Treatment provided in residential or institutional settings often focuses on individual therapy, or peer group therapy, or both.

In community-based programs, individual counseling usually occurs in combination with other modes or types of treatment, such as family system or peer group therapy. The contents of therapy sessions frequently include:

- o Discussions and explorations of family dynamics;
- o Education on human sexuality (which may involve the entire family);
- o Victim awareness exercises (including acceptance of responsibility, familiarity with cycles of victimization, and empathy training);

- o Development of interpersonal social skills (including communication, socialization and group interaction);
- o Anger management training (including conflict resolution and negotiation skills);
- o Stress management training;
- o Grief work (focusing on personal victimization and trauma);
- o Journal entries (records of thought processes and fantasies);
- o Life skills training (including financial management and other day-to-day skills);
- o Survival skill training (including "stop thought" processes related to deviant sexual fantasies);
- o Assertiveness training (including enhancing self-assertive behavior while reducing passive and aggressive behavior); and
- o Training on norms for appropriate sexual behavior.

Residential or institutionally based treatment programs typically utilize individual counseling and peer group therapy. Occasionally, behavior modification techniques, such as masturbatory satiation, covert sensitization, and aversion may also be utilized. Family system therapy is often absent because of the difficulty of encouraging family involvement and the distance of the institution from the family. However, individual and peer group counseling may still focus on family issues. Components of treatment tend to be same as those described above for community-based programs.

Regardless of the location or modality of treatment, a primary focus of all forms of therapy is the development of a

sensitive, caring environment in which the offender can address his sense of powerlessness and feelings of low self-esteem. This is accomplished through the development of a strong peer culture, the enhancement of healthier and more supportive family structure, and/or through the understanding and support of the therapist.

OVERVIEW OF THE RESEARCH

In recent years, the State of Washington has led the nation in the number and variety of publicly supported programs designed to treat juvenile sexual offenders. For example, the Division of Juvenile Rehabilitation has developed extensive treatment programs for adolescent sexual offenders under state supervision (Steiger and Ramseyer, 1983; Ramseyer, 1984). The model provides for a variety of treatment modalities, including offense-specific individual, group and family counseling, as well as skill building and sex education. Simultaneously, many counties in Washington have developed local juvenile sexual offender treatment programs that utilize a variety of different assessment and treatment techniques.

This research project examines juvenile sexual offender treatment programs implemented in Washington State institutions and local jurisdictions. The study focuses on specialized programs hosted by seven counties, two juvenile institutions, and the Adolescent Clinic at the University of Washington.

The primary goal of the study is to examine the reoffense behavior, or recidivism, of juvenile offenders who were treated in one or more of three specialized programs. Four specific research questions are relevant to this goal:

1. What is the recidivism (number and type of new convictions) of juvenile offenders who are adjudicated and/or treated for sexual offense behavior?

2. Is there a discernable difference in recidivism between juvenile sexual offenders treated in community programs and those treated in institutions?

3. Is there a discernable difference in recidivism among juvenile sexual offenders who participated in different modes of treatment?

4. To what extent are other classes of variables (such as offender characteristics, attributes of the offense behavior, and juvenile justice system responses) associated with recidivism?

First Year Research Tasks

Four major tasks were undertaken during the first year of the project. These tasks included: (1) survey and description of the ten juvenile sex offender projects; (2) survey of juvenile courts in all counties without specific projects; (3) development of the sample of juvenile offenders included in the second phase of the research; and (4) development of an instrument to gather client-specific information during the second year of the project. These tasks, which were discussed in detail in the Phase I Report, are summarized below.

1. Survey and Description of Projects

Ten juvenile sex offender projects were selected for inclusion in this research project. Two projects were institution-based (Maple Lane School and Echo Glen Children's Center). These projects were developed and implemented by the Division of Juvenile Rehabilitation, Department of Social and Health Services, and were integrated into the general programming of the respective institutions in 1982.

The remaining eight programs included in the research were all "community based", despite the fact that many projects initiated assessment and treatment services while offenders were detained in local court facilities. Community-based programs consisted of the following:

(1) Spokane County Juvenile Sex Offender Project;

(2) Benton-Franklin Juvenile Sex Offender Project (also serving juveniles sentenced from Walla Walla, Columbia, Asotin and Garfield counties);

(3) Skagit County Sex Offender Project;

(4) Grays Harbor County Sex Offender Project;

(5) Snohomish County Sex Offender Project;

(6) Whatcom County Sex Offender Project;

(7) King County Sex Offender Project;

(8) University of Washington, Adolescent Clinic Sex Offender Project. (Note: This project was discontinued March, 1986).

Project directors at each site were contacted by members of the research team to solicit their participation in the research effort. All directors received copies of the

research protocols and confidentiality/privacy agreements approved by the Human Subjects Research Review Committee of DSHS. All project directors agreed to participate in the research and offered their assistance in this project throughout both phases of the inquiry.

2. Survey of Juvenile Courts Without Projects

Interviews were conducted with court administrators in all Washington State counties not served by a specific project to ascertain the procedures used to evaluate and treat juvenile sex offenders in each jurisdiction. Questions focused on the following:

- o Estimates of the current yearly caseload of sex offenders;
- o Clinical assessment and treatment available prior to adjudication and/or sentencing; and
- o Court ordered treatment as a condition of sentencing (availability and funding).

3. Development of the Sample of Juvenile Sexual Offenders

All juvenile sexual offenders who entered one or more of the 10 treatment programs between March 1, 1984 and October 31, 1984 were considered eligible for inclusion in the study. The project directors in each of the treatment programs identified 237 such youth. Other data obtained on the "sample" youth included types of treatment, location of treatment, referral offenses, and dispositions.

4. Case-Level Data Gathering Instrument

An extensive data gathering instrument (Treatment Data Form) was developed to record case-level data on each youth included in the sample. The items on this form were drawn from the sexual offender literature and were organized on the basis of topical areas (on classes of independent variables)

Second Year Research Tasks

Three major research tasks were undertaken in Phase II of the study. These tasks included: (1) collection of case-level data (Treatment Data Form) on as many juveniles in the study sample as possible; (2) collection of criminal history data on the juveniles in the study sample; and (3) integration and analysis of the data. Each of these tasks is discussed briefly here and in succeeding chapters of this report.

1. Treatment Data Forms (Case-Level Data)

The most difficult of all the research tasks involved tracking and locating the individuals and files necessary to complete the Treatment Data Forms for the juveniles in the study sample. This activity involved the kind assistance of the program directors, program treatment personnel, private therapists, juvenile probation counselors, juvenile parole counselors, administrative staff from the Division of Juvenile Rehabilitation, and State records archivists. In addition, the researchers spent several hundred hours researching the legal and treatment files of the juveniles.

No Treatment Data Forms could be completed for some youth because their files had been destroyed (Grays Harbor County Juvenile Sexual Offender Program) or their files could not be located. However, if criminal history records were available for the juveniles without legal or treatment files, the youth were maintained in the study sample.

2. Criminal History Records

Complete juvenile court conviction records were obtained for each youth included in the study sample. These records served as the source of information on recidivism, as well as the number and types of convictions received prior to the instant sexual offenses which resulted in juveniles' inclusion in the study sample.

3. Integration and Analysis of Data

Once the Treatment Data Forms and criminal history information were collected, it was possible to code, integrate, and enter the data into the computer. Once entered, the data were analyzed using a statistical software program known as STATPAC.

A research advisory committee, comprised of experts in sexual offender and victim treatment, met with the researchers on several occasions during the course of the study. Committee members reviewed and provided guidance on the research design and research instruments. Their assistance in this effort was greatly appreciated.

CHAPTER II

RESEARCH METHODS

Research tasks undertaken during the first year (Phase I) served to establish the foundation for the tasks performed in the second, and concluding, year. During Phase I of this project, all sex offender programs were identified, surveyed and described. Agreements were reached with all program directors to participate in the next phase of the study. A sample of treated sexual offenders was identified by type of treatment modality provided, data gathering instruments were developed, and procedures were established for accessing recidivism data.

Phase Two efforts focused on the collection of extensive case-level data on each juvenile included in the study sample. These data were obtained from a variety of sources, including project treatment personnel, private therapists, juvenile probation counselors, juvenile parole counselors, and case records. Outcome data on recidivism were obtained from JUVIS, the state-wide computerized information system that serves as the repository of criminal history information on all youth who have been referred to juvenile courts. Case-level and criminal history data were then analyzed to assess possible relationships between recidivism and key independent variables, such as type of treatment provided, location of treatment, characteristics of the sexual offenders and the sexual offense behaviors, actions of the juvenile justice system, and responses of the offenders to their crimes and to treatment.

I. Program Descriptions

The first major research tasks involved locating and describing each of the sex offense specific treatment programs for juvenile offenders in the State of Washington. Working with the Project Manager, Dr. Carol Webseter, the research team identified 10 such projects. These consisted of two institution-based programs that were located at Maple Lane School and at Echo Glen Children's Center. The other eight programs were located in communities throughout the state and were operated under the auspices of the local juvenile court or a prosecutor's office.

Program site visits and interviews with project directors and treatment personnel were conducted throughout Phase One. Information obtained in the course of these visits and interviews was used to develop descriptions of each of the projects. (See Appendices A-J for summaries of the individual programs.)

II. Survey of Juvenile Sexual Offender Assessment and Treatment Capabilities in Other Counties

The research team determined that it would be useful to survey all court administrators in juvenile court jurisdictions where no sex offender project was available. Although this survey was beyond the scope of the proposed research, it was worthwhile because it yielded valuable information on the range of services provided to juvenile offenders throughout the State of Washington.

In August, 1986, interviews were conducted with court administrators in 27 counties without specific projects for juvenile sexual offenders. The purpose of the interviews was to ascertain the availability and use of local diagnostic assessments and treatment for sexual offenders. Excluded from this survey were court administrators from Whatcom County, King County, Skagit County, Snohomish County, Benton-Franklin Counties, Grays Harbor County, and Spokane County. Full-scale programs existed in these counties as described in Appendices A-J.

Surveys of administrators in the non-project counties revealed that private therapists often performed assessments and treatment of juvenile sexual offenders at the request of the courts. Services were generally paid from Consolidated Juvenile Services (CJS) program funds and from family contributions or medical coupons.

III. Case Sampling

Directors of each of the ten projects were asked to identify all cases of adolescent sexual offenders referred to their programs for treatment and/or clinical assessment during the period March 1, 1984 to October 31, 1984. The following information was requested for each of these cases:

- Client identifier (alpha or numeric code to ensure client privacy);
- Age;

- Sex;
- Date of referral to program or institution;
- Type of offense;
- Court disposition;
- Duration of incarceration (local detention and state institution);
- Duration of community supervision;
- Type and duration of treatment while incarcerated;
- Type and duration of treatment while in community; and
- Current status.

Program directors were asked to classify type of treatment on the basis of the following definitions:

A. Individual Counseling

Counseling is one-on-one with the youth. Contact with parents or other family members is minimal and is for the purpose of consultation or information. Youth behavioral or attitudinal change is the focus of treatment. Change in family dynamics is not a primary goal.

B. Family Treatment

Counseling may involve some one-on-one sessions with the youth and one or more family members. The primary focus of treatment is change in family dynamics as a vehicle for facilitating change in the youth's behavior and attitudes. Pure family therapy is assigned if sessions involving one or more family members comprise 75% of all treatment sessions.

C. Group Counseling

Group counseling is defined as therapy that involves two or more unrelated youths. Group discussion occurs primarily among the group members and is facilitated by a counselor.

D. Mixed: Individual and Family

Counseling sessions are comprised of approximately 50% individual and 50% family. The focus of treatment is change in both family dynamics and individual youth behavior and attitudes.

E. Mixed: Individual and Group

The youth is involved in one-on-one counseling, as well as group peer counseling sessions. Peer counseling sessions comprise approximately 50% of the total counseling sessions.

F. Mixed: Group and Family

The youth is involved in both family therapy sessions and peer counseling groups. The youth's relationship with family and peers is a major focus of the treatment approach.

G. Mixed: Individual, Family and Group

The youth is involved in all three types of treatment. Each counseling session can be clearly defined as either individual, family or group and the focus of each type of session is distinct.

H. Mixed: Undefined Treatment

The treatment focus is unspecified as either individual, family or group. The topics of discussion are not directed

by the counselor and involvement of the family members or other peers is spontaneous.

All juveniles treated during the test period were classified according to the modalities discussed above and were included in the sample. However, for purposes of some statistical analyses, the sample was restricted to treatment categories with 20 or more subjects.

IV. Client Data Gathering Instrument (Treatment Data Form)

An extensive data gathering instrument, referred to as the Treatment Data Form, was developed to record information on each juvenile included in the sample. Many items on this instrument were adapted from a form used by participating members of the Adolescent Perpetrator Network, a nation-wide organization of sexual offender treatment professionals and agencies. The authors of this form kindly permitted the research team to utilize many of their data elements in the current study, although most items were modified to meet our research needs.

The form is divided into several general sections. The first of these consists of basic demographic data, such as sex, race and age. It also includes other information relevant at the time of the instant sexual offense, including living situation and school attendance.

The second section explores the background experience of the juveniles, as well as dysfunctional behaviors exhibited by youth. Items in this section include a history of sexual or physical abuse, parental violence, substance abuse, and school problems.

Section three explores details of the referral offense. Specific items consist of the relationship of the offenders to their victims, their relative ages, the sex of the victims, and elements of the sexual offense behavior.

The fourth section focuses on the responses of the juvenile justice system to the referral offenses. Data elements include the dispositions of the referrals, the outcomes of the adjudication process, and the sentences and conditions imposed on the juvenile offenders.

Section five examines the areas typically explored during the evaluation and assessment process, such as acceptance of responsibility for the offenses, and who the offenders blamed for the crimes. This section is important because these data elements are used to assess offenders' amenability to treatment. Since many professionals believe that it is difficult to treat clients who deny their guilt or personal responsibility for sex offenses, these items are considered to be important predictor variables of treatment outcomes and recidivism.

The sixth section examines the location of treatment and the modalities used to treat offenders, as well as some of the details of the treatment experience. Examples of these latter details include items such as whether the treatment was sex offender specific, the number of treatment sessions provided, and the extent of clients' participation in treatment. In addition, this section examines the subjective assessments of therapists,

i.e., whether clients demonstrated insight into their offense behaviors and whether they appeared motivated to change.

The last section examines the status of clients at treatment exit. These data elements are particularly important to the research. They not only identify the reasons for treatment termination, they also provide assessments of the need for follow-up treatment and support, as well as the therapists' view of the likelihood of reoffense behavior.

The information necessary to complete the Treatment Data Form for each youth was obtained from a variety of sources. The most significant of these sources was the project directors of the individual treatment programs. In several instances, these directors assumed responsibility for the completion of the forms, usually with the assistance of their treatment staff or the private therapists who actually treated the juvenile offenders included in the sample. In other instances, the research team relied on other sources for the information, including assessment and treatment files, institutional records, and probation and parole counselors who were responsible for the supervision of the juveniles.

Treatment Data Forms were not completed for some youth because their files could not be located or their records had been destroyed. This problem was most significant for juvenile sexual offenders who participated in the Grays Harbor program and in the program operated by the Adolescent Clinic at the University of Washington. The files of all youth who participated in

the Grays Harbor program were destroyed. Similarly, the records of more than a dozen youth who were treated at the Adolescent Clinic could not be located. In both instances, no forms were completed for youth without adequate treatment and legal files.

V. Criminal History Data

The primary outcome measure (dependent variable) of the project was reoffense behavior, referred to herein as recidivism. Recidivism was operationally defined as any conviction in juvenile court for an offense committed subsequent to the disposition of the referral offense that resulted in a juvenile's inclusion in the study sample.

Complete conviction histories of all youth included in the study were obtained through a state-wide juvenile justice information system, known as JUVIS. These data provided a complete record of all convictions in juvenile courts in the State of Washington through September, 1987, or until a youth's eighteenth birthday, whichever came first.

Once the criminal history data were obtained for each youth, it was possible to determine the number and types of all convictions received after the disposition of the referral offense (recidivism), as well as before the referral offense (prior convictions). Data on prior convictions were used as independent variables for purposes of analysis.

VI. Independent Variables

Eight classes of variables were identified as likely to affect juvenile sexual offender recidivism and, therefore, served

as the independent variables for purposes of data analysis. These classes conformed to the seven sections included on the Treatment Data Form (discussed earlier), as well as a class of variables referred to as Prior Convictions. This latter class consisted of the number and types of all prior convictions from a juvenile court in the State of Washington. (See Table 2.1 for a summary of the data elements included in each class of independent variables.)

VII. Dependent Variables

The dependent variables consisted of the number and type of post-referral convictions for all criminal offenses and for sexual offenses only. These variables served as the outcome or effectiveness measures for the research.

VIII. Data Analyses

Several types of data analyses were undertaken. The first of these was descriptive in nature. This form of analysis was used to enumerate the information obtained from Treatment Data Forms and from criminal records. These descriptive data were then used to characterize treatment clients, their family backgrounds and experiences, their referral offenses, and their victims.

The significance of the relationships between the independent and dependent variables was assessed through the application of chi square analysis. This statistical procedure was used to examine the association between each independent variable and recidivism.

TABLE 2.1 SUMMARY OF INDEPENDENT VARIABLES

I. DEMOGRAPHIC CHARACTERISTICS
- o Race of juvenile offender
- o Age at time of instant sexual offense
- o Residence and adults in household
- o School status and grade in school

II. HISTORICAL EXPERIENCES AND DYSFUNCTIONAL BEHAVIORS
- o School problems
- o History of sexual abuse or physical abuse
- o Sexual abuse of sibling
- o Violence between parents
- o Offender substance abuse

III. SEXUAL OFFENSE CHARACTERISTICS
- o Types of referral offenses
- o Elements of sexual offense
- o Sex and age of victim(s)
- o Relationship between offender and victim(s)

IV. JUVENILE JUSTICE SYSTEM RESPONSES
- o Disposition of case(s)
- o Sentence and conditions imposed

V. EVALUATION AND ASSESSMENT
- o Admission that offense(s) occurred
- o Blame for the offense(s)
- o Admission of unreported sexual offenses
- o Sexual orientation
- o Prior age-appropriate sexual relationships
- o Involvement with friends/peers

VI. LOCATION AND TYPES OF TREATMENT PROVIDED
- o Institution vs. community location of treatment
- o Primary treatment modality used
- o Treatment sessions attended; level participation
- o Deviant sexual arousal
- o Empathy and remorse for sexual offense(s)
- o Insight and motivation to change

VII. STATUS OF OFFENDERS AT TREATMENT EXIT
- o Reasons for termination from treatment
- o Need for follow-up treatment or support
- o Risk to reoffend

VIII. NUMBER AND TYPES OF PRIOR CONVICTIONS

CHAPTER III

THE JUVENILE SEXUAL OFFENDER: CHARACTERISTICS, OFFENSE BEHAVIOR, AND PARTICIPATION IN TREATMENT

A total of 237 juvenile sexual offenders were eligible for inclusion in the study. Of this number, treatment data forms and criminal histories were available for 174 youth. Criminal history information only was obtained on an additional 47 youth, bringing the full complement of the study sample to 221 juveniles.

The information presented below is descriptive in nature. The data are organized and discussed in terms of seven classes or categories of independent variables consisting of the following:

I. Demographic Characteristics;

II. Historical Experiences and Dysfunctional Behaviors;

III. Sexual Offense Characteristics;

IV. Juvenile Justice System Responses;

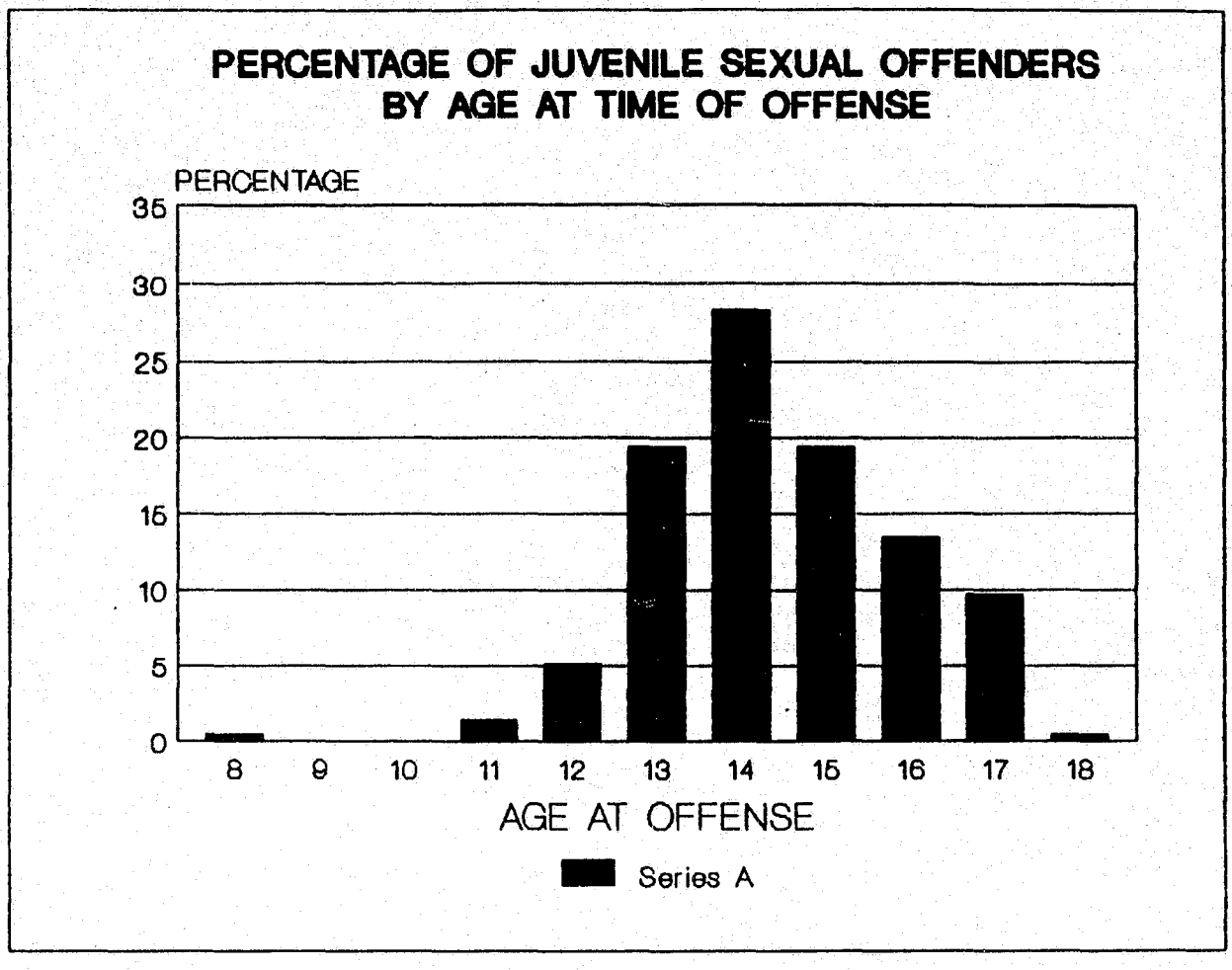
V. Evaluation and Assessment;

VI. Location and Types of Treatment; and

VII. Status at Treatment Exit.

These data are intended to provide an overview of the characteristics and significant life experiences of offenders, the elements of their sexual offending behavior and their choice of victims, the actions of the juvenile justice system, and the responses of offenders to their crimes and to treatment.

Figure 3.1



I. Demographic Characteristics

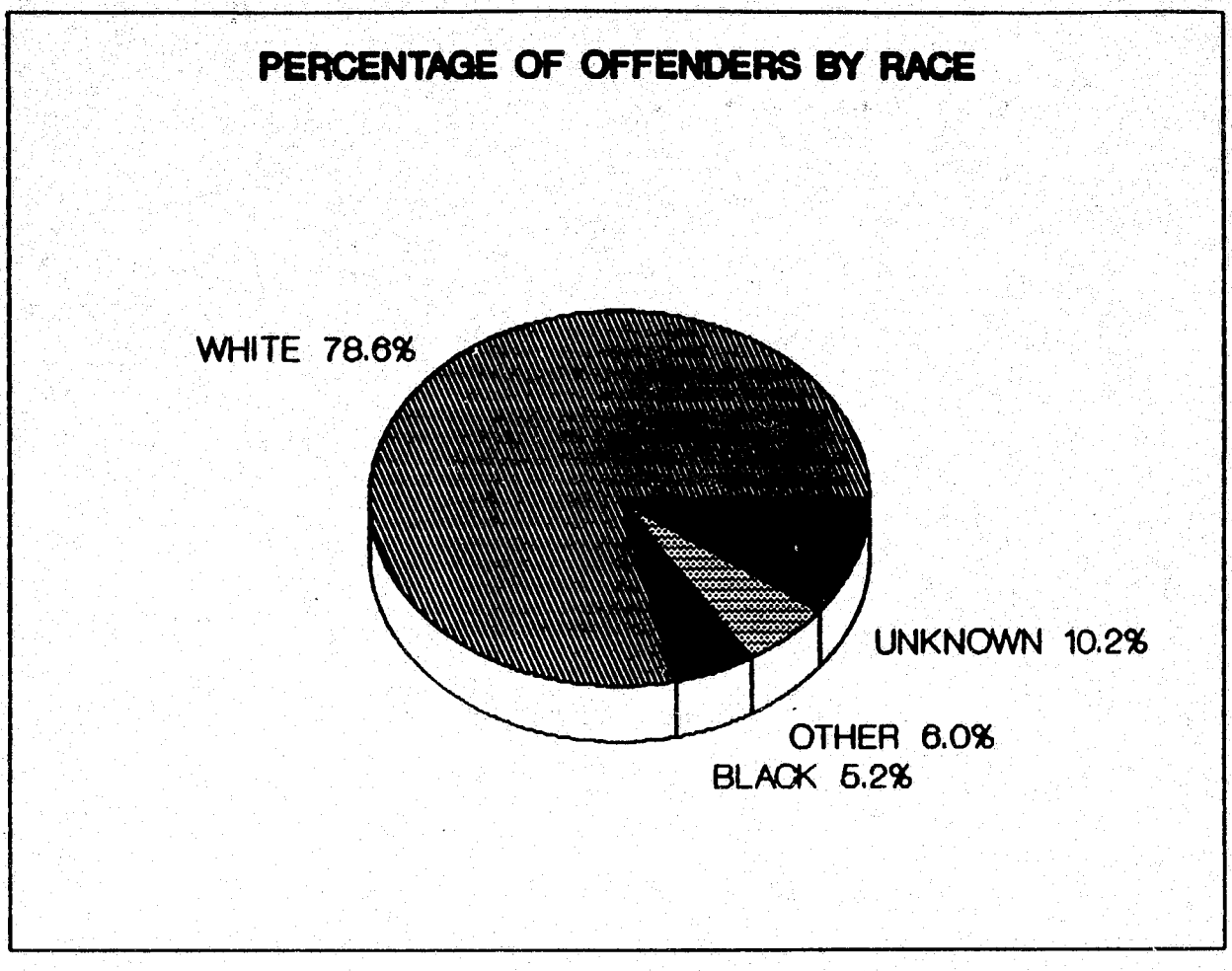
A. Sex of Juveniles

Male juvenile sexual offenders outnumbered female sexual offenders by a ratio of more than 20 to one. Only 10 of the members of the total complement of offenders were female (4.5 percent), while 211 of the youth were male (95.5 percent).

B. Age of Juveniles

The ages of juveniles at the time of the sexual offense(s) ranged from 8 to 18 years with a median age of 14.7 years. As Figure 3.1 illustrates, the most common age range at the time of offense was 13 to 15 years with the largest

Figure 3.2

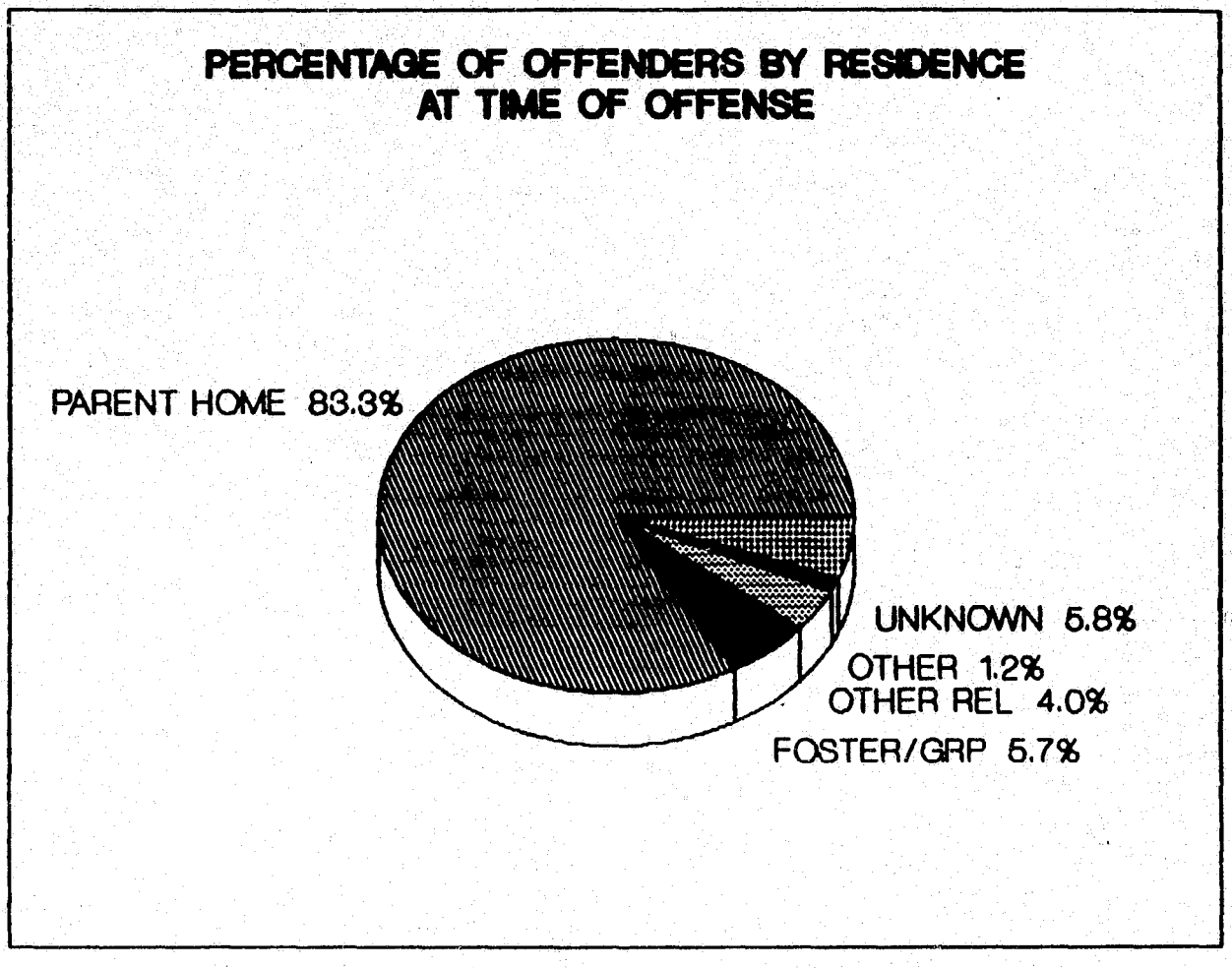


proportion of youth aged 14. There was a gradual decline in the percentage of youth referred each year as they matured beyond their mid-teens.

C. Race of Juveniles

The racial composition of the juvenile sexual offender sample essentially "mirrored" the most recent U.S. Census figures for the State of Washington as a whole (see Figure 3.2). Nearly 80 percent of the youth were known to be Caucasian, 5 percent were Black, and 6 percent consisted of other minorities, including American Indian, Asian American, and Hispanic juveniles.

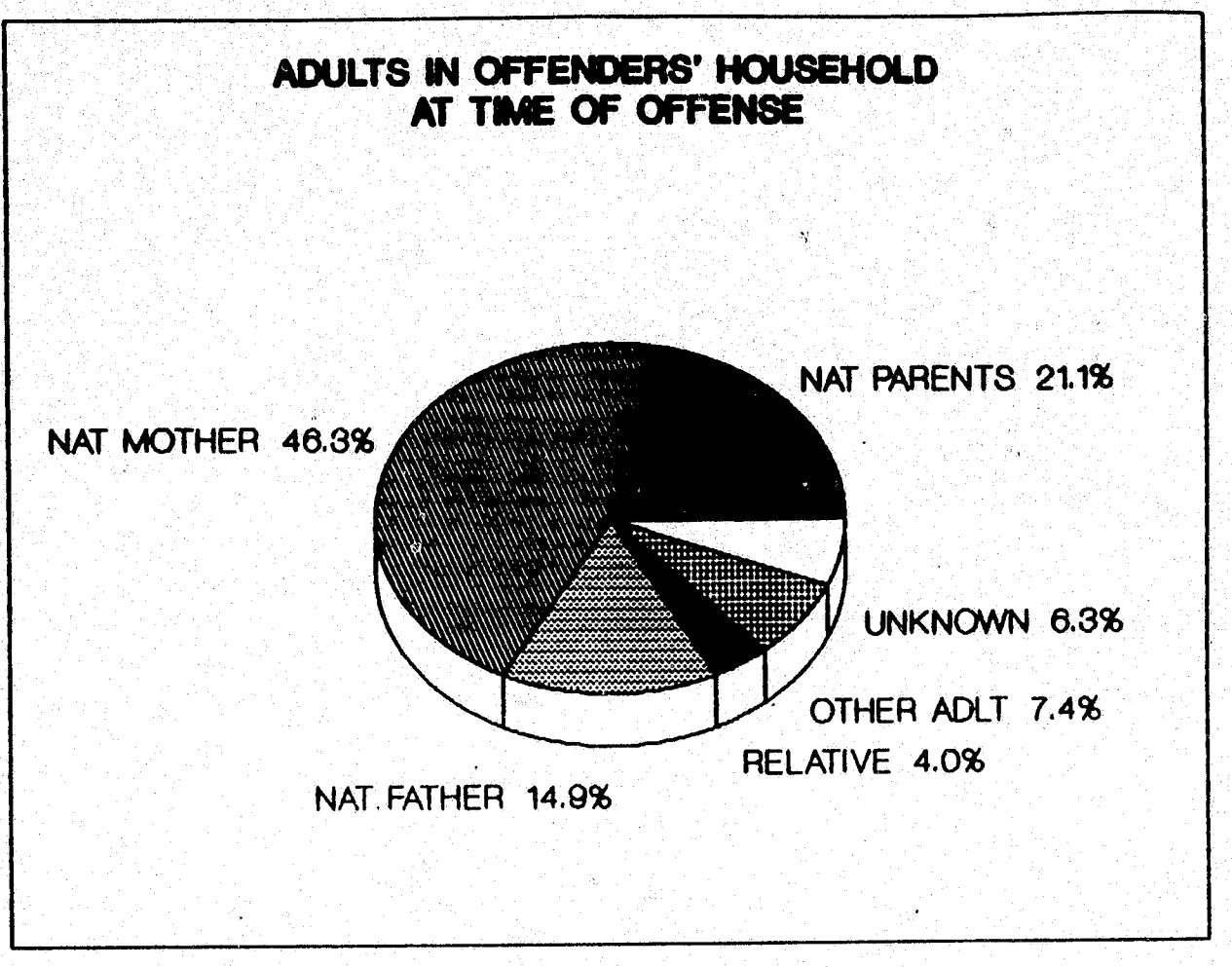
Figure 3.3



D. Residence of Juveniles

Most youth were residing in their parents' home at the time of the sexual offense (see Figure 3.3). Other living arrangements included foster or group care (5.7 percent), other relatives (4.0 percent), and no fixed residence (1.2 percent). These latter juveniles usually lived on the streets or moved from one temporary residence to another.

Figure 3.4



E. Adults in Household

As Figure 3.4 illustrates, only 21 percent of the juveniles were known to live with both natural parents at the time of the sexual offense. Typically, youth lived with one natural parent -- usually the mother. Occasionally youth lived with other non-related adults (group or foster parents) or with adult relatives.

F. School Status

More than three-quarters of the juveniles were enrolled in school or vocational training programs at the time of the

sexual offense. The remaining youth were either not enrolled (16 percent) or their school status was unknown (5 percent).

G. Grade in School

The distribution of youth by grade in school at the time of the sexual offense is presented in Table 3.1. Note that nearly one-half of the juveniles were in the eighth or ninth grades at the time of the offense. These grade levels are consistent with adolescents 14 and 15 years old and corresponded to the age distributions of juveniles presented in Table 2.1.

TABLE 3.1 GRADE IN SCHOOL AT TIME OF OFFENSE

Grade	Number	Percentage
2	1	.7
6	2	1.4
7	26	17.6
8	37	25.0
9	31	20.9
10	13	8.8
11	16	10.8
12	4	2.7
Unknown	18	12.2
Total	148	100.1

In summary, the demographic profile of the "typical" juvenile sexual offender included in the study consisted of the following: a white male with a median age of 14.7 years who resided in his parental home. He came from a broken family and lived with his natural mother. The offender was

in school and was usually enrolled in the eighth or ninth grade at the time of the offense.

II. Historical Experiences and Dysfunctional Behaviors

The clinical and research literature is replete with information that suggests or demonstrates relationships between certain antecedent life experiences/dysfunctional behaviors and subsequent sexual offending behavior among juveniles or adults. Several of these experiences/behaviors were incorporated in the treatment data form to determine their presence or absence in the sample of juveniles selected for this study. Specific data elements included on the form consisted of reported school problems, histories of sexual of physical abuse, violence between parents, and substance use/abuse.

A. Reported School Problems

More than one-half of the juvenile sexual offenders reportedly experienced at least one of three types of problems related to school or educational performance. The most frequently noted problem related to general behavior while in school (52.9 percent), a "catch all" category that included classroom disruptions, fighting, and resistance to authority. In addition, nearly one-third (29.9 percent) of the juveniles had histories of truancy.

The school records of the juvenile sexual offenders indicated that many of them performed well below grade level. Poor academic performance was explained, in part, by the

large proportion of these youth who were considered learning disabled (38.5 percent).

B. Reported Sexual Abuse

The research literature has consistently noted a high correspondence between prior sexual victimization and subsequent sexual offending behavior among juvenile and adult males. Findings from the current study are consistent with these previous observations.

Nearly one-half (42.0 percent) of the juveniles in the sample were known or reported to have been sexually abused prior to their offense behavior. In most instances, the abuse was inflicted by unrelated males (65.8 percent). Others responsible for the abuse included unrelated females (9.6 percent), fathers (6.8 percent), mothers (5.5 percent), and stepfathers (1.4 percent). The relationship between the abusers and the juveniles was unknown in an additional 11.0 percent of the cases.

C. Reported Sexual Abuse of a Sibling

The sisters and brothers of juvenile sexual offenders were not immune from sexual abuse. Sibling sexual abuse was reported in 34.5 percent of the cases included in the sample.

D. Reported Physical Abuse

Nearly one-half (46.6 percent) of the juvenile sexual offenders were known or reported to have been physically abused. In most instances, the physical abuse was inflicted by natural fathers (44.4 percent) or stepfathers (19.8

percent). Other physical abusers included mothers (6.2 percent), unrelated males (4.6 percent), and stepmothers (1.2 percent). An additional 13.6 percent of the juveniles were abused by more than one family member.

E. Reported Violence Between Parents

Violence between parents was noted in more than one-third (37.9 percent) of the cases included in the sample. In most instances, violence took the form of hitting, biting and kicking. In other cases, however, parents threatened or used knives, guns or other objects. In two cases, the offending parent killed the spouse.

F. Reported Substance Abuse

Slightly more than one-third (36.6) percent of the juvenile sexual offenders were believed to abuse substances. The most frequent substances of choice consisted of alcohol and marijuana, although use of LSD, mushrooms, and other hallucinogens was also noted.

In summary, the typical juvenile sexual offender included in the study was likely to have experienced or been exposed to the following: school behavior problems compounded with a learning disability; sexual abuse inflicted by an unrelated male; and physical abuse imposed by a father or stepfather. Violence between parents was common and, in some instances, resulted in serious injury or death. Finally, the offender was likely to abuse one or more substances, such as alcohol and/or marijuana.

III. Sexual Offense Characteristics

The treatment data form included a number of items believed important to a thorough understanding of the elements of the sexual offenses committed by the juveniles in the sample. Specific items included in the study consisted of the types of offenses referred to the courts, the nature of the sexual behaviors inflicted on victims, the relationships between victims and offenders, and the characteristics of victims.

A. Referral Offenses

Juveniles included in the study were referred to the courts (or treatment agencies) for a wide variety of sexual and non-sexual offenses. The referral charges noted most frequently consisted of the following: Indecent liberties with a child under 14 years (N=146); First degree statutory rape (N=36); Second degree rape (N=9); Communicating with a minor for immoral purposes (N=9); Indecent exposure (N=7); Second or third degree statutory rape (N=7); First degree rape (N=4); Third degree rape (N=4); Rape (degree unspecified) (N=4); Indecent liberties with forcible compulsion (N=4); Attempted indecent liberties (N=4); Second degree incest (N=3); and Other sex offenses (N=5). An additional 26 referrals involved non-sex offenses, such as Second degree burglary, Second degree assault, First degree burglary and arson. All of these latter offenses contained sexual overtones or were believed to be committed in the course of an attempted sexual offense.

B. Elements of the Sexual Offense(s)

The legal names or definitions of sexual offenses often obscures the range of conduct manifested by offenders in the commission of their crimes. To better capture the nature and elements of the offenses committed by the juveniles included in the study, the complete referral reports prepared by police and victims were examined. Each report was carefully reviewed and the presence or absence of each of nineteen offense characteristics was noted.

The offense characteristics are presented in Table 3.2 by the number and percentage of juvenile sexual offenders whose conduct best conformed to the category. Note that some of the most frequently reported behaviors involved touching the genitalia or breasts of the victim(s), offenses which were typically identified as indecent liberties. The frequency of touching offenses was nearly matched by offenses that involved actual penetration of the vagina or anus of victims. Depending upon the relative ages of the victims and offenders, or the degree of force used or threatened, these offenses were usually referred to as rapes or statutory rapes. Oral sexual offenses were also commonly reported, particularly in the form of fellatio by the victim.

Nearly all of the offenses were accompanied by some form of actual or threatened force or coercion. In most instances, the force or threats preceded the offense. In

other instances, threats were used to extract promises of silence on the part of victims.

TABLE 3.2 ELEMENTS OF THE REFERRED SEXUAL OFFENSES

Elements	Number	Percentage
Exhibiting	18	10.4
Peeping	2	1.2
Obscene Calls	2	1.2
Stealing Underwear	3	1.7
Verbal Coercion	57	32.9
Verbal Threats of Violence	21	12.1
Physical Force	41	23.7
Weapons Threat	8	4.6
Weapons Use	2	1.2
Touching Victim's Breasts	30	17.3
Touching Victim's Genitalia	98	56.6
Masturbation of Victim	17	9.8
Fellatio on Victim	19	11.0
Cunnilingus on Victim	19	11.0
Vaginal Penetration	57	32.9
Anal Penetration	35	20.2
Masturbation by Victim	17	9.8
Fellatio by Victim	47	27.2
Cunnilingus by Victim	4	2.3

C. Sex and Age of Victims

The treatment data form permitted the entry of sex and age data on as many as three victims per offenders. Analysis of these data determined that 72.6 of the juveniles in the sample were referred for offenses against one victim, 27.4 percent were referred for offenses against two or more

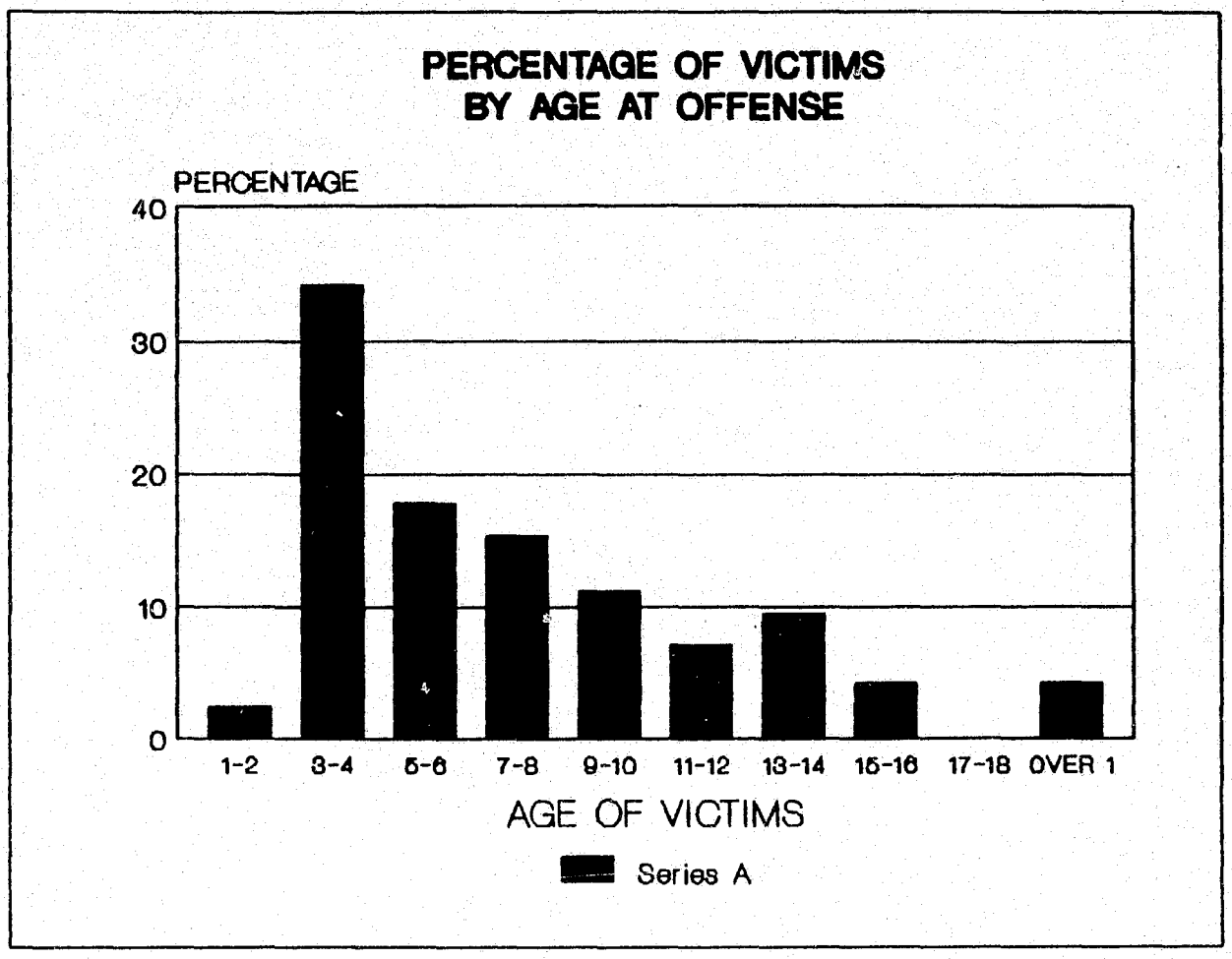
victims, and 7.9 percent were referred for offenses against three or more victims.

The gender of victims by order of victimization is presented in Table 3.3. Note that nearly three-quarters (73.8 percent) of the first or only victims were female. As the order progressed, the proportion of male victims increased until it actually exceeded the percentage of female victims. Thus, it appeared that males were the preferred victims of multiple offenders.

TABLE 3.3 GENDER OF VICTIMS BY ORDER OF VICTIMIZATION

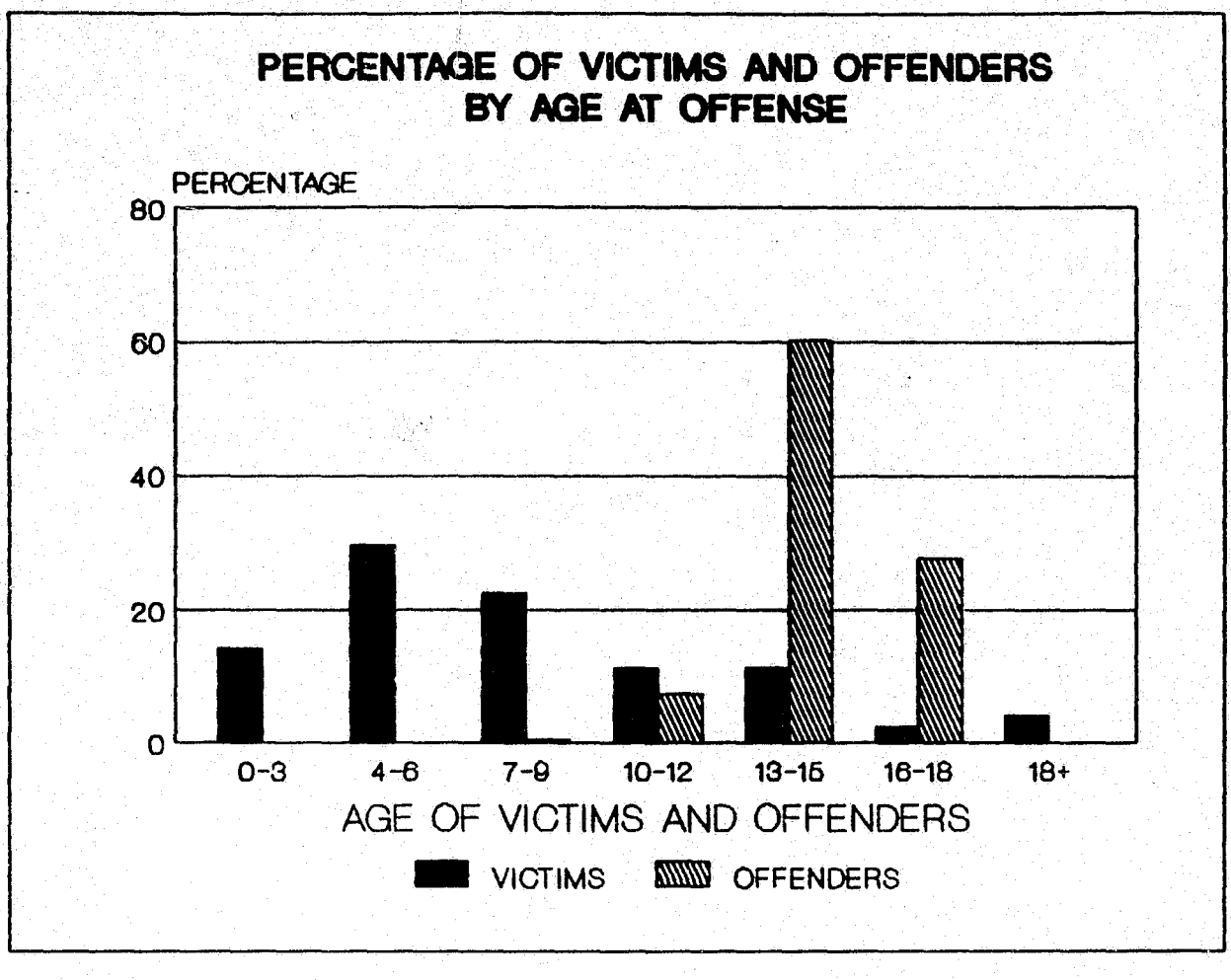
Order	-------Males------		------Females------	
	Number	Percentage	Number	Percentage
1	43	26.2	121	73.8
2	15	33.3	30	66.7
3 (or more)	7	53.8	6	46.2

Figure 3.5



The proportion of victims by age grouping is presented in Figure 3.5. Note that the vast majority of victims were children under the age of 10 years at the time of the offense. The largest single group of victims consisted of 3-4 year olds who were barely beyond the toddler stage. Offenders rarely offended against persons who had achieved adolescence or were sexually mature, and almost never victimized adults.

Figure 3.t6



The relative age differences between offenders and their victims is portrayed in Figure 3.6. The median age of victims was 6.2 years, or slightly less than one-half of the median age (14.7 years) of offenders.

D. Relationship Between Offender and Victim

As Table 3.4 indicates, most juveniles in the sample victimized children whom they knew or to whom they were related. Less than 5 percent of the victims (child and adult) were strangers to the offenders.

The most frequent victims were non-related children who were known to the offenders (30.5 percent). These victims and offenders were often neighbors who had played together on previous occasions and had formed a "friendship". The second most common victims were blood related children (28.2 percent). These latter victims were most often younger siblings or half-siblings, although cousins were occasionally victimized. Babysitting situations offered other opportunities for sexually victimizing children. Nearly 13 percent of the offenses occurred while the victims were in the care of the offenders.

Peer victims were relatively rate (9.8 percent) and usually consisted of persons who were acquainted with the offenders through school or mutual friends. In several instances, the peer victims were sexually assaulted while "on dates" with the offenders.

TABLE 3.4 RELATIONSHIP BETWEEN VICTIMS AND OFFENDERS

Relationship	Number	Percentage
Blood Related Child	49	28.2
Child Not Related, But Living In Household	13	7.5
Child Known To Offender	53	30.5
Child in Care of Offender	22	12.6
Child - Stranger	4	2.3
Blood Related Adult	0	0.0
Adult Known To Offender	3	1.7
Adult - Stranger	4	2.3
Peer	17	9.8
Unknown	8	4.6

In summary, the profile of the "typical" sexual offense committed by a juvenile in the sample consisted of the following: a serious sexual crime involving either touching/oral contact with the genitalia or penetration of the vagina or anus of the victims; and use of physical force, threats, or coercion to obtain compliance. The victim of choice was a child under the age of seven years who was known or related to the offender or under the offender's care.

IV. Juvenile Justice System Responses

The vast majority of the sex offense referrals (97 percent) were sent to prosecutor's offices in the county of occurrence for screening. If the referrals meet the requirements for charging, the cases were filed in juvenile court or formally diverted to community programs.

A. Disposition of Cases

The outcomes of the charging and adjudication process are presented in Table 3.5. The majority of offenders pled or were found guilty either of the sexual offenses as originally charged (54.6 percent or of lesser sexual offenses (13.8 percent). Note, however, that nearly one-quarter of the cases were diverted from the formal court process; that is, the cases were never adjudicated. No offenders were found not guilty of the charges.

TABLE 3.5 CASE OUTCOMES*

Outcomes	Number	Percentage
Charges Dismissed	2	1.0
Case Diverted	47	23.9
Prosecution Deferred	0	0
Found Not Guilty	0	0
Pled to Lesser Sex Charge	27	13.8
Pled to Non-Sex Charge	2	1.0
Pled/Found Guilty as Charged	107	54.6
Unknown	11	5.6
Total	196	99.9

* Disposition of cause numbers. Since offenders can have more than one cause number, the total number of case outcomes exceeds the number of juveniles included in the sample.

B. Attrition of Referral Offenses

Studies of criminal case processing have shown that one-half or more of all felony referrals fail to survive the complex legal, evidentiary and resource requirements necessary to secure convictions. This deterioration in referrals, known as attrition, was observed in the current study.

Table 3.6 presents the number of referrals and convictions by types of offenses. Note that 171 of the 260 referral offenses resulted in convictions (or formal diversions which became part of the juveniles' criminal histories). This deterioration represented an attrition rate

of less than 35 percent, or well below the national average of more than 50 percent for felony referrals. No particular patterns were observed with regard to attrition by types of offenses.

TABLE 3.6 NUMBER OF REFERRALS AND CONVICTIONS BY TYPES OF OFFENSES

Offense	Referrals	Convictions
Rape 1	4	4
Rape 2	9	7
Rape 3	4	1
Rape (Unspecified)	4	1
Att. Rape	2	1
Statutory Rape 1	36	25
Statutory Rape 2	1	1
Statutory Rape 3	1	0
Att. Statutory Rape	1	1
Indecent Liberties/Force	4	3
Indecent Liberties	146	103
Att. Indecent Liberties	4	1
Incest 1	1	1
Comm. Minor Imm. Purposes	9	3
Indecent Exposure	7	4
Peeping	1	0
Unlawful Imprisonment	1	1
Assault 2	5	3
Robbery 1 and 2	2	1
Burglary 1	2	0
Burglary 2	7	5
Other Non-Sex	8	4
Total	260	171

C. Sentences Imposed

The variety of sentences and sentence conditions imposed on offenders is presented in Table 3.7. Note that nearly three-quarters of the offenders were incarcerated either in state operated institutions (48 percent) or in local

detention facilities. Many sentences imposed special conditions on the offenders, such as court ordered sexual offender evaluations, probation, community service and restitution.

TABLE 3.7 SENTENCES AND CONDITIONS IMPOSED

Sentences/Conditions	Number	Percentage
Detention	40	23.5
Institutionalization	82	48.0
Court Ordered Evaluation	58	34.1
Probation	52	30.6
Out-Patient Treatment	55	32.2
Community Service	24	14.0
Restitution	16	9.4
Unknown	11	6.4

In summary, analysis of the charging and adjudication process determined that the attrition of referral offenses was less than expected. The typical offender pled or was found guilty as charged, was incarcerated in a state or local facility, and received a myriad of conditions as a function of the sentence.

V. Evaluation and Assessment of Offenders

Assessment and evaluation information was obtained on all 174 juvenile offenders for whom treatment data forms were completed. The data presented below were generally extracted from the rich

file material maintained by treatment agencies and private therapists who graciously shared this information with the researchers.

A. Admission that the Offense Occurred

A critical element in the treatment of sexual offenders as an admission that the offense occurred at all. Most of the juvenile offenders in the sample (84.5 percent) admitted that the offense occurred. However, only 81 percent of the juveniles admitted participation in the offense.

B. Blame for the Offense

Many therapists believe that sexual offender treatment is most successful when clients accept responsibility for their offense behavior. According to experienced therapists, many sexual offenders deny personal responsibility for the offenses and lay the blame on circumstances or on others, particularly their victims. The juvenile offenders included in this study were no exceptions.

From Table 3.8, it can be seen that less than one-half of the juvenile offenders (44.8 percent) blamed themselves for their sexual offenses. Responsibility for the offenses was most often attributed to victims (34.5 percent), co-participants (13.1 percent), the past (8.3 percent), or the parents of offenders (6.2 percent). In one case, the "devil" was blamed for the offense.

TABLE 3.8 WHO/WHAT RESPONSIBLE FOR THE OFFENSES
(N=145 JUVENILES; MULTIPLE RESPONSES PERMITTED)

Who/What Responsible	Number Responses	Percentage Juveniles
Self	65	44.8
Victim	50	34.5
Co-Participants	19	13.1
Past	12	8.3
Parents (Offender)	9	6.2
"Being Sick"	6	4.1
Drugs/Alcohol	5	3.4
Parents (Victim)	2	1.4
Prior Abusers	2	1.4
Devil	1	.7
No One/Nothing	3	2.1

C. Admission of Unreported Sexual Offenses

Victimization surveys and self-report studies of adult sexual offenders have revealed that many sexual offenses are never reported to authorities. These "hidden victimizations" are believed to facilitate the persistence of sexual offending behavior, since offenders frequently escape detection and punishment.

One-quarter of the juvenile sexual offenders in this study reported committing at least one additional sexual offense that was not previously reported. Nearly 20 percent

of the sample admitted committing several or many additional offenses (see Table 3.9).

TABLE 3.9 ADMISSIONS OF OTHER SEXUAL OFFENSES NOT PREVIOUSLY REPORTED

Unreported Offenses	Number	Percentage
None	109	63.0
One	10	5.8
Several	20	11.6
Many	13	7.5
Unknown	21	12.2
Total	173	100.1

D. Sexual Orientation

Despite the fact that many juvenile sexual offenders selected like-gender victims, the vast majority of juveniles (93 percent) reported that their sexual orientation was heterosexual. The remainder of the juveniles were reported to be bisexual (3.8 percent) or homosexual/lesbian (3.1 percent).

E. Age-Appropriate Sexual Relationships

Less than one-half of the 149 juveniles (43.6 percent) for whom data were available reported that they had ever had an age-appropriate sexual relationship. The remainder were generally totally inexperienced; many had not kissed, or even held hands, with a peer.

F. Involvement with Friends/Peers

The literature suggests that many sexual offenders are isolated and lack a group of friends/peers with whom they feel a part. The juvenile sexual offenders included in this study fit this pattern. Nearly one-half of these youth (48.3 percent) were considered "loners" and without any friends at all. In contrast, only 12.6 percent of the juveniles were believed to have many friends (see Table 3.10).

TABLE 3.10 FRIEND AND PEER RELATIONSHIPS

Relationships	Number	Percentage
None ("Loner")	84	48.3
One or Some Friends	47	27.0
Many Friends	22	12.6
Unknown	21	12.1
Total	174	100.0

In summary, analysis of the evaluation and assessment information on the "typical" juvenile offender included in the study determined the following: the offender admitted participation in the offense, but blamed its occurrence on something or someone other than himself. If he admitted other unreported sexual offenses, they were likely to involve several or many victims. He was heterosexual in his orientation, but he was naive and inexperienced in age-appropriate sexual

relationships. Finally, he was isolated from his peers and was basically a "loner".

V. Location and Types of Treatment Afforded Offenders

A total of 93 percent of the juvenile sexual offenders received treatment through one or more of the projects described in Appendices A-J of this report. Treatment sessions were always conducted by trained project personnel or by private therapists acting under contract to one of the projects. With one exception, the treatment was always sex offender specific.

Most private therapists and project personnel used what can only be described as an eclectic approach to the treatment of sex offenders. Treatment personnel tended to use a variety of therapeutic techniques, including confrontation, sex education, victim sensitization, anger management, assertiveness training, social skill development, and role playing (and role reversal) of sexual offense behavior. Occasionally, desenitization and masturbatory satiation techniques were also utilized to supplement the more traditional "talk" therapies.

A. Location of Treatment

The location of treatment was almost evenly split between the community and a state operated institution. Of the 164 juveniles who received treatment, slightly more than one-half (53.3 percent) were treated in a community program, including local detention facilities. Treatment personnel in community programs frequently specialized in sex offender treatment or had been specially trained in the area.

All youth who were institutionalized (47.8 percent) were treated either at Echo Glen Children's Center or at Maple Lane School. Both institutions hosted sexual offender treatment programs staffed primarily by persons who were trained in sex offender treatment, but who were not specialists in the area.

B. Primary Treatment Modalities Used

Eight types or combinations of treatments were utilized. From Table 3.11 it can be seen that most juveniles were exposed to combinations of modalities. The most frequent of these combinations consisted of individual and group therapy; followed by individual and family therapy; individual, group and family therapy; and, finally, group and family therapy. When a single treatment modality was used, it almost always consisted of individual therapy, although a small number of youth received only group therapy or only family therapy. Only one juvenile was treated exclusively with behavior modification techniques.

TABLE 3.11 PRIMARY TREATMENT MODALITIES USED

Modality	Number	Percentage
Individual Only	33	20.1
Group Only	5	3.0
Family Only	8	4.9
Behavior Modification Only	1	.6
Individual and Family	28	17.1
Individual and Group	42	25.6
Group and Family	1	.6
Individual, Group, Family	27	16.5
Unknown	19	11.5
Total	164	99.9

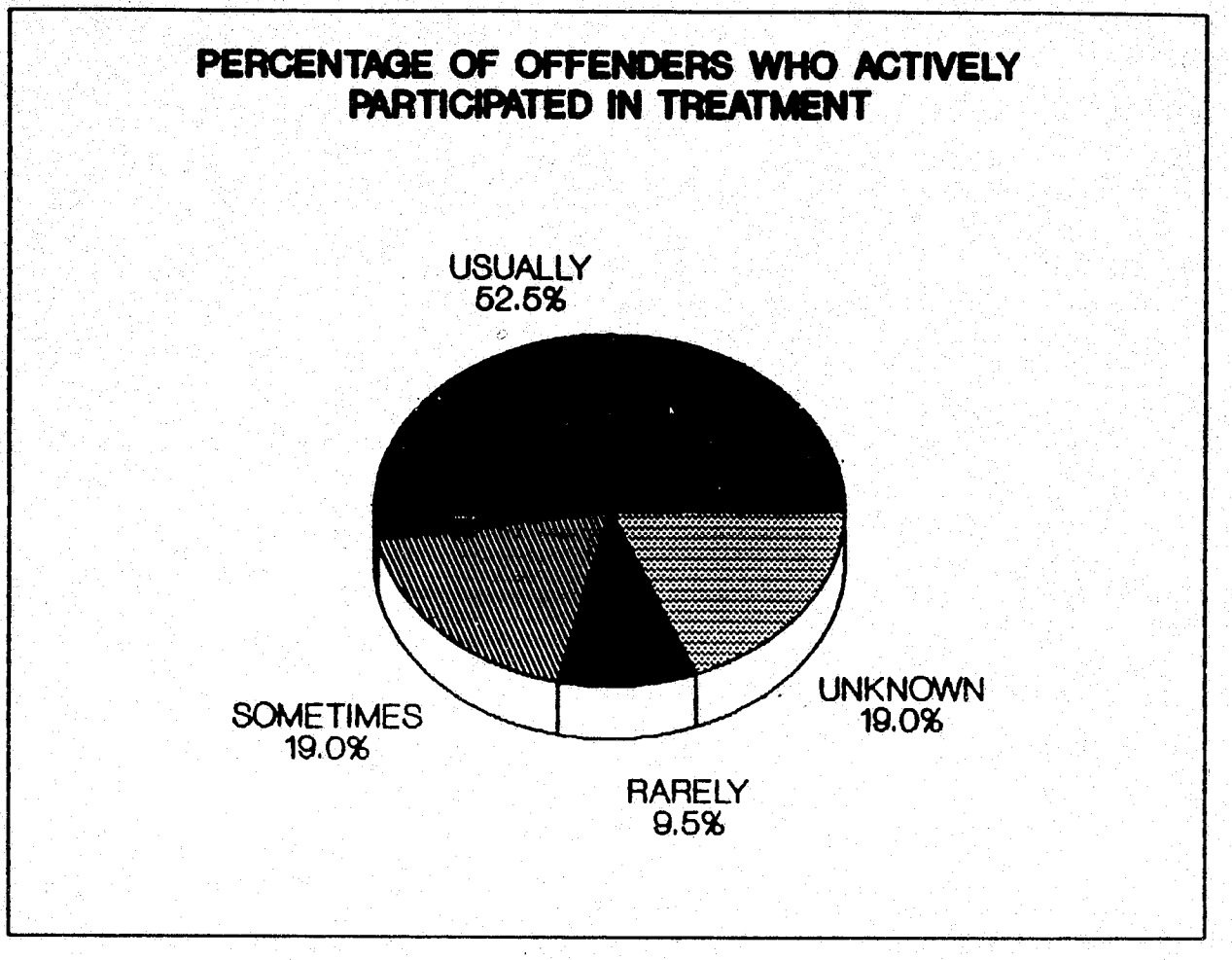
C. Number of Treatment Sessions Attended

Information on the number of treatment sessions attended by juvenile sexual offenders was available for only 95 of the 164 youth who participated in treatment. For those juveniles from whom information was available, slightly less than one-quarter (22.1 percent) received 10 or fewer treatment sessions. An identical proportion of youth received at least 51 or more sessions (see Table 3.12). The median number of treatment sessions was 27 per youth.

TABLE 3.12 TREATMENT SESSIONS ATTENDED

Sessions	Number	Percentage
1-10	21	22.1
11-20	16	16.8
21-30	17	17.9
31-40	13	13.7
41-50	7	7.4
51-60	6	6.3
61-70	2	2.1
71-80	4	4.2
81-90	0	0
91-100	3	3.2
101-110	2	2.1
111 and Above	4	4.2
Total	95	100.0

Figure 3.7



D. Level of Participation in Treatment

Although 93 percent of the juvenile offenders attended treatment sessions, not all youth actively participated in therapy (see Figure 3.7). Based on therapists' assessments, slightly more than one-half of the juveniles usually participated, approximately one-fifth sometimes participated, and one-tenth rarely participated. The frequency with which the offenders usually or sometimes participated in treatment

was refreshingly high, given that most juveniles underwent treatment involuntarily.

E. Functional Deficits

Therapists' assessments and offenders' files were reviewed to determine indications of functional deficits in each of the following six areas: sexual knowledge, self awareness, social skills, assertiveness, thinking/judgment, and education. The deficit noted most frequently was in the area of social skills, where more than one-half of the juveniles (51.8 percent) were considered inappropriate and/or immature in their relationships with others. Education was the second most frequently identified deficit. Nearly one-half of the youth (42.4 percent) were considered functionally disabled in this area. Approximately one-third of the juveniles were judged deficient in their sexual knowledge, self awareness and assertiveness. Finally, approximately one-quarter of the youth were believed to suffer serious errors in thinking and judgment. In all, nearly 80 percent of the offenders were considered functionally deficient in at least one area.

F. Insight

An important goal of most sex offender treatment is the development of insight into reasons for the sex offending behavior. This goal was only party achieved with the juvenile sexual offenders included in this study. According to the assessments of therapists who treated these youth, slightly more than one-half (51.8 percent) demonstrated insight at the

conclusion of treatment. The remaining youth demonstrated little or no understanding of their behavior or the reasons for such behavior.

G. Deviant Sexual Arousal

A common characteristic of many adult sexual offenders is deviant sexual arousal; that is, sexual responsiveness to inappropriate objects, actions or fantasies. This same characteristic was noted among the juveniles included in the study.

Therapists' assessments, rather than physiological methods, were used to determine the prevalence of deviant sexual arousal among the juveniles who were treated. Based upon assessment and treatment information, 44 percent of the youth were believed to have deviant arousal patterns. Possible deviant arousal was noted for an additional 35 percent of the juveniles for whom data were available.

H. Offender Empathy for Victims and Remorse for Acts

An important goal of treatment is to instill in offenders an understanding and concern for their victims, as well as a sense of remorse for the offense behaviors. This goal is predicated on the presumption that offenders who deny or minimize the emotional and physical consequences of their acts on victims, or who experience little or no remorse, are most likely to reoffend.

Of the 137 juveniles for whom data were available, only 39 percent demonstrated concern or empathy for their victims.

Similarly, only 46 percent of the youth expressed remorse for their sex offense behavior. Thus, given these findings, and based upon the presumption discussed above, more than one-half of the juveniles were at some risk to reoffend.

I. Motivation to Change

Table 3.13 presents the therapists' assessment of the number and proportion of offenders believed to be motivated to change. Note that the proportion of "yes" to "no" responses was slightly less than two to one in favor of change.

TABLE 3.13 ASSESSMENT OF OFFENDERS' MOTIVATION TO CHANGE

Motivated to Change	Number	Percentage
Yes, Motivated	78	45.1
No, Not Motivated	46	26.6
Unknown	50	28.4
Total	174	100.1

In summary, the "typical" juvenile sexual offender had about an even chance of undergoing treatment in a community program or a state institution. The treatment was likely to consist of a combination of modes, such as individual therapy coupled with group and/or family therapy, and to involve between 20 and 30 sessions. Although the juvenile actively participated in the treatment sessions, showed some insight into his sexual offense behavior, and demonstrated motivation to change, he did not express remorse for his offense(s) or empathy for his victim(s).

VII. Status of Offenders at Treatment Exit

The information presented below was obtained from therapists and from the files of offenders at the conclusion of their treatment. These data detail the reasons for termination of treatment and the need for follow-up treatment and support, identify the living situations of youth at the time of treatment exit, and provide an assessment of the offenders' future risk to the community.

A. Reasons for Termination from Treatment

From Table 3.14 it can be seen that less than one-quarter of the juvenile offenders (24.5 percent) were released from treatment because they had completed their programs. In most instances, the juveniles terminated treatment when their sentences or court orders expired, although a small proportion of the youth (2.3 percent) continued treatment voluntarily.

TABLE 3.14 REASONS FOR RELEASE FROM TREATMENT

Reasons	Number	Percentage
Program Completed	40	24.5
Sentence Expired	69	42.2
Court Order Expired	9	5.5
Did Not Wish to Continue	2	1.2
Failed to Participate	6	3.8
Left Area	7	4.4
Still in Treatment	4	2.3
Unknown	26	15.9
Total	164	99.9

B. Need for Follow-up Treatment or Support

A total of 85 percent of the juvenile offenders were believed to need additional treatment or support after termination from their respective programs. Only 35 percent of these youth were known to have received the needed follow-up services. In most instances, follow-up services were restricted to youth who were on parole status following release from a state operated institution.

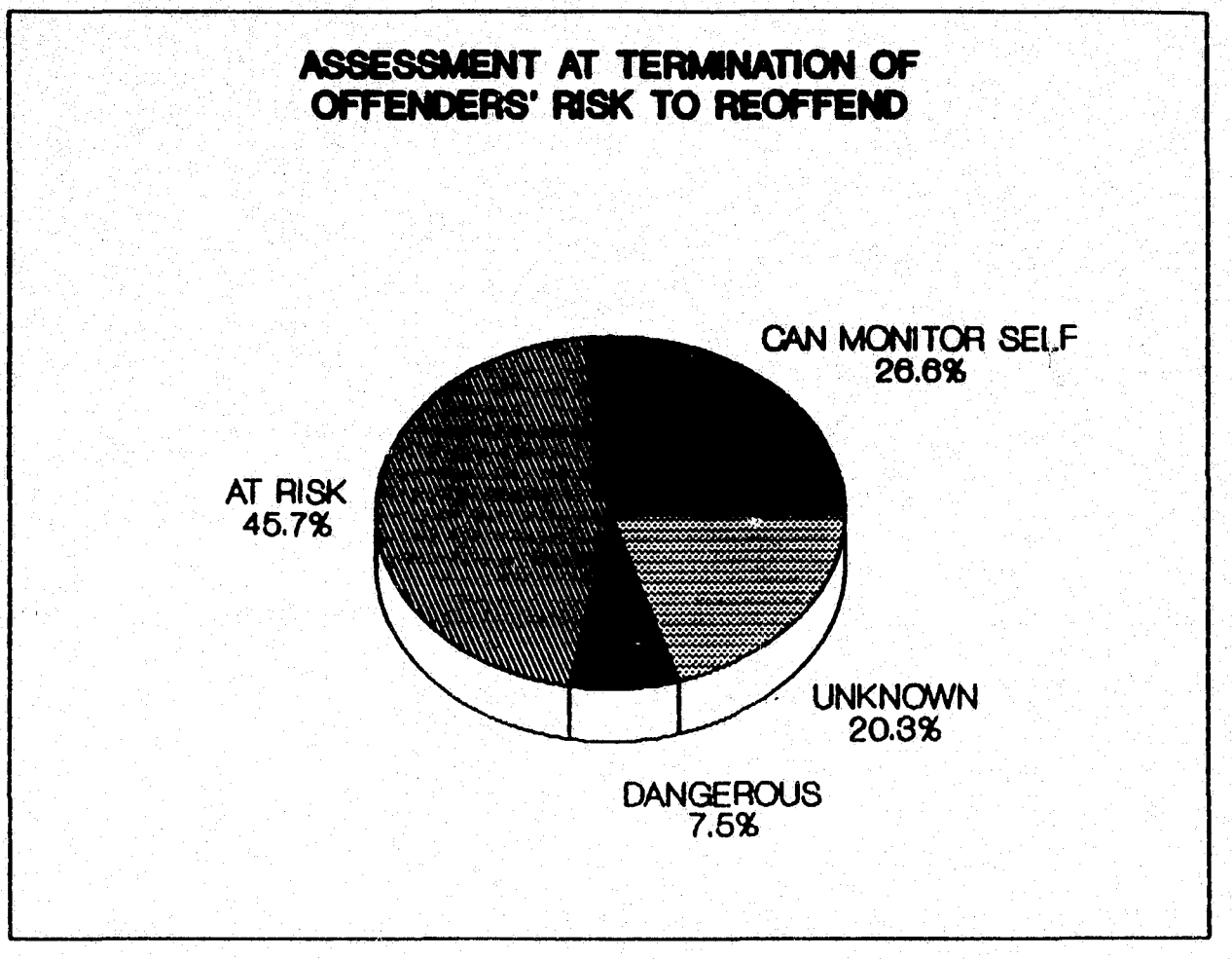
C. Living Situation at Termination

The living situations of many juvenile offenders changed between the commission of their offenses and their termination from treatment. For example, at the time of offense, nearly 90 percent of the offenders lived with parents or relatives (see Table 3.15). At termination from treatment, only 60 percent of the juveniles lived with family members. Although a small proportion of the remaining youth were emancipated and living on their own, the majority of these juveniles were residing in foster or group homes.

TABLE 3.15 LIVING SITUATION AT TERMINATION

Living With	Number	Percentage
Family	99	60.4
Foster/Group Care	34	20.7
Friends	2	1.2
Emancipated	6	3.7
Unknown	23	14.0
Total	164	100.0

Figure 3.8



D. Risk to Reoffend

Therapists and treatment program personnel were asked to assess the status of their juvenile sexual offender clients at the termination of treatment. As Figure 3.8 illustrates, nearly one-half of the juveniles were believed to be "at risk" of reoffending sexually, and an additional eight percent of the youth were considered "dangerous". Only slightly more than one-quarter of the youth were believed capable of monitoring themselves.

In summary, the "typical" juvenile sexual offender participated in treatment only as long as it was required under the terms and conditions of a sentence or court order. Although follow-up services were usually needed, they were rarely available or utilized by the offender. Finally, despite treatment, he was still considered dangerous or at risk to reoffend sexually.

In conclusion, a clear profile of the juvenile sexual offender emerged from the descriptive data presented above. In general, the offender was a white male in his early teens who lived with his natural mother. Although he was enrolled in school at the time of the sexual offense(s), he exhibited behavior problems in the classroom and often suffered from a learning disability. He was likely to have been sexually abused by a non-related male and to have been physically abused by his father or stepfather. A history of violence between his parents was common. He sexually offended against a female child who was known to him and who was at least six years younger. He used force, threats of force, or coercion to obtain compliance with his sexual demands. The sexual offense involved touching the genitalia of his victim(s), and frequently involved penetration of the vagina or anus, fellatio, cunnilingus, or masturbation.

The juvenile offender pled or was found guilty as charged and was incarcerated in a local detention facility or state institution. He was required to undergo sex offender specific treatment in a community program or at an institution. Although

he admitted the offense(s), he blamed its occurrence on the victim or someone/something other than himself. He was a "loner" who was isolated from peers and had never experienced an age-appropriate sexual relationship.

Treatment for the juvenile offender consisted of individual therapy in combination with some other mode, such a group or family therapy. Although he usually participated in his treatment sessions and showed insight into his offending behavior, he expressed no remorse for his act(s) or empathy for his victim(s). He terminated treatment when it was no longer required, despite his need for follow-up treatment or support and his risk of reoffending.

CHAPTER IV

THE JUVENILE SEXUAL OFFENDER AND RECIDIVISM

A primary goal of this study is to examine the reoffense behavior, or recidivism, of juvenile offenders who have received sexual offender specific treatment in a community based or institutional program. Specific research objectives in relation to this goal are four in number:

1. Determine the number and types of new convictions (recidivism) for juvenile offenders who were adjudicated and/or treated for sexual offense behavior;

2. Determine whether there is a discernible difference in recidivism between juvenile sexual offenders who were treated in community programs and those who received treatment in institutions;

3. Determine whether there is a discernible difference in recidivism among juvenile offenders who participated in different modes of treatment; and

4. Determine the extent to which other classes of variables (such as offender characteristics, attributes of the offense behavior, and juvenile justice system responses) were associated with recidivism.

Interest in the four issues identified above was motivated, in large part, by the lack of research on the outcomes of treatment for adolescent sexual offenders. Only two true outcome studies have been conducted. The first of these, reported by Doshay (1943) nearly fifty years ago, examined the recidivism of 256 juveniles who were treated for their sexual offending behavior. The primary element of the treatment was the generation of guilt in the offenders. Using subsequent arrests

within six or more years as the measure of recidivism, Doshay found that of 108 exclusive sexual offenders, only two had reoffended prior to adulthood and none had committed sexual offenses as adults. Only 14 of the non-exclusive sexual offenders reoffended prior to adulthood and only 10 reoffended as adults.

A much more recent study by Smith and Monastersky (1986) also examined recidivism among juveniles referred to a specialized adolescent sexual offender treatment program. Using subsequent referrals to juvenile court as the measure of recidivism, the authors found that 51 percent of the juveniles did not reoffend during the 17 or more months of follow-up. The remainder of the juveniles were found to be non-sexual reoffenders (35 percent) or sexual reoffenders (14 percent).

Becker and Abel (1984) are currently conducting the only controlled group outcome study of the effectiveness of specific treatment strategies for adolescent sexual offenders. Preliminary findings from this study indicated that slightly less than one-quarter of the adolescents had admitted, or were known to have engaged in, deviant sexual behavior within 12 months of the completion of treatment.

Becker and Abel (1984) suggest that any study conducted to evaluate the effectiveness of treatment strategies should incorporate specific features into the design of the research. In particular, the authors suggest that the research should

(1) supplement arrest records with other measures of recidivism; (2) insure adequate follow-up; and (3) evaluate whether the offender is in an environment where reoffending is possible. As we shall see in the following discussion, the current study was not able to incorporate all of these suggested features.

Measure of Recidivism (Outcome)

The measure of recidivism consisted of convictions in juvenile court subsequent to the disposition of the offenses which determined the inclusion of the juvenile sexual offenders in the study. These data were obtained from the state-wide juvenile information system, known as JUVIS, and maintained by the Washington State Office of the Administrator for the Courts.

JUVIS contains the criminal histories of all youth who have been adjudicated, or formally diverted, in each juvenile court jurisdiction within the state. Thus, as long as juvenile offenders included in the study sample continued to reside in the State of Washington, it was possible to determine the number and types of new convictions they received during follow-up. Using these same records, it was also possible to determine the number and types of convictions these youth received prior to the offenses which resulted in their inclusion in the sample.

All prior and subsequent offenses were classified into one of four "types" of offenses: (1) sexual; (2) misdemeanor; (3) non-violent felony; and (4) violent felony. Sexual offenses consisted of rape, statutory rape, indecent liberties with or without force, communicating with a minor for immoral purposes,

incest, peeping, indecent exposure, and obscene phone calls. Misdemeanor offenses were defined by statute and consisted of crimes such as theft under $250 in value, simple assault, and vandalism (malicious mischief). Non-violent and violent felonies were differentiated according to the classifications defined in the Sentencing Reform Act, RCW 9.94A. Using the definitions of this Act, crimes such as burglary, theft over $250, auto-theft, vehicle prowl, and some drug offenses were considered non-violent felonies. In contrast, very serious crimes against persons, such as murder, assault with intent to inflict severe bodily harm, kidnapping, vehicular homicide, and some drug offenses, were classified as violent felonies in accordance with RCW 9.94A.

Follow-up Periods

The total period of follow-up for each juvenile offender consisted of the number of months between the disposition of the instant offense and either the youth's eighteenth birthday or October 1, 1987, whichever came first. However, as Becker and Abel pointed out (1984), the period of follow-up may over-represent the actual time available to reoffend. To address this issue, a second measure was developed to better reflect actual "time at risk" in the community. To obtain this value for each youth, the total number of months of incarceration was subtracted from the total number of months of follow-up. As we shall see below, the length of time at risk was substantially shorter than the average period of follow-up.

Figure 4.1

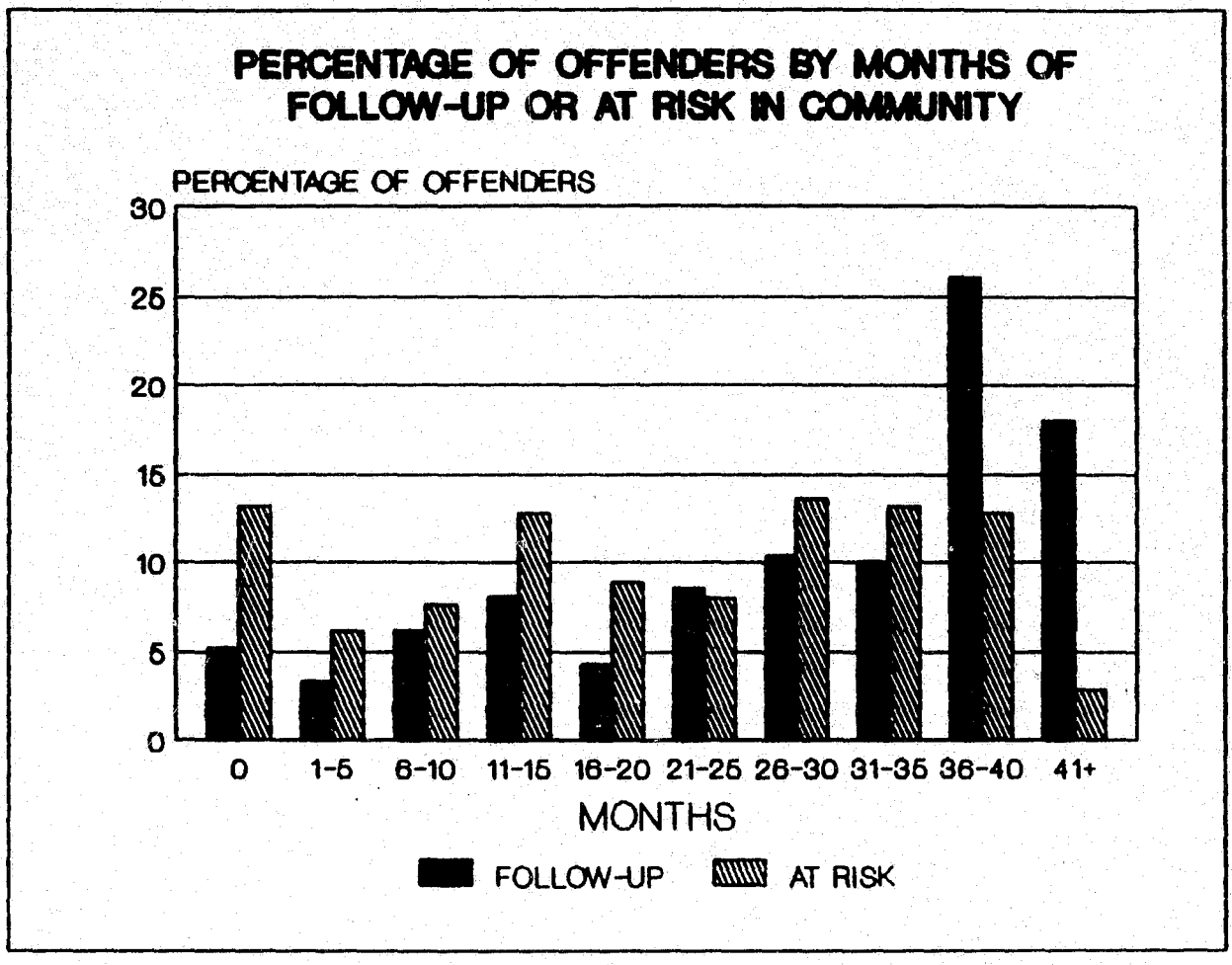
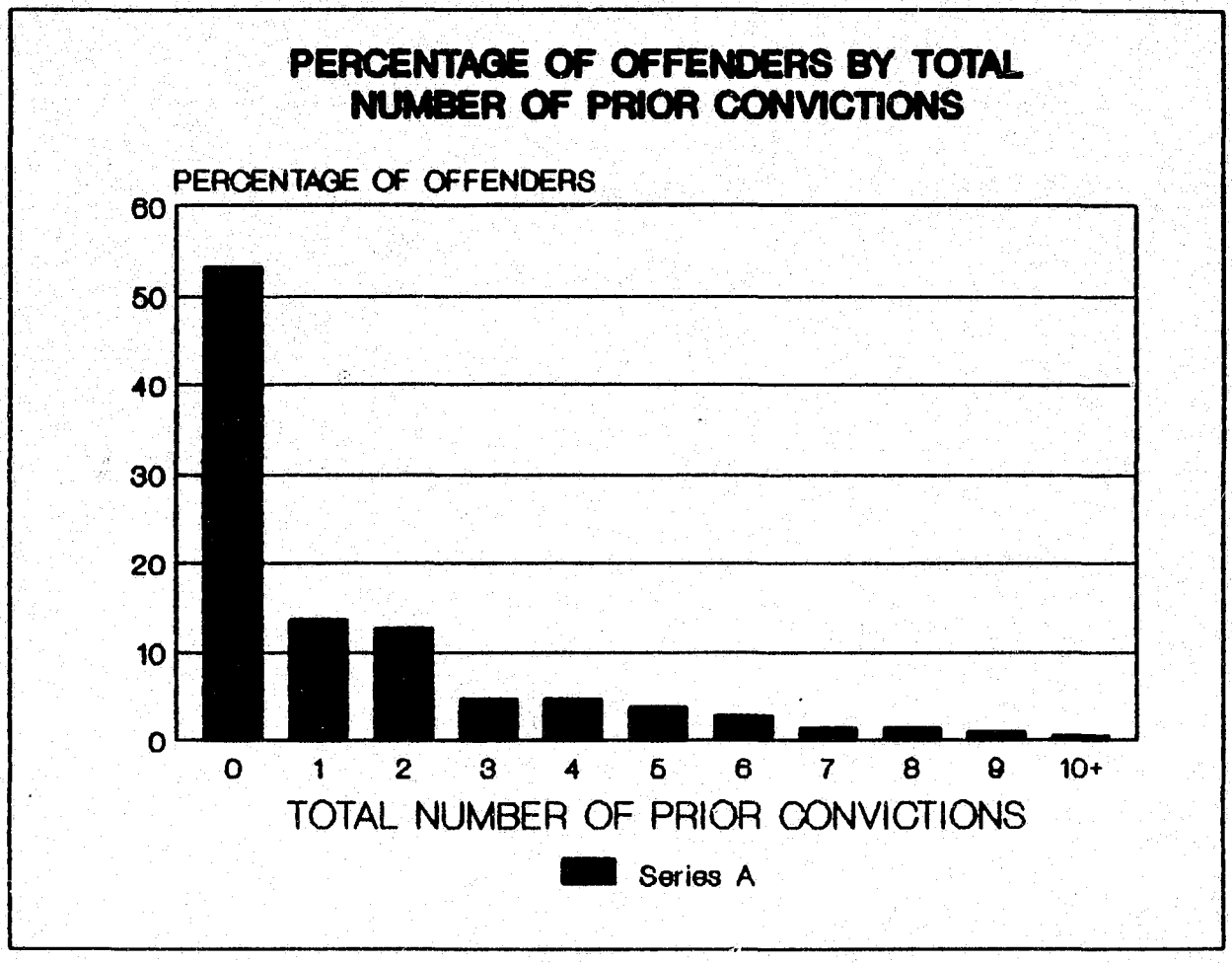


Figure 4.1 presents the percentage of juvenile offenders by months of follow-up or at risk in the community. The difference between groups is a function of the length of incarceration, if any, for each youth in the sample. Note that approximately 5 percent and 13 percent of the youth had "0" months of follow-up and time at risk, respectively. Youth in the former group "maxed out" in the sense that they were 18 years old at the time of disposition of their sexual offenses. Youth in the latter group consisted of these former juveniles in addition to those who turned 18 while incarcerated. No recidivism data were available for juveniles in either of these two groups.

Figure 4.2



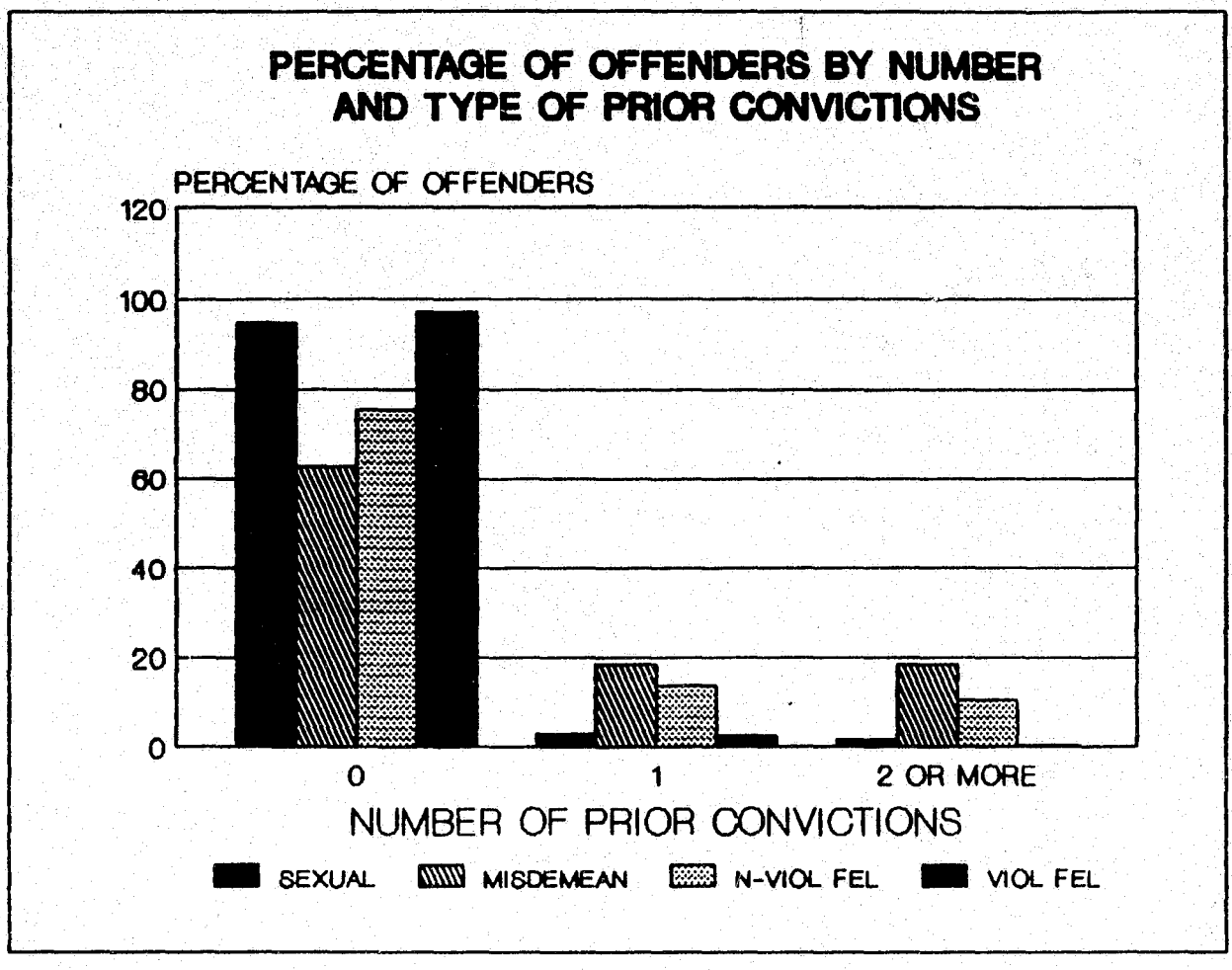
The periods of follow-up and time at risk ranged from 0 to more than 41 months. The median period of follow-up was 31-35 months with a mean of 28.1 months. The number of months at risk was substantially shorter: a median of 21-25 months and a mean of 20.4 months.

FINDINGS

Prior Convictions

As Figure 4.2 illustrates, slightly more than one-half of the juvenile offenders (53.3 percent) had no convictions prior to the instant offense that resulted in their inclusion in the

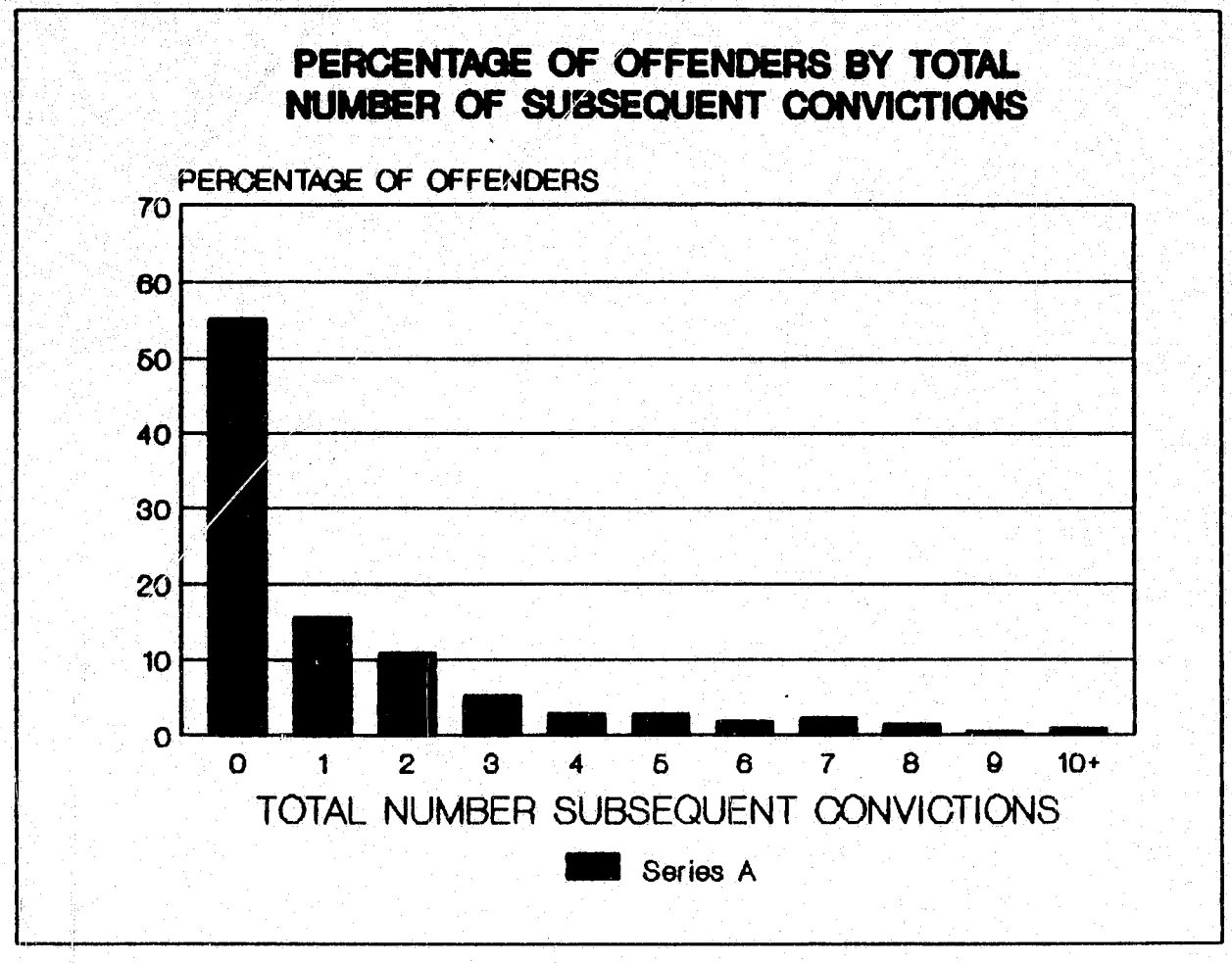
Figure 4.3



study. The number of prior convictions for the remainder of the youth ranged from one (most frequent) to more than 10 (least frequent) with a median of two per juvenile. Thus, nearly half of the juveniles had criminal histories before they entered the study.

The percentage of offenders by number and type of prior convictions is presented in Figure 4.3. Note that the vast majority of juveniles had no prior convictions for violent offenses, and that only a small proportion (5.2 percent) had been convicted of sexual crimes. In contrast, more than one-third of the juveniles (37.4 percent) had been convicted of one or more

Figure 4.4



misdemeanors, while one-quarter (25.5 percent) had at least one prior conviction for a non-violent felony.

Subsequent Convictions

A total of 44.8 percent of the juveniles were convicted of one or more subsequent offenses. As Figure 4.4 illustrates, the number of subsequent convictions ranged from one new offense to more than ten offenses. The majority of the recidivists, however, had fewer than two new convictions each.

Figure 4.5

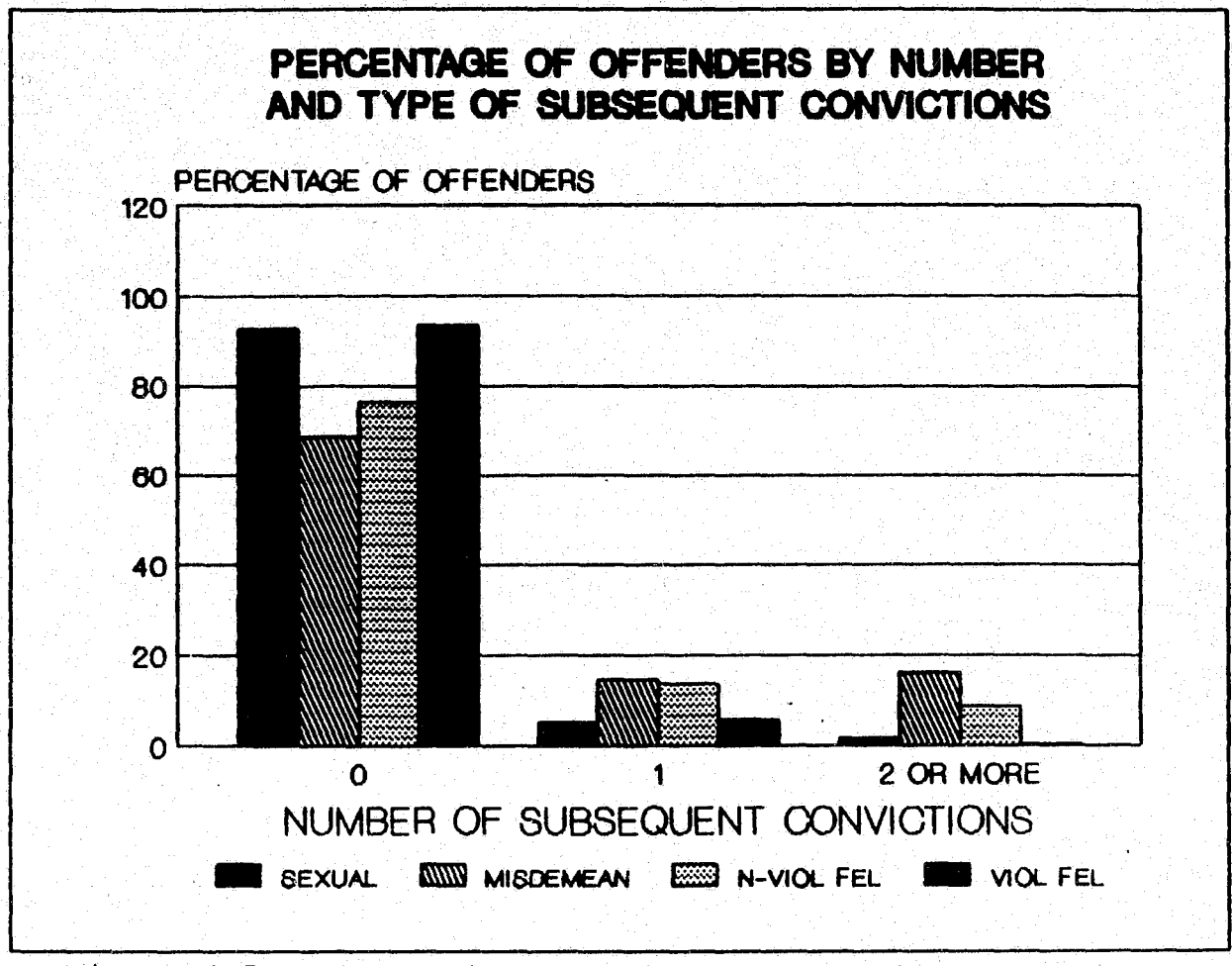
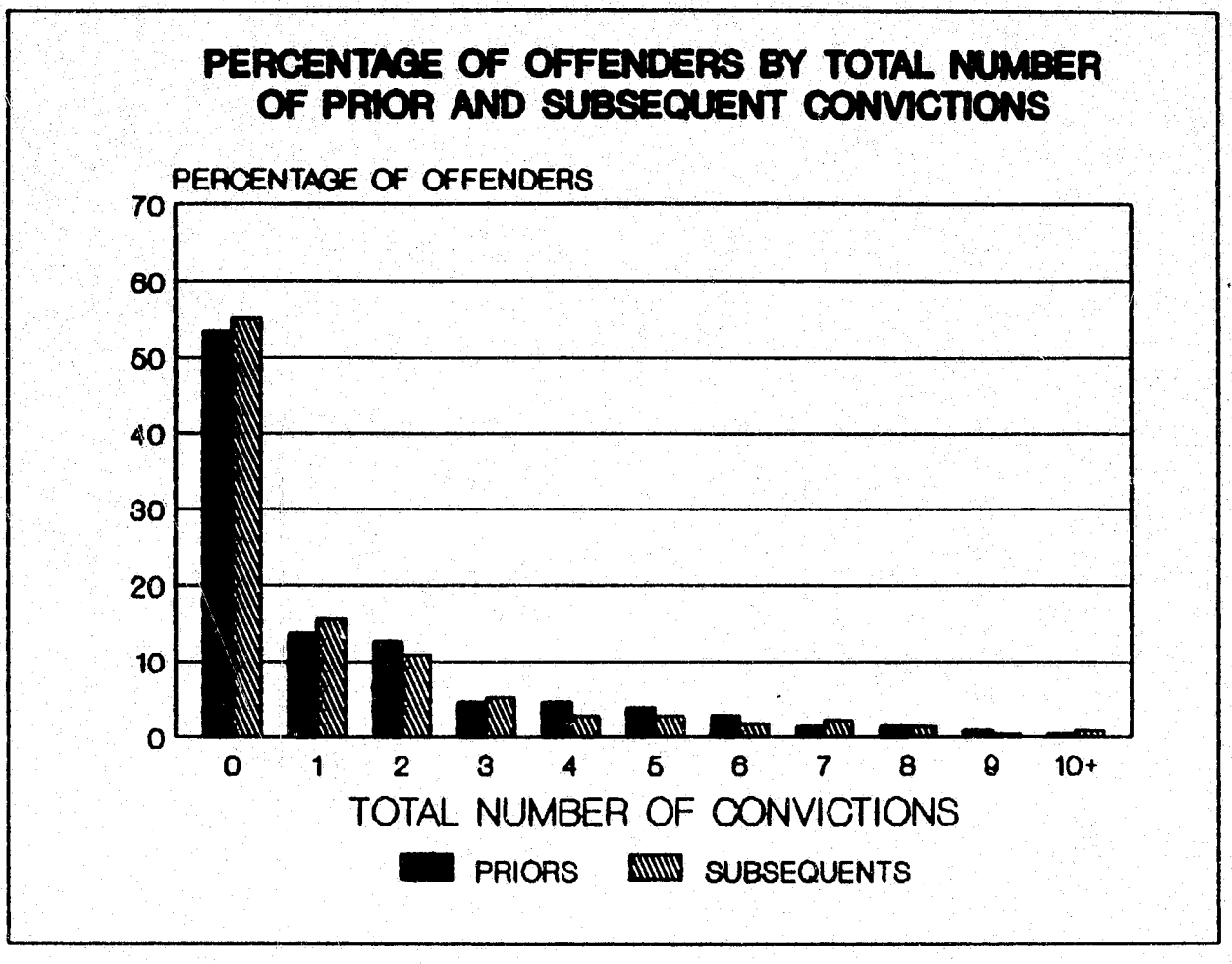


Figure 4.5 presents the percentage of offenders by number and type of of subsequent convictions. The most common forms of recidivism consisted of new convictions for misdemeanor or non-violent felony offenses. A total of 31.6 percent and 23.6 percent of the juveniles were convicted of these types of offenses, respectively.

New convictions for violent felonies or for sexual offenses were quite rare. For example, only 6.6 percent of the youth had subsequent convictions for violent crimes, while 7.5 percent were convicted of new sexual offenses. Of the 16 youth who recidivated sexually, 11 (69 percent) were convicted of one sexual

Figure 4.6



crime. The remaining five recidivists were convicted of 2, 3, 5, 8 and 9 sexual offenses respectively. Thus, repeat offenders committed a total of 38 sexual offenses that resulted in new convictions.

The percentage of offenders by total number of prior and subsequent convictions is presented in Figure 4.6. Note the striking similarity between the distribution of prior and subsequent convictions. Although the proportion of offenders with subsequent convictions (44.8 percent) was slightly less than that for prior convictions (46.7 percent), the distributions of the groups were almost total overlays.

Associations Between Prior and Subsequent Convictions

A series of statistical analyses (chi square, or X^2) were conducted to examine possible associations between types of prior and subsequent convictions. Twenty-five different combinations of prior and subsequent convictions were possible.

From Table 3.1, it can be seen that some associations were statistically significant ($p = .05$ or less). For example, youth with at least one prior conviction of any type (all priors) were significantly more likely to have at least one subsequent conviction (all subsequents). These subsequent convictions were most likely to consist of misdemeanor or violent offenses. The presence of a prior conviction was not related to subsequent conviction for a sexual or non-violent felony offense.

Juveniles with prior convictions for sexual offenses were not more likely to recidivate (all subsequents) than were youth without such convictions. Furthermore, the presence of a prior conviction for a sexual offense was not related to subsequent convictions for misdemeanor, non-violent felony, or violent felony offenses. Although juveniles with prior sexual offense convictions were somewhat more likely than youth without such criminal histories to receive new convictions for sexual offenses (18 percent compared to 7 percent), the differences were not statistically significant.

Prior misdemeanor convictions were not related to overall recidivism (all subsequents), nor to subsequent convictions for sexual, non-violent felony or violent felony offenses. The

presence or absence of prior misdemeanors, however, was associated with subsequent misdemeanor convictions. Thus, misdemeanants tended to recidivate as misdemeanants.

Highly significant associations were found between the presence of prior non-violent felony convictions and overall recidivism (all subsequents). Juveniles with non-violent felony priors were twice as likely to reoffend as youth without such priors (65 percent and 39 percent, respectively). Recidivism was most likely to take the form of new convictions for misdemeanor and non-violent felony offenses.

The presence of one or more prior violent felony convictions was not associated with overall recidivism. Furthermore, juveniles with prior violent convictions were no more likely than other youth to receive subsequent convictions for sexual, misdemeanor, non-violent felony or violent felony offenses.

In summary, recidivism was associated with some types of prior convictions, but not with others. Juveniles with prior convictions for misdemeanor offenses or non-violent felony offenses were significantly more likely to recidivate than youth who were either conviction free or had been convicted of prior sexual or violent felony offenses. Although youth with a prior sexual offense conviction were somewhat more likely than other juveniles to reoffend sexually, the differences were not statistically significant.

TABLE 4.1 ASSOCIATIONS BETWEEN PRIOR AND SUBSEQUENT CONVICTIONS

Prior Type		Subsequent Type	Significant	X^2	p
All	by	All	Yes	5.07	**.024**
		Sexual	No	.00	.988
		Misdemeanor	Yes	7.44	**.006**
		Non-Viol. Felony	No	2.79	.095
		Violent Felony	Yes	4.82	**.027**
Sex	by	All	No	.07	.789
		Sexual	No	.62	.432
		Misdemeanor	No	.00	.987
		Non-Viol. Felony	No	.091	.945
		Violent Felony	No	.08	.778
Misdemeanor	by	All	No	1.52	.218
		Sexual	No	3.82	.537
		Misdemeanor	Yes	5.71	**.017**
		Non-Viol. Felony	No	1.96	.162
		Violent Felony	No	2.43	.119
Non-Violent Felony	by	All	Yes	10.72	**.001**
		Sexual	No	.91	.341
		Misdemeanor	Yes	5.89	**.015**
		Non-Viol. Felony	Yes	7.40	**.007**
		Violent Felony	No	1.18	.278
Violent Felony	by	All	No	.48	.491
		Sexual	No	.01	.906
		Misdemeanor	No	.11	.736
		Non-Viol. Felony	No	1.46	.251
		Violent Felony	No	.05	.822

Associations Between Subsequent Offenses and the Location of Treatment

An important objective of this research was to examine whether the location of treatment (institution versus community program) had an impact on the recidivism of juvenile sexual offenders. To address this issue, chi square analyses were

performed to determine the significance of the statistical associations between the location in which juveniles were treated and subsequent convictions.

Juveniles who were treated in institutions were somewhat more likely to recidivate (one or more subsequent convictions for any type of offense) than youth who were treated in community programs. Overall recidivism for youth treated in institutions was 46 percent compared to 32 percent for juveniles who received treatment in the community. However, this difference in overall recidivism between groups was not statistically significant ($X^2 = 2.588$, $p = .108$): location of treatment was not related to overall recidivism.

Similarly, juveniles who were treated in institutions were also somewhat more likely to be convicted of subsequent sexual offenses than youth treated in community programs. Eleven percent of the institutionalized youth were convicted of new sexual offenses compared to four percent of the youth who were treated in the community. Again, however, the differences between groups were not statistically significant ($X^2 = 1.74$, $p = .187$): location of treatment was not associated with subsequent convictions for sexual offenses.

Associations Between Subsequent Offenses and Types or Quantity of Treatment Afforded Youth

The number and percentage of youth who were treated (by treatment modality) and who recidivated are presented in Table 4.2. Note that among treatment modalities that involved five or

more youth, recidivism was lowest for youth who participated in individual and family therapy (29.6 percent) and highest for youth exposed to the combination of individual, group and family therapy (50.0 percent).

TABLE 4.2 NUMBER AND PERCENTAGE OF YOUTH WHO WERE TREATED AND WHO RECIDIVATED BY TREATMENT MODALITY*

Modality	Number Treated	Number Recidivated	Percentage Recidivated
Individual Only	30	10	33.3
Group Only	5	2	40.0
Family Only	7	3	42.9
Behavior Modif. Only	1	0	0.0
Individual & Family	27	8	29.6
Individual & Group	41	17	41.6
Group & Family	1	0	0.00
Individual, Group & Family	24	12	50.0

* Data include only those cases for which treatment data forms and criminal history information were available.

Although juvenile offenders were exposed to eight treatment modalities (or combinations of modalities), only four types of treatment had the minimum number of participants to perform analyses: individual only; individual and family; individual and group; and individual, group and family. No statistically significant associations was found between type of treatment provided and overall recidivism ($X^2 = 3.999$, $p = .957$). Similarly, no relationship was found between type of treatment

and subsequent convictions for sexual offenses (X^2 = 3.696, p = .296). Thus, recidivism (overall convictions or convictions for sexual offenses) was not significantly influenced by the types of treatment afforded the juvenile offenders included in the study.

Recidivism was also examined in relation to the number of treatment sessions to which youth were exposed. The analysis involved determining the association between the number of youth who fell within each of eight categories (ranging from 1-10 sessions and progressing in 10-session blocks to 80 or more exposures to treatment) and subsequent convictions. The analyses revealed no relationships between the number of treatment sessions and overall recidivism (X^2 = 3.951, p = .526) or subsequent convictions for sexual offenses (X^2 = 6.558, p = .237).

Associations Between Subsequent Convictions and Other Variables Related to Treatment

A. Level of Participation in Treatment

Juveniles were differentiated on the basis of three levels of participation in treatment: usually participated, sometimes participated, and rarely participated. No statistically significant relationships were found among levels of participation and either overall recidivism (X^2 = 2.209, p = .526) or convictions for new sexual offenses (X^2 = .106, p = .745).

B. Functional Deficits

Nearly 80 percent of the juvenile offenders were believed functionally deficient in one or more of the following areas:

education, assertiveness, self awareness, thinking error, sexual knowledge, or social skills. No significant associations were found between the first four of these deficiency areas (education, assertiveness, self awareness, or thinking errors) and overall recidivism. However, the other two deficiencies were inversely related to overall recidivism. Juveniles who were deficient in sexual knowledge were less likely to reoffend than youth without such deficiencies ($X^2 = 6.12$, $p = .013$). Similarly, juveniles who were deficient in social skills were also less likely recidivate ($X^2 = 3.605$, $p = .013$) than youth with more social competence.

Associations between each of these areas of functional deficiency and subsequent convictions for sexual offenses was also examined. No statistically significant relationships were found between any of these deficiencies and subsequent sexual offenses.

C. Insight

The development of insight or understanding of sexual offending behavior was an important goal of many of the therapists who treated youth involved in this study. Despite the importance of insight during the treatment process, youth with insight were just as likely to recidivate as youth without insight ($X^2 = .036$, $p = .851$). Similarly, youth with insight were no less likely than other juveniles to receive new convictions for sexual offenses ($X^2 = 1.15$, $p = .765$).

D. Deviant Sexual Arousal

Marked differences in recidivism were found between youth with and without patterns of deviant sexual arousal. For example, 49 percent of the juveniles with deviant arousal were convicted of at least one subsequent offense compared to 30 percent among youth without such patterns. However, although this difference in overall recidivism between groups approached statistical significance, it did not achieve it ($X^2 = 2.319$, $p = .128$). Similarly, 12 percent of the youth with deviant sexual arousal were convicted of new sexual offenses compared to only six percent without deviant arousal. Again, however, the differences were not statistically significant ($X^2 = .279$, $p = .586$).

E. Offender Empathy for Victims and Remorse for Acts

Absolutely no associations were found between offender empathy for their victims and either overall recidivism ($X^2 = .009$, $p = .926$) or subsequent convictions for sexual offenses ($X^2 = .034$, $p = .854$). Similarly, juveniles who expressed remorse for their sexual offenses were just as likely as juveniles without such remorse to be convicted of a subsequent offense ($X^2 = 0.00$, $p = .983$) or to be convicted of a new sexual offense ($X^2 = .105$, $p = .745$).

F. Motivation to Change

Although juveniles who were believed to be motivated to change were somewhat less likely to recidivate than unmotivated youth, the differences were not statistically signifi-

cant (X^2 = 1.017, p = .313). Similarly, no association was found between motivation to change and subsequent convictions for sexual offenses (X^2 = 6.972, p = .223).

In summary, no significant relationships were found between level of participation in treatment, insight, deviant sexual arousal, offender empathy for victims, remorse for sexual offending behavior or motivation to change and overall recidivism or convictions for sexual offenses. However, the presence of either of two functional deficiencies (sexual knowledge or social skills) was associated with less overall recidivism, but not less sexual offense behavior.

Associations Between Subsequent Convictions and Demographic Characteristics

A. Age at Time of Sexual Offense

A very significant relationship was found between age at the time of the instant sexual offense and overall recidivism (X^2 = 10.394, p = .006). In general, the younger the offenders at the time of the offense, the greater the likelihood of recidivism. No relationship was found between age and the likelihood of subsequent convictions for sexual offenses (X^2 = .803, p = .669).

B. Race of Offenders

The race of offenders was not related to overall recidivism (X^2 = 3.20, p = .661) or to the likelihood of conviction for a subsequent sexual offense (X^2 = .047, p = 0.00).

C. Adults in Household at Time of Offense

Some differences in overall recidivism were noted on the basis of adults in the offenders' households at the time of the offense. For example, the highest level of recidivism (45 percent) was found among youth who lived with their mothers; the lowest recidivism (23 percent) was found among juveniles who resided with their fathers. These differences, however, were not statistically significant ($X^2 = 6.75$, $p = .15$). No relationship was observed between adults in the household and subsequent convictions for sexual offenses ($X^2 = .017$, $p = .965$).

D. Grade in School

An analysis was undertaken of overall recidivism by grade in school at the time of the instant offense. In general, the likelihood of recidivism increased as grade levels progressed. The relationship, however, was not statistically significant ($X^2 = 9.214$, $p = .238$). Too few cases were available to examine the relationship between grade level and subsequent convictions for sexual offenses.

In summary, the only demographic characteristic that differentiated between recidivists and non-recidivists was age at the time of the instant sexual offense. Younger offenders were more likely to be convicted of a subsequent offense than older offenders. Other characteristics, such as race, living situation and grade in school were not associated with recidivism.

Associations with Historical Experiences and Dysfunctional Behaviors

A. School Problems

Three types of school or education related problems were noted among many of the juvenile sexual offenders, namely, behavior problems in the school setting, truancy, and learning disabilities. Two of these problem areas were associated with overall recidivism. First, youth with reported behavior problems were significantly more likely to be convicted of a subsequent offense ($X^2 = 3.847$, $p = .049$), as were youth with truancy histories ($X^2 = 7.344$, $p = .007$). No relationship was found between learning disabilities and overall recidivism, or between any of the problem areas and subsequent convictions for sexual offenses.

B. Reported Sexual Abuse

Youth with histories of sexual abuse were significantly more likely to recidivate than youth without such abuse experiences ($X^2 = 63352$, $p = .012$). However, abused youth were no more likely to reoffend sexually than youth who were not abused ($X^2 = .498$, $p = .481$).

C. Reported Sexual Abuse of a Sibling

Youth from homes with reported sexual abuse of a brother and/or sister were significantly more likely to be convicted of new offenses than youth from homes without sibling abuse ($X^2 = 5.886$, $p = .015$). No relationship was found between sibling abuse and subsequent convictions for sexual offenses.

D. Reported Physical Abuse

Youth who had been physically abused were no more likely than non-abused youth to recidivate (X^2 = .021, p = .886) or to be convicted of new sexual offenses (X^2 = .321, p = .361).

E. Reported Violence Between Parents

No significant relationships were found between parental violence and either overall recidivism (X^2 = .22, p = .639) or new convictions for sexual offenses (X^2 = .25, p = .546).

F. Reported Substance Abuse

Youth who were reported to abuse substances were no more likely than non-abusers to be convicted of a new offense (X^2 = 1.241, p = .265) or a new sexual offense (X^2 = .981, p = .546). Although youth who committed their instant sexual offense while under the influence of substances were somewhat more likely to recidivate, the difference was not statistically significant (X^2 = .453, p = .501).

In summary, historical experiences and two dysfunctional behaviors were associated with overall recidivism. Youth who had been sexually abused, or who came from homes where a sibling had been sexually abused, were more likely to be convicted of a subsequent offense of some kind, but not a subsequent sexual offense. Juveniles with prior histories of physical abuse, parental violence, or substance abuse were not more likely to recidivate than youth without each of these experiences.

Associations with Sexual Offense Characteristics

A. Elements of the Sexual Offenses

The elements of the sexual offenses, as described in police and victim reports, are presented in Table 4.3, along with indications of the significance of the associations between the elements and overall recidivism (all subsequent convictions) or subsequent sexual convictions. Note that only one elements was related to overall recidivism; that is, verbal coercion in the course of the instant sexual offense. In this instance, the relationship was in the opposite direction. Youth who used verbal coercion were significantly less likely to recidivate than youth who used no verbal coercion, or used other means, to attain compliance from their victims ($X^2 = 4.314$, $p = .038$).

Two elements were associated with subsequent convictions for the sexual offenses. The first of these consisted of verbal threats. Youth who threatened their victims were more likely to reoffend sexually than those who did not ($X^2 = 5.308$, $p = .014$). The second element consisted of a particular sexual act. Youths who forced their victims to commit masturbation of them were significantly more likely to reoffend sexually ($X^2 = 4.989$, $p = .026$).

TABLE 4.3 SIGNIFICANCE OF THE ASSOCIATIONS BETWEEN OFFENSE ELEMENTS AND OVERALL RECIDIVISM (ALL SUBSEQUENT CONVICTIONS) AND CONVICTIONS FOR SUBSEQUENT SEXUAL OFFENSES

Elements	All Subsequents	Sexual Subsequents
Exhibiting	No	No
Peeping	*	**
Obscene Calls	*	**
Stealing Underwear	*	***
Verbal Coercion	Yes (p=.038)	No
Verbal Threats	No	Yes (p=.014)
Physical Force	No	No
Weapons Threats	No	No
Weapons Use	*	**
Touch Breasts	No	No
Touch Genitalia	No	No
Masturbating of Victim	No	No
Fellatio of Victim	No	No
Cunnilingus on Victim	No	No
Vaginal Penetration	No	No
Anal Penetration	No	No
Masturbation by Victim	No	Yes (p=.026)
Fellatio by Victim	No	No
Cunnlingus by Victim	*	*

* Insufficient cases to perform analysis.
** Only 2 cases -- none reoffended.
*** Only 3 cases -- none reoffended.

B. Sex and Age of Victims

No significant associations were observed between the gender of victims and either overall recidivism (X^2 = .017, p = .896) or subsequent convictions for sexual offenses (X^2 =

.007, p = .932). The other characteristics of victims, age at the time of the instant offense, was associated with overall recidivism, but not significantly so (X^2 = 28.592, p = .124). In general, juveniles who had offended against very young children (less than seven years old) were somewhat more likely to recidivate (all subsequent convictions), but were no more likely than other youth to reoffend sexually (X^2 = 15.405, p = .802).

C. Relationship Between Offenders and Victims

Although no statistically significant associations were found between offender/victim relationships and overall recidivism (X^2 = 7.195, p = .409), youth who had sexually victimized a blood related child were most likely to be convicted of a new offense (all convictions). In contrast, the likelihood of a conviction for a new sexual offense was greatest among juveniles who had victimized non-related children known to them, and least likely among youth who had offended against peers. These latter associations, however, failed to achieve statistical significance (X^2 = 2.672, p = .263).

In summary, several characteristics of the sexual offense behaviors were found to be associated with recidivism. Youth who had verbally coerced their victims were less likely to be convicted of a new offense. In contrast, juveniles who had verbally threatened their victims, or had forced their victims to masturbate them, were more likely to reoffend sexually. No significant relationships were found between subsequent

convictions (all offenses or sex offenses only) and the ages and gender of victims, or the relationships between offenders and victims.

Associations with Juvenile Justice System Responses

A. Disposition of Referral Charges

Although the majority of the original sexual offense referrals were formally adjudicated by the juvenile courts, the referrals of nearly one-quarter of the juveniles (23.6 percent) were diverted. These latter youth were significantly more likely to recidivate than youth who were adjudicated; that is, to receive a subsequent conviction for a new offense (X^2 = 12.348, p = .015). Sixty-six percent of the "diverted" youth reoffended compared to 43 percent of the youth who pled to, or were found guilty of, at least one sexual offense.

A somewhat different pattern was observed with regard to the disposition of referral charges and subsequent sexual offenses. The youth most likely to reoffend sexually were those who had been convicted of the original charges; youth least likely to reoffend were those who had pled to lesser sexual offense charges. Despite these differences, no statistically significant associations were found between the disposition of referral charges and subsequent convictions for sexual offenses (X^2 = 1.079, p = .583).

B. Conviction/Referral Offenses

No associations were found between the types of conviction/referral offenses and overall recidivism (X^2 = 26.217, p = .569) or subsequent convictions for sexual offenses. Eight of the juveniles who were referred for indecent liberties, and three of the youth who were referred for statutory rape, were convicted of new sexual offenses. The remaining sexual recidivists were originally referred for, or convicted of, rape, indecent exposure and burglary.

C. Sentences Imposed

A multitude of sentences and requirements were imposed on the juvenile sexual offenders, including institutionalization, detention, probation, out-patient treatment, community service, and restitution. No statistically significant associations were found between any of these sentences/requirements and overall recidivism or subsequent convictions for sexual offenses. The only association that even approached significance was between out-patient treatment and sexual reoffending. Juveniles sentenced to out-patient treatment were somewhat less likely than other youth to be convicted of subsequent sexual offenses.

Associations with Evaluation and Assessment Variables

A. Admission That the Offense Occurred

Whether juveniles admitted or denied the occurrence of their sexual offenses bore no relationship to overall recidivism (X^2 = .045, p = .831). However, admission or denial was

associated with subsequent convictions for new sexual offenses. Juveniles who admitted their offenses were significantly more likely to reoffend sexually than youth who denied their offenses (X^2 = 10.83, p = .001). None of the youth who denied their offenses were convicted of new sexual offenses.

B. Blame for the Offense

Who/what the offenders blamed for their offenses were grouped into three categories for purposes of the analysis: (1) self, (2) victim, or (3) other. No association was found between these categories of blame and overall recidivism (X^2 = 6.538, p = .366). However, a highly significant relationship was found between who/what was blamed for the sexual offense and sexual reoffending (X^2 = 7.392, p = .025). Convictions for new sexual offenses were distributed as follows: blamed victim = 22 percent; blamed self = 8 percent; and blamed "other" = 9 percent. Thus, offenders who blamed their victims were much more likely than other youth to commit new sexual offenses.

C. Age Appropriate Sexual Relationships

No associations were found between prior age appropriate sexual relationships and overall recidivism (X^2 = 0.00, p = .992) or new convictions for sexual offenses (X^2 = 2.784, p = .426).

D. Involvement with Friends/Peers

Although no significant association was detected between levels of involvement with friends/peers and overall recidivism (X^2 = 3.384, p = .184), an interesting pattern emerged. Juveniles with many friends reoffended more frequently than youth who were considered loners. Similarly, youth with many friends were three times more likely to be convicted of new sexual offenses than juveniles who were loners. When all levels of involvement with friends were considered, however, the association with new sexual offenses was not significant (X^2 = 1.537, p = .215).

In summary, two assessment variables were associated with the likelihood of subsequent convictions for sexual offenses. The first of these, denial that the offense occurred at all, was inversely related to sexual reoffending. Youth who denied the offenses were significantly less likely to receive convictions for new sexual offenses. Second, who the offenders blamed for their offenses was related to sexual reoffending. Youth who blamed their victims were significantly more likely to be convicted of new sexual offenses than youth who blamed themselves or someone/something else.

Associations with Treatment Exit Variables

A. Reasons for Termination From Treatment

No significant relationship was found between reasons for termination from treatment and overall recidivism (X^2 = 6.658, p = .574) or subsequent convictions for sexual

offenses (X^2 = .006, p = .922). Youth who actually completed their treatment programs were only slightly less likely to reoffend sexually than juveniles who terminated because their sentences or court orders expired (8 percent sexual recidivism compared to 9 percent, respectively).

B. Living Situation at Termination

Living situation at termination was not associated with overall recidivism (X^2 = 2.886, p = .410) or new sex offenses (X^2 = .084, p = .222). Note, however, that juveniles who lived with their families were three times more likely to reoffend sexually than youth who lived in group/foster homes.

C. Need for Follow-up Treatment and Support

Eighty-five percent of the juveniles were believed to need follow-up treatment or support after their termination from treatment. Need for additional treatment or support was not related to overall recidivism (X^2 = .234, p = .629) or to subsequent convictions for sexual offenses (X^2 = 1.887, p = .596).

D. Risk to Reoffend

At the conclusion of treatment, therapists assessed that nearly one-half of the juveniles were "at risk" of reoffending, and an additional eight percent were "dangerous". Only slightly more than one-quarter of the juveniles were believed capable of monitoring themselves. As we shall see, the therapists' forecasts were quite accurate

with regard to subsequent sexual offense behavior, but not to overall recidivism.

Overall recidivism was highest among youth who were believed "at risk" to reoffend (47 percent) and lowest among juveniles assessed as dangerous (27 percent). Recidivism among youth who were considered capable of monitoring themselves was midway between these two extremes, or 36 percent. Despite these variations, no significant association was found between risk assessment status and overall recidivism ($X^2 = 2.171$, $p = .338$).

Therapists were much more successful when their forecasts were narrowed to risk of sexual reoffense behavior. None of the youth who were considered capable of monitoring themselves received a new conviction for a sexual offense, while nine of the youth assessed as "at risk" or dangerous reoffended sexually. The association between risk assessments and sexual reoffense behavior nearly achieved statistical significance ($X^2 = 3.564$, $p = .059$).

In conclusion, the analysis of the outcome data revealed that slightly less than one-half of the juveniles recidivated; that is, that they were convicted of at least one subsequent offense during the period of follow-up. The most common forms of recidivism consisted of convictions for new misdemeanor or felony offenses. Sexual recidivism was rare: only 7.5 percent of the juveniles were convicted of new sexual offenses.

Answers to several important research questions required analyses of the relationships between recidivism and three key treatment variables, namely location of treatment, type of treatment, and quantity of treatment. None of these treatment variables was found to be significantly associated with overall recidivism or with sexual recidivism. Although juveniles treated in institutional programs were somewhat more likely to reoffend than youth treated in community programs, the differences were not statistically significant. Similarly, no significant differences in recidivism were found as a function of the four primary types of treatment provided, or as a result of the number of treatment sessions attended.

No significant relationships were found between the majority of the characteristics of offenders/offenses and recidivism (either a new conviction for any offense or a new conviction for a sexual offense). For example, recidivists were indistinguishable from non-reoffenders on the basis of the presence or absence of any of the following attributes:

- Race;
- Grade in school at time of offense;
- Living situation at time of offense or at termination from treatment;
- History of physical abuse;
- History of parental violence;
- History of substance abuse;

- Reported learning disabilities;
- Insight into the sexual offense behavior;
- Deviant sexual arousal;
- Empathy for victims;
- Remorse for sexual offenses;
- Motivation to change;
- Relationship to victims;
- Types of conviction or referral offenses;
- Sentences imposed;
- Prior age appropriate sexual relationships;
- Involvement with friends/peers;
- Reasons for termination from treatment; or
- Need for follow-up treatment and support.

Overall recidivists and sexual recidivists were distinguishable on the basis of a small number of characteristics. For example, youth who blamed their victims for the sexual offenses, or who verbally threatened their victims, or who forced their victims to masturbate them were more likely to recidivate sexually. In contrast, youth who denied their sexual offenses were significantly less likely to reoffend sexually. Therapists were very accurate at identifying those youth who were at low risk to reoffend sexually. No juveniles who were assessed as capable of monitoring themselves were convicted of new sexual offenses.

A different set of variables characterized the overall recidivists. These youth were distinguished on the basis of

their relative youthfulness, reported behavior problems in school, and histories of truancy and sexual abuse. Recidivists were less likely than non-reoffenders to use verbal coercion in the commission of their instant sexual offenses. Finally, youth were more likely to reoffend if their sexual offense referrals were diverted from the formal adjudication process. Overall recidivism was significantly lower among youth who had pled to, or were found guilty of, their instant offenses.

CHAPTER V

DISCUSSION

The findings from this study paint a tragic, but alarming, portrait of the juveniles who were treated for their sexual offense behavior. Nearly all of the youth were raised in families in which divorce, domestic violence and physical abuse were common. The offenders were rarely exposed to adult males who might have served as appropriate role models and assisted in their social and psychological development. Instead, relationships with older, non-related males often resulted in exploitation and sexual abuse.

The offenders exhibited a variety of problems and social deficits prior to the onset of the sexual offending behavior. Fights, poor academic performance, classroom disruptions, truancy and learning disabilities were commonly noted in school reports. Most of the youth were socially isolated, immature, sexually inexperienced and naive. Nearly one-half had been convicted of at least one non-sexual offense, usually a misdemeanor or non-violent felony prior to the commission of the sexual offense(s) for which they were treated. Only 5 percent had a prior conviction for a sexual crime. However, approximately one-quarter of the juveniles self-reported committing prior sexual offenses for which they had never been apprehended.

Most juveniles sexually molested or assaulted female victims less than half their age. In most instances, these child victims were known to them and were frequently under the supervision or

care of the offenders at the time of the sexual offenses. Although most youth acknowledged that the sexual offenses had taken place, many refused to accept responsibility for the acts. These latter offenders typically blamed the offenses on their victims, co-participants, their own parents, or even the parents of their victims.

Nearly all of the juveniles in the study participated in some form of sexual offender treatment. Regardless of the types of treatment utilized (individual therapy, group therapy, family-systems therapy, or some combination thereof), the goals of therapy were similar. Typically, treatment was designed to help youth understand their behavior, accept responsibility for their offenses, develop empathy for their victims, and experience remorse for their crimes. In addition, treatment also focused on the dysfunctional family environments and socialization experiences of the juveniles. As we shall see, these goals were not always achieved (or achievable).

According to the reports and assessments of therapists, approximately 60 percent of the juveniles were motivated to change during the course of treatment. However, less than one-half of the youth were believed to have attained the specific goals of treatment mentioned above: insight, empathy for victims, or remorse for the sexual offense behavior. At the conclusion of treatment, nearly one-half of the juveniles were believed to be "at risk" for reoffending sexually, and an additional 8 percent were believed to be "dangerous".

Despite the rather ominous predictions of the therapists, the actual rate of recidivism (new convictions) for sexual offenses were only 7.5 percent during the period of follow-up. However, when all subsequent convictions were considered, the rate of recidivism rose to 44.8 percent. Most of these latter convictions consisted of misdemeanor and non-violent felony offenses.

The recidivism data must be treated with considerable caution, since they represented only those new offenses which resulted in convictions. This measure of recidivism is particularly problematic for sexual crimes. By their very nature, these crimes are covert, frequently unreported, and difficult to prove in court. Thus, the actual incidence of sexual reoffending may have been much higher than the reconviction data suggest.

The rates of sexual recidivism and overall recidivism observed in this study were remarkably similar to those reported by other researchers. For example, Doshay (1943) conducted a long-term follow-up study of juveniles who underwent treatment as a result of their sexual offense behavior. Only 7 percent had recidivated sexually, while approximately 40 percent had subsequent criminal convictions in general. Similarly, Smith and Monastersky (1986) tracked 117 juvenile sexual offenders for a period of 17-49 months after they had received treatment at the University of Washington Adolescent Sexual Offender Program. Using new referrals to juvenile court as the measure of recidivism, the authors found that while 14 percent of the youth

had recidivated sexually, nearly half (48 percent) had been referred for some type of new offense.

Despite the limitations of the measure of recidivism used in the current study, it seems reasonable to conclude that while many of the juveniles continued to commit crimes, few continued to engage in sexual offense behavior. At this time, it appears that the therapists' cautionary warnings were unwarranted. Only 14 percent of the juveniles who were judged to be "at risk" or "dangerous" recidivated sexually during the period of follow-up. On the other hand, therapists accurately assessed those youth whom they believed capable of monitoring themselves. None of these youth reoffended sexually.

Few of the independent variables examined in this study were significantly associated with sexual recidivism. None of the treatment variables (location of treatment, types of treatment, or quantity of treatment) were related to outcomes. The only variables that were significantly associated with sexual reoffense behavior were: (1) who juveniles blamed for the instant offense (someone/something else); (2) use of verbal threats; (3) masturbation of the offenders. In contrast, juveniles who denied their instant sexual offenses were significantly less likely to reoffend sexually.

Several interesting, but non-significant, relationships were observed in the data. For example:

- Juveniles with prior sexual offense convictions were somewhat more likely than youth without such criminal histories to receive new convictions for sexual offenses (18 percent compared to 7 percent).

- Juveniles who were treated in institutions were also somewhat more likely to be convicted of subsequent sexual offenses than youth treated in community programs (11 percent compared to 4 percent). This difference may have reflected the fact that the more serious and chronic offenders -- those at greatest risk to reoffend -- were sentenced to institutions more often than the first-time or less serious offenders.

- Juveniles with suspected deviant sexual arousal patterns were more likely to reoffend sexually than youth without such patterns (12 percent compared to 6 percent).

With the exception of the few differences described above, sexual reoffenders were generally indistinguishable from the non-reoffenders. For the most part, most offenders did not reoffend sexually either during or after participation in treatment. However, the design of the study did not permit the conclusion that treatment itself was responsible for the low rates of recidivism. To determine the effectiveness of treatment (regardless of type of treatment), the research would have required the use of a comparison group of non-treated sexual offenders. No such comparison group was available -- nor is one ever likely to be available for this type of field research.

REFERENCES

Abel, Gene G.; Becker, Judith V. and Skinner, L.J. "Treatment of the Violent Sexual Offender" in L. Roth (ed.) Clinical Treatment of the Violent Person. Crime and Delinquency Issues, A Monograph Series, National Institute of Mental Health, 1983.

---------; Blanchard, E. "The Role of Fantasy in the Treatment of Sexual Deviation". Archives of General Psychiatry, 30, 467-475, 1975.

---------; Harlow, Nora. "The Child Abuser". Redbook, August, 98-141, 1987.

Ageton, S.S. Sexual Assault Among Adolescents: A National Study. Final Report to the National Center for Prevention and Control of Rape, National Institute of Mental Health, Washington, D.C., 1983.

Becker, Judith V. and Abel, Gene G. Methodological and Ethical Issues in Evaluating and Treating Adolescent Sexual Offenders. Draft Monograph to the National Institute of Mental Health, Washington, D.C., 1984.

Deisher, Robert; Monastersky, Caren and Smith, Wayne. Causes and Treatment of Juvenile Sexual Offending Behavior. University of Washington Juvenile Sexual Offender Program, in-house paper, 1984.

---------; Wenet, Gary; Paperny, David; Clark, Tony and Fehrenback, Peter. "Adolescent Sexual Offense Behavior: The Role of the Physician". Journal of Adolescent Health Care, 2, 279-286, 1982.

Doshay, L.J. The Boy Sex Offender and His Later Career. New York: Grune and Stratton, 1943.

English, Diana J. Report on Study and Case Management Issues for Sexually Aggressive Children. Department of Social and Health Services, Region 3, 1986.

Gagnon, J.H. "Sexuality and Sexual Learning in the Child". Psychiatry, 28, 212-218, 1965.

Fortune, Marie M. Sexual Violence, The Unmentionable Sin. New York: Pilgrim Press, 1983.

Groth, A. Nicholas. "The Adolescent Sex Offender and His Prey". International Journal of Offender Therapy and Comparative Criminology, 21, 249-254, 1977.

---------, and Birnbaum, H.J. Men Who Rape: The Psychology of the Offender. New York: Plenum Press, 1979.

---------, and Loredo, C.M. "Juvenile Sex Offenders: Guidelines for Assessment". International Journal of Offender Therapy and Comparative Criminology, 25, 32-33, 1981.

---------; Longo, E. and McFadin, J. Bradley. "Undetected Recidivism Among Rapists and Child Molesters". Crime and Delinquency, 28, 450-459, 1982.

Knapp, F.H. Remedial Intervention and Adolescent Sex Offenses. Syracuse: Safer Society Press, 1983.

Longo, R.E. and McFaden, J.B. "Sexually Inappropriate Behavior: Development in the Sexual Offender". Law and Order, December, 1981.

Ramseyer, Judy. Treatment Services for Sexual Offenders. Report prepared by Department of Social and Health Services, State of Washington, 1984.

Reiss, A. "Sex Offenses: The Marginal Status of the Adolescent". Law and Contemporary Problems, 25, 1960.

Smith, Wayne and Monastersky, Caren. "Strategies for Studying the Role of the Family in the Commission of Sexual Offenses by Adolescents". University of Washington Juvenile Sexual Offender Program, in-house paper, 1984.

---------, and Monastersky, Caren. "Assessing Juvenile Sexual Offenders' Risk for Reoffending". Criminal Justice and Behavior, 12, 115-140, 1986.

Sonderman, M.F. Benton-Franklin Sex Offender Project. Report to the Juvenile Justice Section, Department of Social and Health Services, State of Washington, 1984.

Steiger, John C. and Ramseyer, Judy. The DJR Sex Offender Project. Report prepared by the Division of Juvenile Rehabilitation, Department of Social and Health Services, State of Washington, 1984.

Uniform Crime Reports (1980). Annual Report prepared by the U.S. Department of Justice, Government Printing Office, Washington, D.C., 1981.

Wenet, G.A.; Clark, T. and Hunner, R.S. "Perspectives on the Juvenile Sexual Offender" in Hunner and Walker (eds.) Exploring the Relationship Between Child Abuse and Delinquency. Allanheld, Osmun, Montclair, 1981.

APPENDIX A

DESCRIPTION OF THE

MAPLE LANE SCHOOL SEX OFFENDER PROJECT

1.0 INTRODUCTION

The Maple Lane School Sex Offender project was implemented in 1982 as an outgrowth of a comprehensive planning program for sex offenders initiated by the Department of Social and Health Services, Division of Juvenile Rehabilitation (DJR). The project was implemented in response to the need for specialized institutional services for juvenile sex offenders. The goal of the project was to supplement the array of other services provided by the institution to help sex offenders manage their lives without resorting to criminal or destructive behavior. The project resulted in the development of agency-wide standards and goals, a training program for institutional personnel, and a treatment model for juvenile sex offenders at Maple Lane School and Echo Glen Children's Center.

2.0 PROJECT MODEL

2.1 Goals and Objective

The Maple Lane project incorporates the basic principles of sex offender treatment into existing institutional programs. According to the program standards, all interventions with sex offenders are designed to move the offender toward the following broad treatment objectives:

* Increased responsbility for one's sexual behavior;
* Increased awareness of the impact of the sexual abuse on the victim;
* Increased understanding of the emotional and psychological processes which led to the offense; and
* Increased skill in meeting one's sexual and interpersonal needs without victimizing others.

Offenders who achieve these objectives are expected to demonstrate increased control of deviant sexual arousal and a reduced risk of reoffending.

2.2 Target Population

The target population for the Maple Lane project includes all youth committed for sex offenses as well as those with sex offense histories. These youth are identified at the time of the diagnostic assessment. Upon arrival at Maple Lane, sex offenders are routinely referred to the project as part of their treatment plan. Youth who refuse to participate can be denied privileges and retained at the institution until their maximum sentences expire.

At any time, approximately 18-30 youth meet the requirements for project inclusion. This number constitutes approximately 20 percent of the total youth population at the institution. The overwhelming majority of these juveniles are committed for indecent liberties or statutory rape. The victims of these offenses are usually children -- often siblings who resided in the homes of the offenders.

2.3 Services

The project provides services for juvenile sex offenders in two forms. These services are summarized below.

1. Sex Offender Group Sessions

   The primary treatment modality used at Maple Lane consists of group therapy sessions. The nature of these sessions has gone through several modifications over the years as the Director has experimented with different methods.

   For the first few years of project operation, groups consisted of 8-10 sex offenders who met for 10 sessions of one to two hours each. Currently, Maple Lane provides group therapy to sex offenders in the form of mini-marathons, that is, six sessions of five hours each.

   Group sessions are used as the primary means of sex offender therapy at Maple Lane for several reasons. First, group involvement and treatment are believed to be consistent with adolescent developmental psychology. Teenage offenders are thought to be more responsive to their peers than to adult therapists. Young offenders, particularly sex offenders, are reluctant to discuss their crimes, sexual fantasies, and deviant arousal patterns during one-to-one sessions with adult counselors. Group sessions with peers can overcome this reticence and provide an opportunity for frank discussion of sexual behavior and sexual offenses.

   Group sessions are believed to serve a second function for sex offenders at Maple Lane. These offenders often minimize or deny their offenses or the seriousness of the criminal behaviors. Group support and confrontation diminish denial and help offenders understand and assume responsibility for their acts.

2. Victim Group Session

   An additional variant of group sessions was added in late 1985 to address a common experience shared by many juvenile sex offenders -- sexual abuse and victimization suffered in childhood or early adolescence. These sessions were named

"Survivor Groups" to avoid labeling offender participants as previous victims of sexual assault.

The rationale for the creation of "Survivor Groups" was predicated on empirical studies which found a strong relationship between sex offense behavior and prior sexual victimization. Maple Lane addressed this relationship by creating victim groups made up of a small number of sex offenders who meet for six sessions of approximately two hours each.

Other treatment techniques, such as covert sensitization and masturbatory satiation, have been used on a very limited and experimental basis. These techniques are not used frequently because the institution lacks the privacy and equipment necessary for their application. In addition, unresolved ethical/procedural issues have prevented the use of behavior modification techniques commonly used in the treatment of adult sex offenders.

3.0 RESOURCES

Staffing consists of a project coordinator and nine institutional counselors who co-lead sex offender group therapy sessions. Five of these counselors also co-lead the survivor (victim) groups. All staff perform group therapy functions as part of their general counseling responsibilities within the institution.

4.0 OPERATIONS

Juveniles are received by DJR following commitment by court order. Diagnosis and assessment of youth commences immediately after the court order of commitment. This function is performed at a local site, such as the detention facility operated by the committing court.

At the conclusion of the diagnostic assessment process, a decision is made regarding the most appropriate institutional placement for juveniles. Many of the older, more amenable, sex offenders are sent to Maple Lane because of the availability of sex offense-specific group sessions.

An offender referred for sex offender group therapy is generally involved in weekly treatment sessions. The nature of the group sessions may range from guided group discussion to the use of psychodrama. This latter activity often takes the form of acting out sex offense scenes in which participants play various roles, such as victims, offenders, family members, and so forth. The most common theme involves actor-victims asking actor-offenders to explain why they committed a specific sex crime, exploring

motives for the offense and role-playing the impact of the crime on victims.

The counselors responsible for case management of sex offenders are required to develop treatment plans and prepare progress reports on each youth at the end of the first month, the sixth month, and/or at 45 days prior to release from the institution. These reports serve two functions. First, they are used by treatment supervisors to monitor the progress of cases assigned to counselors. Second, they are sent to the community services staff of DJR; that is, to juvenile parole services in an effort to secure needed local services in advance of the release of offenders.

The Maple Lane Sex Offender Project maintains close liaison with sex offender treatment programs in the community and with juvenile parole staff. However, community based offense-specific services are quite limited, even in large metropolitan areas such as Seattle, Tacoma and Spokane. Thus, sex offenders rarely participate in post-release treatment programs.

APPENDIX B

DESCRIPTION OF THE

ECHO GLEN CHILDREN'S CENTER SEX OFFENDER PROJECT

1.0 INTRODUCTION

The Echo Glen Children's Center is a coed state institution for young offenders (12-18 years of age) who have been convicted of a felony and sentenced to serve institutional time ranging from as short as four weeks to as long as four years. The typical sentence term for a juvenile sex offender is one year.

The sex offender program was implemented February 1980, following initiatives begun by the University of Washington. For youths sentenced to Echo Glen, involvement in the sex offender treatment program is voluntary and not a requirement of the sentence.

2.0 PROJECT MODEL

2.1 Philosophy and Goals

A major focus of the Sex Offender Therapy Program (SOTP) at Echo Glen is group therapy, although other treatment modalities are available. Group therapy is used as a vehicle in treating the sex offender because of its potential to break through denial, to support responsible behavior and to provide modeling of honest communication and social skills. The staff at SOTP have noticed virtually all of the youths they see at Echo Glen have poor peer relationships, may have been victims of physical or sexual abuse, and generally have an inability to develop trusting relationships with anyone, including family. The orientation of the program is to encourage youth, teach them the skills to take control of their own actions, and learn how to appropriately relate to and interact with peers and adults.

2.2 Project Objectives

The primary treatment objectives of the Echo Glen SOTP are as follows:

* To increase his acceptance of responsibility for his sexually aggressive behavior;

* To increase his empathy by developing his awareness of the impact of his assault on his victims;

* To help him plan ways to maintain control of his sexually aggressive behavior in the future.

2.3 Target Population

Although the Echo Glen Children's Center must accept all children who are sent there, the treatment modalities differ depending on the needs and abilities of the offenders. Thus, the Sex Offender Therapy Program can refuse youths not considered appropriate.

Generally they prefer not to treat highly aggressive rapists who require more secure institutions and structured programs, or low risk types of sex offenders who can be treated in the community.

The SOTP accepts juveniles into the Program who have a history of sexual offending whether or not they were adjudicated specifically for the sex offense. For example, the juvenile may have been convicted of an arson charge, but is known to have engaged in a sexual offense. A person with a history such as this is encouraged to participate in the sex offender therapy group. At any time, however, a juvenile can refuse treatment and simply "serve time".

2.4 Services

Services at the Echo Glen SOTP primarily involve treatment. Diagnostic evaluations are usually unnecessary since most of the offenders have been evaluated in the community prior to sentencing and commitment to Echo Glen. In the occasional instance when no diagnostic evaluation was conducted, Echo Glen will conduct their own diagnostic assessment.

Treatment modalities utilized at Echo Glen include group therapy, individual counseling, behavior therapy (through contact with an outside private therapist), and family conferences.

Through these treatment modalities, a number of topics are addressed.

* Social skill training;
* Interpersonal dynamics;
* Communication skills;
* Sex education;
* Assertiveness training;
* Family relationships; and
* Community reentry.

The formal group therapy sessions (usually lasting 2 hours) occur once a week and extend over sixteen weeks. The marathon session lasts five hours.

3.0 RESOURCES

Since the SOTP is an integral element of the Echo Glen Children's Center, staff allocations for this program change somewhat depending on the volume of juvenile sexual offenders. Typically sex offenders are referred to three or four of the total 10 cottages at Echo Glen. In addition, the SOTP makes use of a consultant psychologist and a consultant psychiatrist.

Funding for the sexual offender therapy program at Echo Glen is provided exclusively through the Washington State Department of Juvenile Rehabilitation.

4.0 OPERATIONS

The SOTP receives only adjudicated offenders court-ordered to state institutional commitment. Youths entering Echo Glen are usually assigned to the 'diagnostic' cottage until the case is reviewed. Echo Glen staff conduct their own clinical evaluation of the juvenile if no evaluation were conducted in the community prior to adjudication. Following screening, the youth is assigned to a specific treatment cottage.

The treatment program is incorporated both formally and informally into a youth's day at Echo Glen. From 9:00 - 3:00 the youths attend school which includes academic work, social skills training, lifeskills training and sex education. Formal therapy groups run twice a day 3:30 - 5:00 p.m. and 6:00 - 8:30 p.m.

In addition to the sex offender group sessions, other therapy groups available at Echo Glen include:

* Social skill building groups;
* Problem solving;
* Drugs and alcohol;
* Sex offense victim group for girls;
* Sex offense victim groups for boys; and
* Death therapy group.

An offender will attend a variety of these groups depending on the 'individualized' case plan. The sex offender therapy group is generally offered once a week.

At the termination of the youth's stay at Echo Glen Children's Center, and thus termination of treatment, an attempt is made to refer the youth and family to ongoing family or individual counseling in the community. A detailed assessment of the released sex offender's progress while at Echo Glen is noted in his or her file. Recommendations are often given that the youth should be restricted from babysitting or going near playgrounds. This file goes with the youth to the DJR parole officer. However, depending on the parole officer, and whether there are treatment resources available to the community to which the youth is returning, these recommendations may or may not be acted upon.

APPENDIX C

DESCRIPTION OF THE

UNIVERSITY OF WASHINGTON JUVENILE SEX OFFENDER PROJECT

1.0 INTRODUCTION

The University of Washington Adolescent Clinic's Juvenile Sexual Offender Project (JSOP) officially began diagnostic services in the fall of 1975. A community-based treatment component was implemented in 1978 under a three-year grant from the U.S. Department of Justice, administered through the Washington State Office of Law and Justice Planning. A fourth year of funding from this office was 50% cost-shared with the Department of Juvenile Rehabilitation. In 1982, an additional three years of funding were provided through the Washington State Department of Juvenile Rehabilitation and the Governor's Juvenile Justice Advisory Committee.

2.0 THE PROJECT MODEL

2.1 Philosophy and Goals

The primary focus of the University of Washington's Juvenile Sexual Offender Project is family systems therapy. JSOP has taken the position that the youth's behavior is a product of what has been learned in the family environment. The youth may be a witness to sexual exploitation, frequent use of pornographic materials or, perhaps, the victim of sexual abuse himself. Thus, the JSOP will accept an adolescent into the program only if the family also becomes involved.

Peer group counseling sessions are also used since many of the adolescents have serious peer socialization problems, as well as dysfunctional family relationships. The purpose of these sessions is to promote peer socialization and to use peer input as a means to increase offenders' understanding and awareness of the inappropriateness of their sexual activities and the damage they inflict on their victims.

2.2 Project Objectives

Clinical objectives of the JSOP are to:

* Identify and resolve disruptive dynamics in family relationships that are impacting the offenders' behavior;

* Encourage families to be more flexible, but set clear behavioral boundaries;

* Resolve sexual abuse or sexual exploitation dynamics occurring in the family setting;

* Interrupt the potential cycle of sexual offending behavior;

* Identify whether the offenders have established a deviant sexual arousal pattern and to use behavioral techniques to break deviant arousal;

* Promote better communication, socialization for the youth, as well as within the family unit; and

* Promote better peer socialization.

2.3 Target Population

The University of Washington Sexual Offender Project accepts referrals for clinical assessment and diagnosis from many sources, including Child Protective Services, mental health agencies, parents, and the courts. However, treatment services are offered only to those offenders and families considered appropriate for JSOP's family system therapy.

2.4 Services

The University of Washington Sexual Offender Project offers three types of treatment services: 1) peer group therapy; 2) individual therapy; and 3) family therapy. Each type of treatment is summarized below.

1. Group Therapy generally involves 1-2 sessions each week extending over six months. The therapy focuses on understanding the sexual offenses committed, acceptance of responsibility for the offense, and on the development of empathy for victims.

2. Individual Therapy generally involves 1-2 hour sessions each week for 8-12 months. Individual therapy can involve psychotherapy or behavioral work focused on interrupting the deviant sexual arousal pattern.

3. Family Therapy sessions include the offender, at least one parent and siblings, when possible. Sessions generally last 1-2 hours and occur weekly or bi-monthly.

3.0 RESOURCES

Prior to the termination of the project in 1986, the JSOP maintained four half-time therapists, a full-time director and a part-time researcher/psychologist. Evaluation of the adolescent and his family was generally conducted by one of the therapists. Interpretation of the psychological tests was performed by the licensed psychologist on staff.

4.0 OPERATIONS

Upon receipt of a referral, the case is reviewed by project staff in a weekly case conference. If the referral is accepted, a clinical assessment is conducted and a report is prepared evaluating the likelihood of reoffending and recommending treatment or incarceration.

Consideration for treatment at the University of Washington program was given depending on the level of motivation from the youth and family, the availability of alternative resources and the residence of the youth. Youths living in King County tended to have priority because of ease of access to the program.

If youth care to be treated by the program staff, a therapist is assigned to the youth and family. A youth can be involved in one or more of the treatment options, depending on the circumstances of the case. Family involvement is required. In addition to weekly family sessions, individual therapy sessions with the youth are also required. Involvement in the peer group sessions is more optional and depends upon a youth's need and whether there is a 'spot open' in a group.

Individual counseling tends to be psycho-social depending very much on the expertise of the assigned therapist. Youths thought to require rigorous behavioral modification therapy or desensitization because of deviant arousal patterns are generally referred to private therapists who specialize in that area.

APPENDIX D

DESCRIPTION OF THE

KING COUNTY SEX OFFENDER PROGRAM

1.0 INTRODUCTION

The King County Sex Offender Program is a community-based diagnostic assessment and treatment program developed by the King County Department of Youth Services for adjudicated juvenile sex offenders. The program commenced in 1983 with funding from the Department of Social and Health Services, Division of Juvenile Rehabilitation (DJR) under the Consolidated Juvenile Services Program. The primary purpose of the program is the provision of an affordable community based service for a client population that does not require residential or institutional care.

2.0 PROJECT MODEL

2.1 Philosophy and Goals

The orientation of the King County Project is toward treatment and supervision of the juvenile sex offender in a community setting with involvement of families if at all possible. The fundamental philosophy and design of the project is similar to the program once operated by the University of Washington Adolescent Clinic, although the treatment approaches are more varied. Currently, the project treatment personnel use individual and group therapy, as well as the favored family therapy approach. In addition, the project personnel are beginning to experiment with behavior modification techniques. The objectives of the project are to:

* Provide evaluations of all juvenile sex offenders referred to the Department of Youth Services;

* Prepare dispositional recommendations on sex offender cases for consideration by sentencing judges;

* Identify the most appropriate course of offense-specific treatment for project participants; and

* Provide treatment services to youth who demonstrate the greatest need and the least ability to pay.

2.2 Target Population

The King County Sex Offender Project targets all adjudicated sex offenders, with special emphasis on "middle offenders" most likely to receive sentences that include community supervision requirements.

2.3 Services

The activities and services of the King County project include (1) evaluation and clinical assessment of adjudicated sex

offenders; (2) team staffing and consultation regarding dispositional recommendations; and (3) treatment of sex offenders under community supervision. The following is a description of each of these activities.

Evaluation Services

Since October 1985, juvenile probation counselors, specialized in juvenile sex offender diagnostic assessments, conduct all diagnostic evaluations of youth referred to the project. The evaluations include assessments of the nature and degree of the juvenile's sexual deviance, an analysis of the risk of reoffense, his/her amenability to treatment and the willingness of the family to support or participate in the treatment process. Evaluations rely on clinical interviews with the child and family, psychological testing, police and school reports and other relevant information from the community.

Team Staffing and Case Consultation

Once the assessment is completed, the case is presented to a group of specialists for discussion and review.

At the conclusion of the case staffing, the team considers the offender's risk to the community (based upon the University of Washington risk-criteria) and assesses the offender's likelihood of reoffense and amenability to treatment. The team then prepares pre-dispositional recommendations for consideration by the sentencing judge. Recommendations may range from incarceration to community treatment or some combination of the two requirements.

Treatment Services

Under the initial program model, which was operational until October 1985, all treatment services were provided under a contract at the University of Washington Adolescent Sex Offender Project. The University program reserved 16 treatment openings to serve youths and families referred by the court. The preferred treatment mode of this program was family-centered therapy. Under this model, sex offenders and their family members participated in weekly treatment sessions for as long as 12 months. (For a description of this model, refer to Appendix C.)

Treatment modalities used under the current model are more varied, although family therapy remains the preferred treatment approach. The two contracted therapists responsible for treatment also use individual and group therapy. In addition, some behavior modification therapy is used on a selective basis.

3.0 RESOURCES

The King County Sex Offender Project is coordinated by a Court Services Supervisor. This person is responsible for establishing procedures and managing project operations. Clinical assessments are performed by seven Juvenile Probation Counselors (JPCs) specially trained in this function at the Adolescent Clinic Sex Offender Project.

For the first several years of program operation, treatment services were contracted through the Adolescent Clinic. Currently, these services are contracted with two private sex offender therapists who were formerly with the Adolescent Clinic. Staff consultation services are available via contract with a local psychologists with many years of sex offender treatment experience. Project support services are provided in the form of a half-time secretary.

The King County Sex Offender Project is funded through the Consolidated Juvenile Services program. Since the intent of the program is to provide no cost sex offense-specific treatment, families that can afford treatment are asked to pay or to use other treatment resources.

4.0 OPERATIONS

All juveniles adjudicated for sex offenses, or other crimes wherein the elements are substantially sexual, are assigned to two of the seven intake JPCs who perform diagnostic assessments. Each assessment requires an average of three to four interviews with all family members. At the conclusion of this process, the specialists prepare the case for staffing.

All cases are staffed by an assessment/evaluation team. The team members consist of the specially trained JPCs, two contracted therapists, the program coordinator and consulting psychologist. At the conclusion of the case staffing, the team develops pre-dispositional recommendations for the sentencing judge. If the offender (and family) is considered appropriate for treatment, formal recommendations are prepared and presented to the court.

If the court finds treatment appropriate in a given case, the case is referred to the Adolescent Clinic Sex Offender Program (pre-October, 1985) or to one of the DYS contracted therapists. The therapist develops a treatment plan which may include individual, family and/or group therapy.

Treatment sessions are usually held on a weekly basis. Treatment usually continues throughout the period of court-ordered community supervision, unless it is determined that the youth has

successfully completed sex offense specific therapy prior to termination of supervision.

Treatment provided by the project is discontinued at the termination of the community supervision order. The youth and family may elect to continue treatment, but the family must pay for this or find other means of support.

APPENDIX E

DESCRIPTION OF THE

WHATCOM COUNTY SEX OFFENDER PROGRAM

1.0 INTRODUCTION

The Whatcom County Sex Offender Project was implemented in September, 1983, with funds from the Department of Social and Health Services, Division of Juvenile Rehabilitation (DJR) under the Consolidated Juvenile Services program. The intent of the project was to reduce the county's dependence on state institutions for the supervision of sex offenders by establishing a community-based project with greater access to the youth's family. The project is coordinated by the Whatcom County Juvenile Probation office. A 'Collective' of therapists and psychologists was formed to conduct clinical assessment and treatment of juvenile sex offenders.

2.0 PROJECT MODEL

2.1 Philosophy and Goals

The goal of the Whatcom County Sex Offender Collective is to provide community evaluation for all sexual offenders referred to the Whatcom County Juvenile Court. A Collective of therapists provides treatment for selected offenders who meet specific criteria for community treatment. Since the Collective believes it is important to distinguish and separate the investigation/prosecution from the evaluation/treatment arms of the system, they work only with adjudicated offenders.

2.2 Project Objectives

The objectives of the project are to:

* Provide community evaluation for all sexual offenders referred by the Whatcom County Juvenile Court;

* Provide treatment to selected offenders who remain in their own homes and whose families are willing to participate in treatment; and

* Provide treatment to sexual offenders who have been placed in an institutional environment and who are returning to reside with their families.

2.3 Target Population

The Whatcom County project targets all adjudicated sexual offenders 11-18 years of age who have been ordered by the court to undergo diagnostic clinical evaluations prior to sentencing, or who have been ordered to participate in sex offense specific treatment.

2.4 Services

Clinical diagnosis and evaluation services commence with a 3-4 hour intake interview involving the juvenile, his family, and the Probation Department Project Coordinator. A social history and risk assessment is obtained. Following the interview, a referral is made to professional therapist to obtain a clinical assessment of the youth and family. This information is summarized in a pre-sentence report prepared by the Probation Coordinator. This report commonly recommends probation and community treatment. Commitment to an institution is recommended only in cases where there is evidence of violence or excessive denial of the offense or when there is insufficient family support.

Treatment is provided through contract with a professional therapist from the Collective. Family and individual therapy is available. Peer group therapy is not offered in Whatcom County at this time. The treatment focuses on the following issues:

* Youth assuming responsibility for the offense;
* Victim empathy;
* Understanding the emotional/psychological factors underlying or precipitating the offense situation; and
* Learning new ways to get needs met without victimizing others.

The Collective endorses a co-therapy treatment model, particularly in the early stages of treatment. A male and female therapist counsel or treat the offender as a team. Later, counseling may continue with an individual therapist.

3.0 RESOURCES

The Whatcom County Sex Offender Project is coordinated by a Whatcom County juvenile probation officer (30% FTE). This person is responsible for receiving the referral from court, conducting the initial intake with the youth and family, and referring the case to the Whatcom Collective for assessment or treatment. The Collective currently consists of 7 therapists and 1 psychologist, all of whom have developed specialized skills in juvenile sex offender treatment. Services are contracted as needed on a rotating basis to a therapist team from the Collective (a male and female therapist).

The Whatcom County Sex Offender Project is funded through the Consolidated Juvenile Services program of the Department of Juvenile Rehabilitation, DSHS. No additional community resources or funding are utilized.

4.0 OPERATIONS

Juveniles are referred to the Sex Offender Project following adjudication and a court order for assessment and/or treatment services. Juveniles may also be referred to the project following transfer from another county. The Whatcom County Sex Offender Project generally provides treatment for youth on probation, but also accepts youth (on parole) referred from the Department of Juvenile Rehabilitation.

Cases are initially screened by the project coordinator through an intake interview (3-4 hours) with youth and family. If a clinical assessment is appropriate, a referral is made to a Collective therapist team (male and female). An initial meeting between the probation coordinator and the therapist(s) is held in the Whatcom County juvenile probation office. A form specifying conditions of release while awaiting sentence is signed by the juvenile and the parent. A standardized evaluation procedure is followed, which generally involves 3-9 hours of time.

At the end of the evaluation process, the Collective meets with the coordinator and attempts to further assess the offender's suitability for community treatment and to develop a treatment plan. Should conflicting views of the appropriateness for community treatment exist among members of the Collective, both minority and majority opinions are included in the evaluation report. However, only those therapists directly involved in the evaluation process are permitted to testify in court.

If, as a result of evaluation, the offender is seen as high risk for reoffense or as being uncooperative, the probation coordinator presents an alternative to community treatment during the disposition hearing.

Depending upon the nature of the offense and the degree of family dysfunction that often exists, community treatment is usually recommended for one year.

Following referral to the Collective, the youth is generally involved in treatment with a team of two therapists. Usually family therapy is initiated in the beginning, followed by individual counseling. Generally the youth is involved in four therapy sessions per month and the family in two sessions per month. Treatment usually continues for a period of one year.

At the end of each three month period, the treatment team formally presents the case to the full Collective and the probation coordinator for discussion and internal peer review. A report is generated for the court and a decision made concerning the course of further treatment. If further treatment is indicated, another three month contract is initiated at the discretion of the therapists and the court.

Payment for services is seen as an important therapeutic issue that must be resolved. The family is required to bear part of the financial responsibility for treatment, although subsidization is provided through funds from the Consolidated Juvenile Services Program.

Treatment funded by CJS is discounted following termination of the probation order. The youth and/or family may elect to stay in treatment, but the family must pay for this privately or find other support.

APPENDIX F

DESCRIPTION OF THE

SPOKANE COUNTY SEX OFFENDER PROJECT

1.0 INTRODUCTION

The Spokane County Sex Offender Project is a community based diagnostic assessment and treatment program developed by the Spokane County Juvenile Detention Center to serve adjudicated juvenile sexual offenders. The program commenced in 1984 with funding from the Governor's Juvenile Justice Advisory Committee.

2.0 PROJECT MODEL

2.1 Philosophy and Goals

The philosophical model upon which the project is based presumes that the etiology of sex offense behavior lies within the family matrix. By keeping the offender in the community and, therefore, closer to the family, treatment can be more immediate, salient, and effective. It is assumed that early intervention with family-centered treatment (Minuchin's model) facilitates the treatment process.

The main goals of the Sex Offender Treatment Project are to:

* Develop an effective, community-based treatment program for sex offenders and their families;

* Train court personnel (detention staff as well as probation counselors) to identify sex offenders who are appropriate for treatment and to refer them to the treatment group;

* Protect the community by employing procedures to closely monitor and supervise sex offenders;

* Provide a continuum of treatment services to sex offenders commencing during incarceration at the Detention Center and continuing into the period of community supervision.

The following consequences are anticipated:

* Reduced recidivism rates for offenders assigned to the project;

* System changes in the handling of sex offenders, particularly in the areas of treatment and placement recommendations; and

* Immediate intervention services for sex offenders in the form of diagnostic assessments and treatment sessions.

2.2 Target Population

The Spokane County Sex Offender Project targets all youth adjudicated of a sex offense and sentenced to detention. For the most part, sex offenders qualifying for project admission consist of juveniles convicted of indecent liberties. Sentencing standards applicable to more serious sex offenses, such as forcible rape, require institutionalization in state-operated facilities.

2.3 Services

Three services are contracted through the Spokane County Sex Offender Project. These services, provided by Driecus Associates, consist of staff training/consultation, diagnostic assessment, and treatment. These services are described as follows:

Training/Consultation Services

Driecus Associates provides training seminars for detention staff, probation counselors and mental health personnel. The content of the training focuses on the following topics:

a) characteristics and the dynamics of the sex offender and his/her family;

b) types of sex offenders;

c) importance of family relationships and attitudes in changing or reinforcing the offender's behavior;

d) risk criteria for reoffending; and

e) effective case management of sex offenders under supervision.

Evaluation Services

Driecus therapists perform diagnostic assessments of sex offenders at one of two decision points subsequent to conviction. The first of these is an evaluation conducted prior to sentencing on juveniles convicted of a sex offense which, in combination with their ages and criminal histories, yields an offender score of 110 or more points (presumptive institutionalizations). This evaluation is used in combination with a diagnostic assessment performed by court personnel to develop sentencing recommendations. Juveniles believed amenable to community treatment are recommended for detention sentences and project inclusion. Sentencing judges consider the recommendations and decide whether these

juveniles are to be institutionalized or placed in the project.

Evaluation services are also provided to convicted sex offenders with less than 110 points. Diagnostic assessments on these youth are provided post-sentence. The results of the evaluations are discussed with Investigation Probation Counselors and a determination is made with regard to inclusion of the offenders in the project for the purpose of treatment services.

The diagnostic assessment process involves one or more interviews with the offender and his/her family. The evaluation focuses on the dynamics of the entire family as well as a thorough assessment of the sex offense committed by the juvenile. A social history is obtained and a risk assessment is performed. Psychological testing is conducted when it is deemed appropriate.

Driecus Associates developed a risk assessment tool, referred to as the Sex Offender Scale, and began using the scale for diagnostic assessments as well as pre- and post-treatment evaluations of treated sex offenders. The scale is designed to assess an offender's current functioning in six areas: psychological status, social status, school, family, sex and offense. Change scores (pre- and post-treatment assessments) are used to evaluate the effectiveness of treatment services.

Treatment Services

Treatment is provided through contract with Driecus therapists. Family and individual therapy sessions are available and were the preferred treatment modes during the initial period of the project. Currently, the preferred treatment approaches consist of frequent peer group therapy sessions combined with monthly or bi-monthly family therapy sessions. Peer group therapy is believed to be more effective in reducing denial and inducing empathy for victims.

3.0 RESOURCES

The Spokane County Sex Offender Project is coordinated by a Spokane County juvenile probation administrator, with the assistance of the Detention Program Coordinator. These persons coordinate identification of project eligible sex offenders, participate in case staffings, oversee the treatment progress of offenders, and arrange for needed training sessions. An additional probation administrator oversees the disbursement of funds and coordinates treatment activities for the Intensive Community Treatment Project, the follow-on project that continues

funding for treatment services beyond the period provided by this detention-based sex offender project.

Driecus Associates provides training, diagnostic and treatment services under contract with the Spokane County Juvenile Court. Driecus Associates consists of six professional therapists or counselors who specialize in sex offender treatment and adolescent development.

For the first two years, the Spokane Sex Offender Project was funded through grants from the Governor's Juvenile Justice Advisory Committee. Since that time, services have continued with funds from the Consolidated Juvenile Services Program.

4.0 OPERATIONS

Juveniles are referred to the Spokane Sex Offender Project through Spokane County Juvenile Court. All cases referred to the Spokane Sex Offender Project are required to have a diagnostic evaluation performed by Driecus Associates. This evaluation is performed prior to sentencing for those sex offenders with presumptive institutional sentences. Subsequent to this evaluation, a "diagnostic team", composed of a court staff person and a therapist, prepares sentencing recommendations for the court.

Driecus therapists routinely provide the same diagnostic functions to less serious or less chronic offenders (i.e., those with fewer than 110 points) and determine the appropriateness of offenders for treatment. The therapists determine whether offenders are eligible and, if so, identify the course of treatment while juveniles are in detention and in the community.

If the court and/or contracted therapists determine that treatment is appropriate in a given case, the offender and his/her family are encouraged to participate in a course of treatment. The contracted therapist is required to prepare a treatment plan prior to implementation. The plan may include individual, family, and/or group therapy sessions. Treatment must be sex offense specific.

The offender participants are generally involved in weekly treatment sessions. Family members participate in therapy sessions less frequently -- usually once or twice a month. Treatment continues throughout the period of detention and may extend for a period of 60 days after release into the community. Treatment services with some therapist(s) may continue beyond that period with other funds provided by the court.

APPENDIX G

DESCRIPTION OF THE

SNOHOMISH COUNTY SEX OFFENDER PROJECT

1.0 INTRODUCTION

The Snohomish County Sex Offender Project was proposed in the summer of 1981 as a response to an increase in the number of juvenile sex offenders adjudicated in Snohomish County and to the need for local treatment alternatives to institutional commitment. The project commenced in 1982 with state funds from the Consolidated Services Program, Division of Juvenile Rehabilitation.

2.0 PROJECT MODEL

2.1 Goals and Objectives

The goals of the project were to reduce the county's dependence on state institutions for the supervision of sex offenders by establishing a community-based project with greater access to the youth's family. It was hoped that such an approach could provide more effective treatment and assure community safety at a considerable savings to the state. Specific objectives for offenders were as follows:

* Establish and maintain situational controls for community safety (i.e., no babysitting, no unsupervised contact with victim or potential victims, etc.);
* Reduce/eliminate denial and minimization of sex offense;
* Learn appropriate anger management and other emotional expression;
* Develop victim empathy and sense of remorse;
* Learn assertiveness;
* Acquire additional factual information about sexuality; and
* Improve self image.

2.2 Target Population

The project targets all adjudicated sex offenders between the ages of 10-19 years of age who are awaiting sentence or who are being paroled from state institutions. Family members (where appropriate) are also targeted.

2.3 Services

The project provides both diagnostic evaluation and treatment services, as summarized below.

1. Diagnostic Evaluation of Sexual Offenders

The diagnostic evaluations involve assessment of the nature and degree of the juveniles' sexual deviance, an assessment of the likelihood of reoffense, their amenability to treatment and the advisability of remaining in the community receive treatment. All assessments are conducted by a licensed psychologist or therapist under a contract assignment.

2. Treatment Services

Treatment services are provided under contract by a licensed psychologist or therapist. The therapist is required to establish a treatment plan that specifies individual, family and/or group therapy. The primary focus of treatment is on reducing sex offenses through increasing the youth's accountability, victim empathy, and control over his or her behavior. Specific treatment strategies utilized by the Snohomish County therapists include: family therapy, group counseling, individual therapy, aversion conditioning, masturbatory satiation, and special education.

3.0 RESOURCES

Staffing consists of a project coordinator (.25 FTE) and eight private therapists who work on contract on an as-needed basis. The therapist group consists of licensed psychologists, social workers, marriage counselors, etc. The composition of this group changes slightly from time to time as members drop out and new members join.

4.0 OPERATIONS

The prosecutor's office is the only source of referrals to the Snohomish County Sex Offender Project for diagnostic evaluation of the adjudicated juvenile offenders prior to sentencing. If the court finds treatment is appropriate in a given case, the program coordinator refers the particular case to a professional therapist. The therapist is required to prepare a sex-offense specific treatment plan that may require individual, family and/or group therapy.

Treatment is usually provided in the form of weekly sessions that generally continue for the period of time the juvenile is under the jurisdiction of the court or Juvenile Parole Services. The contracted therapist is required to submit quarterly progress reports during the calendar year of treatment. Each report must contain the following information:

* Clear identification of problem areas;
* Desired outcome or goals of the treatment;
* Action/approach taken to reach the desired outcome;
* Projected future length of treatment required; and
* Progress of the treatment.

Juveniles who continue treatment beyond the probation or parole period may terminate at any time or at the discretion of the therapist.

APPENDIX H

DESCRIPTION OF THE

BENTON-FRANKLIN COUNTY SEX OFFENDER PROJECT

1.0 INTRODUCTION

The Benton-Franklin Sex Offender Project was initiated in 1983 in response to an alarming increase in the number of sex offense referrals to the juvenile court. Because of the availability of the Community Commitment Program in Benton-Franklin Counties, the sex offender project was viewed as a means to maintain adjudicated youth in a local facility while providing treatment. During the second year of project operation, treatment was extended to sex offenders from Walla Walla-Columbia and Asotin-Garfield Counties via the Community Commitment Program. Treatment for these latter offenders was begun immediately upon placement in the facility.

From March, 1983 until February, 1986, the Benton-Franklin Sex Offender Project was supported with funds from the Governor's Juvenile Justice Advisory Committee, Department of Social and Health Services. Currently, a somewhat modified program is supported with funds from the Consolidated Juvenile Services Program and from local governments (county current expense funds).

2.0 PROJECT MODEL

2.1 Goals and Objectives

The primary purpose of the project is to reduce the dependence of Benton-Franklin Counties on state institutions for incarceration of sex offenders. Sex offenders sentenced to CCP can receive needed treatment and, at the same time, maintain access to their families. Objectives for the project are as follows:

* Provide sex offender evaluations for all youth referred from the six county catchment area;
* Provide ongoing training for therapists and other project staff;
* Provide local treatment to sex offenders;
* Maintain a low average period of confinement for adjudicated sex offenders;
* Reduce sex offender recidivism; and
* Conduct ongoing research.

2.2 Target Population

The project targets all adjudicated sex offenders who could be committed to state institutions by virtue of their point total.

2.3 Services

The project provides both diagnostic evaluation and treatment services. These services are described below.

Diagnostic Evaluation of Sex Offenders

A diagnostic evaluation is performed on all adjudicated sex offenders from Benton-Franklin Counties and on offenders sentenced to the CCP from nearby counties. This evaluation includes a psychological assessment, educational testing, sex offense assessment, intelligence testing, personality testing (MMPI), and a review of probation reports.

JPCs performing the diagnostic evaluations rely primarily on interviews with offenders to assess risk and amenability to treatment within the program. No interviews with parents are conducted as part of the evaluation process.

Treatment Services

The juvenile sex offender may be referred by the juvenile court for treatment. From 1983 through February 1986, treatment services were provided, under contract, by licensed therapists affiliated with three local agencies. Treatment consisted of any combination of individual, family or group counseling, although family-centered therapy was the preferred treatment approach. Juveniles appropriate for group therapy attended a weekly session at the CCP facility. Typically, youth were also seen weekly for individual and/or family therapy.

Currently, the variety of treatment services provided to sex offenders has been curtailed. All individual treatment and much of the group counseling is now provided by the two JPC specialists. No family therapy is available through the project, although a parent group may be established in the future. Two contracted therapists continue to lead one group consisting of older offenders.

Specific treatment strategies utilized in the project include:

Group Therapy: Group counseling has been a fundamental treatment approach of the project since its inception. Offenders discuss their offense behavior in a group setting co-led by male and female counselors. Group sessions are held weekly for one and one-half hours. Each participant is expected to attend group sessions from 6-18 months.

Family Therapy: Despite the preference for family-centered therapy, the project has been able to involve only a limited

number of families in treatment. The basic approach to family therapy is based upon the model used in the Spokane Sex Offender Project.

Individual Therapy: All therapists and counselors who provide individual treatment for sex offenders have been trained by specialists from the University of Washington and Driecus Associates. Treatment is offense-specific and follows the general model prescribed by the Adolescent Clinic.

3.0 RESOURCES

Initial staffing consisted of a project coordinator, two evaluations, five juvenile court staff and three-four contracted therapists. The therapists were affiliated with Mid-Columbia Mental Health, Lutheran Social Services and Tri-Cities Chaplaincy. Current staffing consists of two juvenile court staff (.80 FTE) and two contracted therapists.

The Benton-Franklin Sex Offender Project was supported with funds from the Governor's Juvenile Justice Advisory Committee from March 1983 through February 1986. Since that time, project operations have been maintained with funds from Consolidated Juvenile Services and local government.

4.0 OPERATIONS

Diagnostic assessments are routinely conducted on all sex offenders prior to sentencing disposition. One or more interviews are generally conducted with each offender by contracted therapists (old project model) or by trained JPCs (new model). Information and impressions from the interviews are then combined with information from other sources (psychological tests, social history, etc.) and reported to the court in the form of sentencing recommendations.

If, as a result of the evaluation, the offender is seen as high risk for reoffense or as inappropriate for project inclusion, the report will recommend an alternative to community treatment during the disposition hearing.

Following referral to the project, sex offenders are generally involved in several forms of treatment. Under the old project model, families were encouraged to participate in family therapy. Although the project no longer funds this form of treatment, some families seek this type of assistance from private therapists in the community.

Individual treatment is available and provided to all sex offenders. However, not all offenders are permitted to participate in group therapy. Approximately one-quarter of the offenders are believed to be too disruptive or too resistive to contribute to, or gain from, participation in peer sessions.

In most cases, offenders participate in one or more forms of treatment for one year or more. Shorter periods of treatment are considered counterproductive and are discouraged.

APPENDIX I

DESCRIPTION OF THE

SKAGIT COUNTY JUVENILE SEX OFFENDER DIAGNOSTIC

AND TREATMENT PROJECT

1.0 INTRODUCTION

The Skagit County Juvenile Sexual Offender Project is a project sponsored and managed by the Skagit Community Mental Health Center, Mount Vernon, Washington. A grant was obtained through the Juvenile Justice Section of the Department of Social and Health Services for the first two years of operation. The project began March 1, 1984.

2.0 PROJECT MODEL

2.1 Philosophy and Goals

Project staff view the young sex offender not as an adolescent with an individual problem, but as a person who is part of a larger family system and who has a problem that serves some kind of function for the rest of the family.

Project staff assume responsibility for treatment of juvenile sexual offenders only if the diagnostic evaluation indicates community-based family treatment is appropriate. If project staff recognize that other types of community-based treatment (e.g., group therapy, behavioral techniques) might be more appropriate for some youth, the case can be referred to other non-project therapists.

The purpose of the project is to develop a comprehensive diagnostic and treatment program for juvenile sexual offenders and their families living in Skagit County. Project activities focus on three areas: 1) obtaining advanced training for project staff provided through the University of Washington's Juvenile Sexual Offender Program and other specialists in the treatment of juvenile sexual offenders; 2) development, training and maintenance of a case assessment and project advisory committee of local juvenile justice representatives; and 3) the provision of direct diagnostic and treatment services for juvenile sexual offenders and their families.

2.2 Target Population

The intended client population consists of children and adolescents living in Skagit County who have been accused of a sexual offense against a peer, a younger child or an older person. Both male and female offenders are accepted for assessment.

All referrals from Skagit County probation or court are accepted for assessment and risk diagnosis. Other referrals are accepted on a first-come-first-served basis.

Acceptance of cases for treatment by the sexual offender staff or other clinic staff from Skagit Community Mental Health Center depend upon the type of offender, the risk to the community, the offender's psychological ability to remain in the community, and the appropriateness of family systems therapy.

2.3 Services

1. Diagnostic Evaluations

The clinical evaluation of the juvenile sex offender involves an interview with the youth and family to obtain a psycho-social profile. Psychological tests (specifically the MMPI and FACES) are given to the youth and are interpreted by a psychologist attached to Skagit Community Mental Health Center. The University of Washington Risk Decision Criteria Scale is used to assign a level of risk for the youth to reoffend.

The assessment information and risk diagnosis are presented to an advisory committee composed of a prosecutor, a CPS supervisor, a DJR officer and juvenile court administrator. Following extensive discussion, recommendations for treatment of the offender and whether the individual should be institutionalized or remain in the community are made to the probation officer responsible for the case. This probation officer may accept none, all or part of the recommendations provided in this forum. If the alleged offender is convicted and sentencing includes referral to the clinic for treatment, treatment begins.

2. Treatment Services

Treatment at Skagit Community Mental Health Center is undertaken only for certain types of youths; those who have been placed on probation, will remain in the community and who live with (or will be returning to) a reasonably functional family. However, the youth's family is not necessarily involved in each treatment session.

The family treatment approach is not appropriate for all offenders. Inappropriate offenders are referred to other treatment programs in the community or committed to an institution. Other community-based treatment services available include psychiatric therapy, one-on-one personal counseling, specialized group home placement, specialized foster home placement, group therapy, and behavior modification treatment.

3.0 RESOURCES

Two professionals with MSW degrees from the Skagit Mental Health Center's treatment staff are responsible for coordinating the case assessment team, and for providing direct diagnostic and treatment services to sexual offenders and their families. Funding provided that only 40 percent of each staff person's weekly time was to be devoted to the project, but in fact, the project staff (a male and female therapist) spend much more time than this.

The project was initially supported with funds from the Governor's Juvenile Justice Advisory Committee. Since March, 1986, funds from the DJR Consolidated Juvenile Services (CJR) program are used to pay for therapist services.

4.0 OPERATIONS

Juveniles are referred to the Skagit project by the Skagit County Juvenile Probation Department. On occasion, referrals are accepted from other neighboring counties for diagnostic evaluations of the juvenile, but these juveniles are not accepted into treatment in Skagit County.

The clinical assessment generally involves a 2-3 hour session with the youth and family and a 2-3 hour testing session with the youth. The findings and recommendations are generally presented to the next management advisory committee (usually within two weeks of the referral). A final report is submitted to Juvenile Probation within a week.

Family systems treatment is provided by the two project therapists for youths and family considered appropriate. This generally involves a one-hour session once a week for as long as the juvenile is on probation. Some sessions involve the whole family, at times just the youth, and, on occasion, just the parents.

More intensive individual counseling services are available through other therapists associated with the Skagit Community Mental Health Center. This usually involves one-hour sessions once a week. Behavior modification treatment is available through a contracted specialist in Whatcom County.

APPENDIX J

DESCRIPTION OF THE

GRAYS HARBOR SEX OFFENDER DIAGNOSTIC

1.0 INTRODUCTION

The Grays Harbor Sex Offender Program is a community-based diagnostic assessment and treatment program developed by the Grays Harbor Juvenile Probation Department for adjudicated juvenile sexual offenders. The program began in March 1984 with funding from the Governor's Juvenile Justice Advisory Committee, Department of Social and Health Services.

2.0 PROJECT MODEL

2.1 Philosophy and Goals

The orientation of the Grays Harbor Juvenile Probation Department is toward treatment of the juvenile sexual offender in an open community setting with involvement of families, if at all possible. The fundamental philosophy and design of this program is similar to the program once operated by the University of Washington.

Although the orientation of the Grays Harbor Juvenile Probation Department and its program is toward community-based family treatment, there is recognition that high risk offenders should be 'committed' in a state institution. An alternative is the Grays Harbor Community Commitment Program, which involves commitment in a local institution program and a gradual release from structured detention to a less secure environment in the community, such as a foster home, group home or family home.

The goals of the program as funded by the OJJDP are to:

* Train present staff (of the Juvenile Probation Department) and one local therapist, to be skilled sex offender counselors;

* Develop and provide a community-based treatment program for sex offenders; and

* Reduce institutional confinement for sex offenders.

2.2 Target Population

The Grays Harbor Sex Offender Program targets all adjudicated juvenile sex offenders 11-18 years of age.

2.3 Services

The activities or services of the Grays Harbor Sex Offender Project include assessment and clinical diagnosis of adjudicated sex offenders, treatment of sex offenders under community supervision, training of local staff, and development and

coordination. Following is a summary description of each of these activities.

1. Assessment and Clinical Diagnosis

Assessment and clinical diagnosis of adjudicated juvenile sex offenders commences with an interview conducted by the probation department coordinator who obtains a psycho-social history of the youth and family. Further assessments are performed by a psychologist contracted by the project direct.

2. Treatment Services

Treatment services include individual counseling and family counseling, wherever possible. Treatment is provided under contract by a local therapist with a focus on the following elements:

* Sex-offense specific behavior;
* Victim empathy;
* Offender-family relationships;
* General sex education; and
* General behavior adjustment.

3. Training

Training is made available to several staff persons of the Grays Harbor Juvenile Probation Department and other members of the Aberdeen and Hoquiam social services and mental health network. Special workshops and presentations are conducted by well known sex offender specialists.

4. Community Development and Coordination

Community development and coordination are promoted through several joint training workshops involving numerous social services and mental health professionals in the community, as well as members of the Grays Harbor Juvenile Probation Department. A treatment coordination team was formed, consisting of the diagnostic coordinator, a family therapist, and two consultants, Dr. Traywick of Tacoma and Dr. Clifford Scharnel of Olympia.

3.0 RESOURCES

The Grays Harbor Sex Offender Project is staffed by a 1/4 time project coordinator who is a staff person with the Grays Harbor Juvenile Probation Department, and two private therapists who are contracted to provide individual and family therapy and clinical evaluations. Part-time secretarial and bookkeeping services are

provided by the Grays Harbor Juvenile Probation Department. Funding is provided by the Governor's Juvenile Justice Advisory Committee, Department of Social and Health Services.

4.0 OPERATIONS

Juveniles are referred to the Grays Harbor Sex Offender Project through the Grays Harbor Juvenile Court, Pacific County Juvenile Court, the Department of Social and Health Services, and parents of juvenile offenders. Based upon the psycho-social assessment and psychological evaluation, high risk offenders (i.e., those at high risk of reoffending as judged by the diagnostician) are typically referred to one of the state institutions, and low or moderate risk offenders are referred for community supervision and treatment.

Treatment is court ordered for all juveniles sentenced to community supervision. Treatment begins while the juvenile offender is still being held in detention (generally less than 30 days) and continues while under community supervision, usually for a period of twelve months. During this time, the juvenile is required to participate in individual counseling for one hour per week for as long as 4-12 months. Quite often family counseling is also required.

Treatment is generally terminated at the end of the probationary period. Juveniles and their families can remain in treatment past this time only if private resources are available to pay for the therapist.