

A Prosocial Collaborative Model for Juveniles Who Sexually Offend

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Introduction

Developing an adolescent specific assessment and treatment model for juveniles who sexually offend (JSO) is important for several reasons. There are many differences between adults and juveniles, generally, and between the subset of each group who have sexually offended. These differences include their cognitive, physical, and developmental status, as well as their rate of development. It also includes their motivation for offending, type and evolution of sexual interests, and patterns of sexual and nonsexual reoffending. School, family, and peer influences are powerful factors for JSOs—different from adult populations. These multiple differences dictate different supervision, treatment, and assessment models for the JSO population. Describing a distinct JSO model is also important because adult models tend to dominate, and are imported uncritically at times for use with juveniles. The adoption of adult models and their assumptions into JSO treatment, while a seemingly easy solution, is not optimal. These types of issues are an ongoing challenge. For example, as of July 1, 2012, the State of California required all programs treating registered sexual offenders be certified by the State and use the California Containment Model (California Sex Offender Management Board, 2012). While as of May 2012 there were five individuals less than 18 years old registered, juvenile probation departments are considering adopting the California Containment Model for use with juvenile populations generally. It should be noted, however, that the State board responsible for implementing relevant regulations never intended this model be used for juveniles. Other states such as Colorado had similar challenges where state boards tasked with monitoring adult offenders were to be used for JSOs. Colorado resolved this by having one board, but separate adult and juvenile standards (Sex Offender Management Board, 2012).

In this paper, we will describe a proposed JSO model—the Prosocial Collaborative Model. We will review relevant issues and research for this model including:

1. Cognitive, social, and ecological factors
2. Effective treatment
3. Epidemiological patterns of risk
4. Nonsexual factors
5. Comprehensive assessment models
6. Collaboration
7. Evidence based practice

We will then discuss how these factors relate to the Prosocial Collaborative Model and the

limitations of using the Adult Containment Model for adolescents.

The Prosocial Collaborative model emphasizes the need to help JSOs develop prosocial as opposed to antisocial goals and skills—in a collaborative fashion with the youth, their family, probation, and the courts. This point of view is similar to the thinking that led to the development of the juvenile justice system focusing on rehabilitation of delinquent youth, as distinct from the adult criminal court system. The narrative and approach implied in the Prosocial Collaborative Model in our view is important in helping JSOs move towards a positive future and prevent future recidivism. The Adult Containment Model emphasizes the need for acknowledgement and control of the antisocial characteristics of those who offend. When used with juveniles, the Containment Model creates a certain narrative that influences supervision and treatment planning, interactions with family and professionals, and self-image.

Approaches similar to the Prosocial Collaborative Model have been described. Washington State developed a model for JSOs on parole (Rongen, 2010), in part because of the limitations related to the relapse prevention model. The “Washington Model” emphasizes the development of prosocial skills, goals, and behaviors. It does not use the following: the term “sex offender”, the sexual offense cycles, offense disclosure in group settings, or coercive or confrontive approaches. It uses a Healthy Living Plan and a strength-based methodology for identifying prosocial goals, while avoiding high-risk situations and abusive behaviors. The treatment approach uses Aggression Replacement Training (ART), Functional Family Therapy, and Dialectic Behavior Therapy. Washington also has implemented a statewide methodology for evaluating treatment outcomes.

Another approach is that advocated by Leversee and Powell (2012), who describe a model of treatment for youth that includes use of the “risk, need, responsivity” principles, the importance of normal adolescent and neuropsychological development, a strength based approach, and emphasizes a positive therapeutic relationship. Another model was advocated by Creeden (2005) in his chapter *Trauma, Attachment, and Neurodevelopment-Implications for Treating Sexual Behavior Problems*. In their book *Juvenile Sexual Offending*, Ryan, Leversee, and Lane (2010) described causal factors, evaluation, and treatment for JSOs. In addition, in *Understanding, Assessing, and Rehabilitating Juvenile Sexual Offenders*, Rich (2011) describes victim, developmental, attachment issues, assessment, and treatment approaches.

Cognitive, Social, and Ecological Factors

When a pediatrician treats an ear infection, it is based on a thorough understanding of childhood anatomy and physiology, growth and development, the disease process, child and family behavior and compliance, and the efficacy of various treatment approaches. No one would want someone treating children for a medical condition without an understanding of the relevant research, theory, and treatment methods. Likewise, treatment models for JSOs should also be based on relevant research regarding adolescent development, criminogenic risk factors, and treatment. Cordoni (2010) at the Association for the Treatment of Sexual Abusers convention, noted a model based on the best research was not the norm for treatment with offending populations. Most practitioners did not use “best practices”; rather, they used the models with which they had the most comfort.

As noted by Knopp, Freeman-Longo, and Lane (1997), JSO treatment models in the late 1970s

were developed by trial and error and were not scientifically based. Initially, little research was done to assess the effectiveness of these models in regard to key outcomes such as sexual and nonsexual recidivism. Initial models were imported from adult treatment of sexual offenders, which in turn was imported from relapse prevention models from adult substance abuse treatment. There has been over 30 years of experience since those initial efforts, and there is now significant research relevant for the treatment of JSOs.

The Prosocial Collaborative Model proposed here suggests relevant theory and research to be used in JSO treatment. One such set of research and theory is Aggression Replacement Training (ART) (Goldstein, Glick, & Gibbs, 1998) developed for treatment of probation youth. ART, and related approaches, are a synthesis of research on adolescent development and treatment relevant for probation youth. A recent survey of JSO practitioners in California found it was the most widely used manualized “name brand” treatment method, with 32% using it. Major contributors include Luria’s (1961) neuropsychological theory of language and social development, Kohlberg’s (1984) research on moral development, social learning theory articulated by Bandura (1973), and Meichenbaum’s (1977) model of anger management training. Related models are the *Prepare Curriculum: Teaching Prosocial Competencies* (Goldstein, 1999) and *Thinking for a Change* developed by Bush, Glick, and Taymans (1997). The ART model has been validated in numerous outcome studies (Goldstein, Nensen, Daleflod, & Kalt, 2004). Amendola and Oliver (2010) reported that ART is a “model program” for the United States Office of Juvenile Justice and Delinquency Prevention and the United Kingdom Home Office. It is classified as a “promising approach” by the United States Department of Education. Ralph (2012a) reported the first randomized trial of ART and the first trial with JSOs. ART in this study had beneficial results for changes in symptom ratings. ART was associated with a greater capacity to delay responses and the use of prosocial options.

ART identifies as modifiable criminogenic risk factors deficits in social skills, moral reasoning, and emotional control. Rather than being “street smart” or socially sophisticated, research indicated that prosocial deficits in these areas contribute to delinquent behaviors. Ralph (2012a) cited newer complementary research with the Roberts Apperception Test for Children (Roberts 2), an objectively scoreable Thematic Apperception type test, with a large normative population and well-designed validation methodology. This research identifies a steep developmental gradient in cognitive complexity and reasoning over the adolescent years. Youths change in their thinking about social situations—from relatively undifferentiated analysis and problem-solving of social dilemmas to more sophisticated formulations that manage both the objective situation, associated feelings and behaviors of others, and long-term outcomes. It also describes the transition to more adult types of thinking that takes place during adolescence, similar to Piaget’s formulation of the formal operational stage and the development of abstract thinking (McLeod, 2010). The research with the Roberts 2 was consistent with the ART view of social development during adolescence, but provided a more detailed and empirically validated approach. Also, the development of counterfactual reasoning in adolescence (Baird & Fugelsang, 2004) shows similar cognitive changes in social reasoning during the adolescent years. Counterfactual reasoning describes the ability to think about a situation by examining “what if” and “then what” possibilities about real life situations. Changes over this period are based in part on neuropsychological development, experience, and physical brain changes.

Another important body of research that addresses social and ecological factors in juvenile recidivism is Multisystemic Therapy (MST). This approach has been shown to reduce sexual and nonsexual recidivism for high risk JSOs. As noted on their website, “Multisystemic Therapy (MST) is an intensive family-and community-based treatment program that focuses on the entire world of chronic and violent juvenile offenders—their homes and families, schools and teachers, neighborhoods and friends” (MST Services, 2012). This model empowers the family and youth to develop skills for reducing criminogenic risk factors. It also improves social skills to increase age appropriate relationships. The MST model requires a high level of program resources, training, supervision, cost, and fidelity monitoring. An open question is whether less expensive approaches using this model can be effective.

Effective Treatment

Any model of JSO treatment should include a consideration of what is effective treatment. Research on the effectiveness of JSOs is modest compared to adult studies. Reitzel and Carbonnel (2006) conducted a meta-analysis of nine studies of JSO treatment with a total sample size of 2,968 primarily male youth. Sexual recidivism of the total sample was 12.5%, compared to 20.4% for other/unspecified, non-sexual recidivism, and 28.5% for non-violent, non-sexual recidivism. Comparing those who received treatment versus those receiving no treatment, the recidivism rates were 7.4% versus 18.9%. Every study included had a positive effect size superior to the control groups for reducing recidivism. There did not appear to be differences regarding program effectiveness among program types; rather, other factors influenced effectiveness such as participant characteristics (e.g., more effective programs had high risk youth). Effectiveness was not limited to cognitive behavioral programs, but was evident with other models.

Borduin, Schaffer, and Heiblum (2009) examined treatment outcomes for 48 high risk JSOs using a randomized design and the MST model, with an 8.9-year follow-up. The MST model was adapted for JSO populations. The treatment group had an 8% and 29% rate for sexual and nonsexual recidivism respectively, compared to 46% and 58% for the treatment as usual group. The goal of the MST model was to reduce parental and youth denial about the sexual offense, increase parenting effectiveness, promote family cohesion, and communication. Improving school performance and involvement were also targeted. In addition, age-appropriate friendships and sexual experiences were encouraged by social skills training and by avoiding association with delinquent peers.

Worling, Littlejohn, and Bookalam (2010) conducted a 20-year follow-up using a non-randomized, matched control design with the SAFE-T program in Toronto. There were 58 treatment cases and 90 in a comparison group. Over 90% of the subjects were male. Charges rather than convictions were used to indicate recidivism. The treatment group had recidivism rates of 9%, 28%, and 22% for sexual, nonviolent, and violent offenses, while the comparison group’s rates were 21%, 52%, and 22%, respectively, for the same categories. Treatment components included the youth taking responsibility for the offense, developing relapse prevention plans, increasing awareness of victim impact, reducing the impact of past trauma, and increasing positive family functioning. Prosocial interpersonal and sexual relationships, knowledge, and attitudes were targeted for treatment.

Lipsey, Howell, Kelly, Chapman, and Carver (2010) identified two general philosophical approaches in dealing with probation youth. The first can be described as Control/Discipline oriented, and emphasized approaches that instill discipline such as boot camps, those that increase fear of negative consequences such as Scared Straight, or those that had intensive surveillance and probation supervision. A contrasting approach can be described as Prosocial/Case Management oriented. It emphasized social skill building, counseling services, victim restitution, and coordinated case management services. Approaches that emphasized Control/Discipline were associated with an increase in recidivism, except for those that emphasized surveillance, which produced a 5% reduction. Those that emphasized a prosocial approach—including restorative, skill building, counseling, and multiple/case management services—produced about a 10% or higher level of reduction in recidivism. Programs that fit the needs of youth were more likely to have lower recidivism rates. Locally developed programs were effective if they selected clients appropriately, and were well designed and implemented. Effectiveness was not limited to “name brand” or more well-known programs. Providing an adequate amount and quality of services was associated with better treatment outcomes.

Epidemiological Patterns of Risk

Understanding epidemiological patterns of risk is central in designing appropriate JSO treatment. Several empirically validated instruments exist for risk assessment including the Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II—Righthand et al., 2005), the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR—Worling, 2004), and the Juvenile Sexual Offender Recidivism Risk Assessment Tool-II (J-SORRAT-II—Epperson, Ralston, Fowers, & DeWitt, 2006). The J-SORRAT-II was adopted as the approved instrument for assessing juvenile risk by the California Sex Offender Management Board. A survey of JSO providers in California indicated that two thirds used this instrument for JSO risk assessment (California Coalition on Sexual Offending, 2012). The J-SORRAT-II was validated initially with all adjudicated juvenile sexual offenders in Utah from 1990 to 1992. The population studied was 76% white and all male. Sexual recidivism was examined in a 10-year follow-up. The study used statistical methods to specify 12 items that best identified youth who sexually recidivated as either adolescents and adults. The base rate for juvenile sexual recidivism before age 18 in the sample was 13.2% and the rate for sexual offenses as an adult was 9.1%. Since this research examined the entire population from one state, it can be used for describing risk patterns across this population for re-offense, and we can approximate the number of individuals victimized; however, only for this population (Utah) at this point.

Table 1 describes the different risk groups. Seventy percent of the youth fell into the low or moderate low risk groups with an average 3% risk of sexual reoffense. Thirteen percent fell into the moderate high or high risk groups with average risk of sexual reoffense of 43% and 82% respectively. The number of victims can also be estimated. It is approximate, since some sexual crimes, such as child pornography, do not have direct victims, and there may also be multiple victims for one instance of recidivism. While the low and moderate low risk categories have a lower incidence of recidivism, because of their larger numbers, they account for 14% of victims with this methodology. Likewise, the moderate-high and high risk categories accounted for 55% of total victims. Differentiating between risk groups is essential for rational treatment planning and resource allocation. For example, the low risk group, with a 1% risk of sexual reoffense, and

constituting 50% of the JSOs in this population, has different containment and treatment needs than the high-risk group who has an 82% risk of recidivism, constituting 3% of the population. The high-risk group had 82 times the risk level of the low risk group. This data is from the development sample and results reflect "over-fitting" related to the tool being developed on this sample.

Table 1: JSO Risk Groups and Estimates for Victims

J-SORRAT-II Category	Score	Number of Youths	Number of Sexual Recidivism	% Recidivism	% of Total Sample	Estimated Victims	Cumulative Victims
Low	0-2	305	3	1%	48%	>/=3	>/=3
Mod-Low	3-4	137	9	7%	22%	>/=9	>/=12
Moderate	5-7	107	26	24%	17%	>/=26	>/=38
Mod-High	8-11	65	28	43%	10%	>/=28	>/=66
High	12+	22	18	82%	3%	>/=18	>/=84

Epperson (2012) noted the importance of an adequate risk assessment in treatment planning. For high risk youth, inadequate treatment and containment of these youth might likely lead to higher levels of recidivism and future victims. He also noted that overly restrictive or intensive treatment for low risk youth could be problematic as well. For example, if low risk youth were put in secure treatment settings, there is the possibility that their risk level might increase. They might likely be exposed to more aggressive and higher risk youth, and possibly be further traumatized and socialized into more deviant sexual patterns. Likewise, lower risk youth who get no or inadequate treatment might have an increase of risk. Some professionals suggest that for the low or moderate-low risk groups that Epperson identified, they might recommend no treatment or brief psychoeducational treatment only. However, as noted above, while individually low risk, these groups collectively account for an approximately future 14% of victims using the Utah sample. As noted below, these "low risk" youth are also at higher risk of nonsexual recidivism, may be at risk for out-of-home placement, and often have psychiatric comorbidity that requires separate treatment. An exclusive focus on sexual recidivism may miss other treatable issues.

Nonsexual Factors

Both assessment and treatment of JSOs has justifiably emphasized the problematic sexual elements of the JSOs' history and functioning. The emphasis has been on sexual behaviors that are harmful or nonconsenting, including prominently pedophilic interests. Since the youth's offense was sexual in nature, that focus has been taken for granted. There is, however, research and a rationale that JSO assessment and treatment should also focus on other areas in addition to sexual issues.

Nonsexual recidivism. As noted in the Borduin et al. (2009) study of high-risk JSOs using the MST model, and a nearly 9-year follow up, the treatment group had an 8% sexual recidivism rate versus the comparison group which had a 46% rate, and the nonsexual recidivism rates were 29% versus

58%, respectively. Another study of outpatient treatment in Toronto (Worling, Littlejohn & Bookalam, 2010), found that the treatment group had a 20-year sexual recidivism rate (for charges only) of 9% compared to 21% for the comparison group for sexual offenses. The treatment group had a 28% and 22% rate for nonviolent and violent sexual recidivism respectively, and the control group had a 52% and 39% rates for the same categories. For the treatment group in these JSO studies, nonsexual recidivism was about three times higher than sexual recidivism. Akakpo and Burton (2012) found in their sample of JSOs in residential treatment, almost 50% had used strong-armed methods to commit robbery or carried a hidden weapon, in addition to an adjudicated sexual crime.

Psychiatric Comorbidity. Similar to the general probation population, JSOs have a high level of comorbid psychiatric and neuropsychological conditions. In a study of 22 adolescent males who sexually molested children and met the DSM-III-R criteria for pedophilia, Galli et al. (1999) reported that 94% of the subjects were diagnosed with Conduct Disorder and 71% with Attention-Deficit/Hyperactivity Disorder. They also found that 82% met the criteria for a Mood Disorder, 55% for an Anxiety Disorder, and 50% for Substance Abuse. The Commission on Youth, Commonwealth of Virginia (2011), reports regarding JSOs that they have difficulties with impulse control and judgment, up to 80% have a diagnosable psychiatric disorder, and 30% to 60% exhibit learning disabilities and academic dysfunctions. Psychiatric and educational treatment of these conditions is important for the youth's future life functioning, reducing symptoms, reducing out of home placement, and sexual and nonsexual recidivism.

Social-Ecological Factors. Research from MST, as noted above, indicates that delinquent peer associations, and problems in school and family functioning are modifiable risk factors for sexual and nonsexual recidivism (Borduin and Schaeffer, 2002). Their causal model of modifiable risk factors that increase delinquency includes:

- Family Factors: Low parental monitoring, high conflict, and low affection
- School: Low school involvement and poor academic achievement
- Prior delinquent behavior
- Delinquent peers
- Poor peer relations and/or isolation from non-delinquent youth

Pedophilic Interests. Pedophilic interests for JSOs appears to be rare, although this clearly needs careful evaluation at every point. We discussed pedophilic rates of youth under treatment with programs in California. The Department of Juvenile Justice staff in their secure detention facility noted no youth currently with pedophilic/paraphilic orientation. Dr. Gerry Blasingame estimated that in his 20-plus years of experience with JSO programs, less than 5% of youth he has seen in outpatient and residential programs had pedophilic interests. Two California JSO treatment programs—Teen Triumph in Stockton and Gateway in Roseville—noted less than 5% of JSOs in their residential programs had pedophilic interests. A secure detention facility in New Jersey reported about 1% (three of 300 youth) had pedophilic interests. These findings are from **interviews with program staff**, and do not include more rigorous methods such as reviewing case records or **interviews with staff**. However, in our view, this is reasonable evidence regarding this issue.

Sexual, Physical, and Community Trauma/Violence History. Using their terminology, Ford and Linney (1995) noted the rates of sexual victimization for juvenile child molesters was 50%, compared to 17% for juvenile rapists, and 17% for nonsexual violent offenders. They also reported 25% to 50% of offenders experienced physical abuse as children. The Commonwealth of Virginia (2011) reported 20% to 50% of JSOs had histories of physical abuse, and 40% to 80% had histories of sexual abuse. Ford (2012) reported that more than three-quarters of youth in the juvenile justice system had exposure to traumatic stressors, including abuse or family or community violence, life-threatening accidents or disasters, and interpersonal losses. Post-traumatic Stress Disorder (PTSD) in these youth was 10 times greater than community samples. Vulnerable subgroups regarding PTSD include girls, ethno-racial minority youth, and juveniles charged with sexual offenses.

In summary, while the primary emphasis for assessment and treatment of JSOs needs to be on sexual offending, significant research exists to suggest that targeting factors other than sexual offending may contribute to more effective JSO assessment and treatment outcomes. An exclusive focus on sexual offending may miss modifiable criminogenic factors and an opportunity to reduce the incidence of future crimes and victims. It may also miss treatable issues related to nonsexual recidivism, psychiatric comorbidity, social-ecological factors, and histories of victimization. Addressing nonsexual areas of functioning is warranted to promote prosocial functioning in these youth, over and above preventing recidivism. Assessment and treatment models are available to address these areas.

Comprehensive Assessment Models

The “traditional” emphasis on assessment of sexual interest and factors for JSOs is prudent, given that the offense is of a sexual nature. This approach benefits by being complemented with an assessment for nonsexual issues. These include nonsexual factors described above, including cognitive, academic, psychiatric, neuropsychological, social problem-solving, victimization and violence trauma, family and school functioning, and peer associations. The model currently in use in San Francisco County for the assessment of post-adjudicated JSOs is presented in Table 2 (Ralph, in press). It is assumed that optimal assessment utilizes multiple relevant methods, with multiple informants, using “best practices” assessment approaches, and this is similar to the methodology suggested by Ralph and Barr (1989). Due consideration is given to limitations of this approach including using results only a year post-assessment. The systematic and complementary use of quantitative and qualitative methods is also recommended (Ralph, 1976; Ralph, 1980). Different techniques contribute differentially in assessing different diagnostic conditions. For example, a clinical interview and history with the youth and their parents, and a symptom rating scale, are helpful for assessing depressive conditions. In assessing a learning disorder, it is important to ensure that cognitive, academic, and selective neuropsychological testing and an adequate developmental history are considered. On the other hand, for a youth in detention, consulting with detention and medical staff as well as the youth, are the most appropriate ways to assess enuresis. Further, the definitive diagnosis of fetal alcohol or fetal effects syndrome are best made by a physician experienced in diagnosing such conditions in youth with relevant histories and psychological testing.

Table 2: Psychological Assessment Components for JSO Youth in San Francisco County

- *Review of Records:* from probation and other sources with annotation of important information
- *Interview with Probation Officer:* regarding information and relevant records
- *Interview with Defense Attorney:* regarding information and relevant records
- *Interview with Parents:* regarding referral issues, family relations, peer and delinquent influences, school adjustment, substance abuse, violence trauma, mental health history, aggression problems, prosocial activities, DSM IV-TR symptoms, criminogenic factors
 - Include developmental history; prebirth history, marital issues, pregnancy history, family medical history, maternal/paternal substance abuse, perinatal history and birth weight, early growth, developmental milestones, school behavior and learning history, special education history, function at home, etc.
 - Include history of sexual behavior problems
 - Parent knowledge and “beliefs” regarding offense
- *Interview with Youth:* regarding referral issues, family relations, peer and delinquent influences, school, substance abuse, violence trauma, aggression problems, mental health history, prosocial activities, DSM IV-TR symptoms, criminogenic factors
 - Also includes sexual history, experiences, and interests
 - Youth narrative of offense and responsibility
- *Mental Status Examination:* and behavioral observations
- *Cognitive and Academic Achievement Batteries:* to identify youth with developmental delay, cognitive challenges, and learning disabilities
- *Objective Assessment Instruments:* to assess personality and temperamental characteristics, and/or DSM IV-TR type psychiatric symptoms
- *Projective Assessment Instruments:* Roberts 2, assessing level of psychiatric distress and interpersonal problems solving
- *Sexual Risk Evaluation Instrument:* JSORRAT-II
 - Could also use J-SOAP-II or ERASOR 2.0
- *Specialized Assessment:* as needed, neuropsychological, competency evaluation, learning disorders, ADHD, mental retardation, etc.
- *DSM IV-TR Diagnosis:* rationale for diagnoses, based on history, records, collateral sources, interview with youth, mental status exam, and test results
- *Recommendations:* linked to assessment findings, and based on research regarding what are effective treatments for specific problems in probation youth; consideration should be given whether resources for recommendations are reasonably available
- *Time Limits and Qualifications:* assessment should not be used for more than a year; also qualifications for assessing certain risk factor (e.g., risk of reoffense, etc.)

Collaboration

The JSO model advocated here includes a collaborative approach. The juvenile justice system was set up to be distinct from the adult system in several ways. In addition to public safety, the goal was to promote better social functioning for these youth. Part of the juvenile justice system is to emphasize collaborative approaches where possible, rather than strictly an adversarial model. In many jurisdictions, such as San Francisco, this approach has been further developed into juvenile

Collaborative Courts (San Francisco Superior Court, 2012). Collaboration between agencies is essential in effective JSO treatment. As described by Ralph (2012b), this model has been implemented in the City and County of San Francisco. The collaboration consists of the Probation Department working with the treatment team—a part of the Department of Public Health clinic assigned to Juvenile Hall, which staffs the total JSO caseload for the County monthly. Collaboration is also done with the juvenile court judges, and the Public Defender’s and District Attorney’s Office. Case management, including linkage, is done with a contract agency. The Public Defender’s office includes an educational advocacy lawyer and a social worker to help with special education needs. Both case management/brokering and intensive probation supervision of these youth are associated with effective treatment (Lipsey et al., 2010). Model counties regarding JSO supervision in California include San Diego and Sonoma, which had manuals regarding probation supervision of JSOs.

Evidence Based Practice

An important part of the model advocated here, as noted by Ralph (2012c), is the use of evidence-based practice (EBP). EBP has been widely endorsed as a principle for adults and juveniles who sexually offend. Juvenile probation departments in California are increasingly requiring EBP for funding and referrals. Eighty-four percent of programs in a recent survey of JSO practitioners in California reported using EBP, and those not doing so indicated that they would if it were practical and affordable (CCOSO, 2012). The underlying principle is that management and treatment approaches need to use the methods with demonstrated effectiveness—to promote both community safety and the prosocial development of the JSOs.

Various approaches have been suggested for EBP, but no clear “consensus” definition exists for JSO programs. The Clearinghouse for Child Welfare (2012) has a set of definitions for classifying treatment models, including those for JSO treatment that rely on publication in peer-reviewed journals. It uses a definition from the Institute of Medicine (2001), who defined “evidence-based practice” as a combination of three factors: (1) best research evidence, (2) best clinical experience, and (3) consistent with patient values. Ralph (2012c) suggested a modification of this approach to include a “Provisional” category that includes outcomes studies not in peer-reviewed journals. This is consistent with Reitzel and Carbonnel’s (2006) approach and others using meta-analytic approaches who include unpublished studies. Washington State and Minnesota systematically evaluate JSO programs on a statewide basis to establish program effectiveness without the use of peer-reviewed journals. Individual programs, such as Team Triumph in Stockton, California, are assessing program outcomes using a simple, low-cost method. This consists of assessing sexual recidivism by seeing if program graduates appear on the State public sexual offender registry. While such methods are not perfect, they represent a reasonable approach to assessing outcomes and documenting program efficacy.

The effective use of EBP requires that implementation be with populations similar to the validation studies (Lipsey et al., 2010). Implementation of evidence based practice, they go on to note, often means trying to implement a model after attending a training and trying to implement it without appreciation of the needs for investing significant time, money, intensity of services, and fidelity with what the model developers intended.

Lipsey et al. (2010) reports on a promising approach to establishing EBP. They conducted research on an instrument assessing whether programs demonstrated evidence-based practice. The instrument is the Standardized Program Evaluation Protocol (SPEP) and is based on research regarding characteristics of effective programs. Research using this instrument was done in North Carolina and Arizona. In Arizona, 90 juvenile programs with the highest scores had five percentage points lower recidivism than predicted, while programs with lower scores had average recidivism rates, about four points higher than predicted. Use of this or similar methodology would constitute evidence-based practice in these authors' view. They note clinicians are often ambivalent about the role of science in clinical practice. They note, "Therapists tend to rely on a mixture of good intentions, some theory, practical wisdom, and—depending on how long they have engaged in this difficult work—the use of specific techniques guided by their experience. This is often referred to as 'treatment as usual.' Unfortunately a number of studies have demonstrated that usual care is at best uneven and, at times, harmful" (Lipsey et al., 2010, p. 41).

A significant body of research notes that program outcomes are related to the quality of relationships between staff and probation youth. EBP should also include consideration of this body of research. Leversee and Powell (2012) noted the importance of relationship factors in JSO treatment, and that it was associated with positive treatment outcomes. In their meta-analytic study, Norcross and Lambert (2011) noted 8% of the positive change in psychotherapy treatment as being attributed to the specific method, 12% to the therapy relationship, and 7% to the therapist's qualities. This point of view while compelling, it should be noted hasn't been replicated with JSO populations.

The Adult Containment Model and The Prosocial Collaborative Model

The California Sex Offender Management Board (CSOMB) began certifying all treatment providers for registered sexual offenders beginning in July 2012 (California Sex Offender Management Board, 2012). The legislation mandated specific features are included in Table 3 below:

Table 3: The California Containment Mode

- Containment team:
 1. Probation officer
 2. Sex offender treatment provider
 3. Polygraph examiner
- Sex offender specific treatment
- Relapse prevention mandated.
- Use of the term "Sex Offender"
- Risk, Needs, and Responsivity
- Use evidence based and emerging best practices to the greatest extent possible
- Assessment-based treatment and supervision planning
- Includes specialized psychological/neuropsychological testing if required
- Victim advocacy
- Extensive offender related treatment goals
- Cooperative features of Containment Team:

- Release of information and consents
- Exchanging information in support of each other's roles
- Ongoing monitoring of behavior
- Cross-training
- Creating resources
- Problem-solving
- Joint decision-making

NB: The model is not designed for teens per CASOMB

This model was designed for and based on best practices with adult offender populations. The CASOMB board did not intend the model for use with adolescents and, for example, there were a total of five registrants less than 18 years of age in May 2012. The Containment Model, while having many elements relevant to JSOs, is not readily appropriate for JSO populations for several reasons. Polygraph use, for example, is an active area of controversy, especially with low risk adolescents or those not in secure or residential settings. Polygraph with JSOs may produce more disclosure of information, but no research has shown its connection with better treatment outcomes. Due to the objections of defense attorneys in some jurisdictions, polygraphy is sometimes not used with youth. It may also add to the negative narrative in treatment (e.g., that the youth needs to be caught lying). Prescott (2010, p.7) notes, "The use of polygraph examinations with juveniles, to the present, remains empirically unsupported and potentially counterproductive". Others recommend that polygraphy not be used with probation youth generally (National Research Council, 2003; Fanniff & Becker, 2006).

Most JSOs, as noted above, do not have an underlying primary sexual disorder, and pedophilia is infrequent with JSOs. The Containment Model's primary emphasis on sexual offending, especially for low risk teens, would miss addressing nonsexual recidivism and psychiatric comorbidity. In our view, the general "narrative" of the Containment Model is not optimal for adolescents. The "narrative" used with JSOs influences the views of all parties, including the youth's own self-image. Sole focus on how they "fouled up"—to the exclusion of building prosocial skills, interests and, importantly, hopes—may miss opportunities to help reduce recidivism and improve future life adjustment for these youth. The emphasis on effective probation supervision, however, as Lipsey et al.'s (2010) research indicates, is one element from the Containment Model that should be done with JSOs. Effective probation supervision for those in outpatient care—in collaboration with the treatment team—is often omitted in discussions of JSO treatment, even though it plays a vital role.

Summary

It has been over 30 years since JSO programs first were developed. A collective experience has also been accumulated regarding what works and what does not, which has been informed by a substantial body of research. Articulation of a JSO-specific model has always been important, and is especially so now, as demonstrated by states such as California moving towards regulation of treatment of those who sexually offend. In the discussion above, we have outlined elements of a model based on available research and theory regarding this population. The model we advocate includes current theories regarding psychological and social-ecological factors affecting this

population, research regarding effective treatment models, epidemiological patterns of risk, nonsexual factors including nonsexual recidivism and psychiatric comorbidity, comprehensive assessment models, collaborative models of treatment, and principles of evidence-based practice and program evaluation. We have also discussed how the Prosocial Collaborative Model contrasts with the adult Containment Model. Important considerations include treatments regarding nonsexual recidivism, psychiatric and neuropsychological comorbid conditions, the low rate of pedophilic interests, and that the risk for sexual recidivism for 70% of JSOs is 3% (as reported in one statewide study). For example, most of the youth seen in our San Francisco JSO outpatient program are like the 70% of youth with low sexual recidivism risk. They have higher risk for nonsexual recidivism, and frequently have family, psychiatric, and neuropsychological issues that could benefit from treatment. They are routinely seen in the child mental health system. If the treatment focus is solely on sexual pathology and sexual recidivism, then much may be missed for most JSO, which implies to all parties a presumed “diagnosis” of sexual pathology and risk that is not grounded in the evidence.

In our experience, most treatment providers for JSOs are “on a mission” to provide excellent treatment for their youthful clients. They are committed, informed, and work hard to implement effective treatment for this population. Likewise, funding agencies are requiring rigorous criteria for treatment programs, including evidence-based programming. For the JSO program director, the program model and its implementation key areas of concern. Program design and implementation is always a dialogue between best practices and practical practices—using finite resources—and staff gifts and challenges. The Prosocial Collaborative Model described above gives JSO program directors research-based ideas for this challenging area.

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