Evidence-Based Practice with Juveniles

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Introduction

Programs for treatment for juveniles who sexually offend (JSO) are a relatively new development; for example, the Adolescent Clinic of the University of Washington School of Medicine opened in 1978 (Knopp, Freeman-Longo, & Lane, 1997). The impetus for these programs was the passage of the federal Child Abuse Prevention and Treatment Act of 1974. In identifying and protecting child victims, perpetrators were identified who then required services, some of whom were adolescents. Knoff, Freeman-Longo, and Lane (1997) note, "Because there were not scientifically based theories or model programs to guide their development, most of the early programs developed their understanding of sexually abusive youth and designed treatment approaches through trial and error. Common elements of these programs were family, group, and individual therapy with an educational component" (p. 186).

Eleven years ago when I first entered the field of JSO treatment, the dominant approach was the "Sexual Offense Cycle Model" and based on the writings of Kahn (2001), Steen and Monnette (1989), and Lane (1997). This model has been described in more detail elsewhere (Ralph, 2012) and was influenced by relapse prevention strategies and an understanding of sexual offending behavioral cycles. Relapse prevention was derived from adult sexual offender treatment which, in turn, was developed from adult substance abuse models.

A major movement presently in both adult and adolescent treatment of those who sexually offend, is evidence-based practice (EBP). EBP is endorsed by the American Psychological Association in several documents, including practice with children and adolescents (APA Task Force on Evidence-based Practice with Children and Adolescents, 2008). The Association for the Treatment of Sexual Abusers (ATSA, 2012, www.atsa.com) notes on its home page, "ATSA promotes evidence based practice..." California has new legislation specifying that all providers of treatment for registrants for sexual offending use evidence-based methods (California Sex Offender Management Board, 2008). In California, county probation departments are increasingly requiring the use of evidence-based practices for the treatment of JSO youth.

The goals of this article are to suggest criteria for EBP suitable for JSO treatment, and to consider alternatives and practical challenges in the use of EBP for practitioners and researchers.

What is EBP?

Cochrane (1972) articulated the fundamental rationale for EBP. That is, since health care dollars are always finite, it is best to use proven and effective methods based on sound research methodology, the most reliable of which are randomized controlled trials. Criteria for evidence-based practice has been developed by various groups, including the Society of Clinical Child Adolescent Psychology (2012) and the Substance Abuse and Mental Health Services Administration (2012). A practical set of definitions that includes JSO treatment was developed by the California Evidence-based Clearinghouse for Child Welfare (CEB4CW, 2012). CEB4CW used 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.

I propose that the following adaptation of CEB4CW EBP categories be considered in describing EBP treatment methods for juveniles and adults who sexually offend. This modification includes using program-based evaluations. The categories are as follows:

1. Well-Supported by Research Evidence
   - No evidence of significant harm caused by treatment.
   - Treatment methods are documented in a manual or equivalent indicating how to implement it.
   - At least two rigorous randomized trials indicating effectiveness compared to appropriate comparison practice, and published in peer-reviewed journals.
   - Effectiveness beyond one year.

2. Supported by Research Evidence
   - No evidence of significant harm caused by treatment.
   - Treatment methods are documented in a manual or equivalent indicating how to implement it.
   - At least one rigorous randomized trial indicating effectiveness compared to appropriate comparison practice, and published in a peer-reviewed journal.
   - Effectiveness beyond six months.

3. Promising Research Evidence
   - No evidence of significant harm caused by treatment.
   - Treatment methods are documented in a manual or equivalent indicating how to implement it.
   - At least one study using a control group compared to the treatment group and found to be comparable regarding outcomes to a practice rated #1 or #2 above, and published in peer-reviewed journals.
   - If multiple studies done, then the overall weight of evidence supports the benefit of the practice.

4. Provisional Research Evidence
   - No evidence of significant harm caused by treatment.
   - Treatment methods are documented in a manual or equivalent indicating how to implement it.
   - At least one study comparing outcomes of the treatment group and found to be comparable regarding outcomes for similar risk youth to a practice rated #1, #2, #3 above, but not published in a peer-reviewed journal.
   - If multiple studies done, then the overall weight of evidence supports the benefit of the practice.

5. Evidence Fails to Demonstrate Effect
   - At least two rigorous randomized trials indicating the practice has not resulted in improved outcomes compared to appropriate comparison practice, and published in

peer-reviewed journals. If multiple replications, then the preponderance of studies does not support improved outcomes.

6. Concerning Practice
   - If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention has a negative effect upon clients served, and/or case data suggesting a risk of harm of treatment method.
   - There is a legal or empirical basis suggesting that compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

NR. Not Able to Be Rated
- There's no evidence of the practice causing harm, but no documentation of methods, or research regarding outcomes.

In theory, categories 1 through 4 represent a rank order of likelihood that a given practice will be effective. For example, “Well-Supported by Research Evidence" would have the strongest evidence that the practice would likely produce an effective outcome, "Supported by Research Evidence" would be the next most likely, and so forth. As CEB4CW notes, regarding JSO treatment, Multisystemic Therapy (MST—Borduin, Schaeffer, & Heiblum, 2009) is the only method that qualifies as #1. There are no programs listed as #2, and only one comprehensive outpatient program meets the terms specified in #3—the Safe-T program in Toronto (Worling, Litteljohn, & Bookalam, 2010). The Pathways model by Kahn (2001) is rated as NR, meaning there is no outcome research available to demonstrate effectiveness.

Additional criteria may be used. One might consider specifying a given level of "effect size", say medium, to be considered for including a treatment method (Cohen, 1988). As defined by Cohen, effect size is a measure of not just whether a difference is statistically significant, but large enough to matter in clinical terms. For example, a treatment which lowers recidivism by 3% may be statistically significant, but clinically not meaningful. Also the cost effectiveness of a treatment may be considered, as has been done by Washington State (2007) in their comparative research of treatment methods.

Practice Challenges with the Use of EBP

If the JSO program administrator looks for EBP models, as the CEB4CW website indicates, there are relatively few choices available. On the other hand, many JSO programs believe firmly that they have effective treatment, but there is no practical prospect of **using** randomized, or other controlled trials to demonstrate that the treatment methods they use are effective. That is one reason why category #4 was added above. Let's assume that a JSO program is able to document it has youth with comparable levels of risk for re-offense to "model" programs such as the SAFE-T or MST programs. Additionally, assume that it is able to demonstrate comparable levels of recidivism to those "model" programs. While not as rigorous as category #3 above, it offers reasonable evidence for effectiveness, and represents an improvement in the use of evidence and practice, particularly if there is outside review of implementation of the research.

It should be noted, however, that the methodological limitations of such an approach have been well described. This approach could be described as a "post-test only nonequivalent control

group" design. Even if the community-based program showed comparable recidivism to the "model" program, this might not be due to program effectiveness. It might be due to what are described as "rival hypotheses", such as effective probation supervision in that jurisdiction, for example. While correct, the use of program evaluation to establish evidence for the effectiveness of a given program is reasonable, in my view, and **an** advancement over present practice. Methodologically "perfect" should not be the enemy of "better than what we use now." Some type of program evaluation is within the capability of many JSO programs. JSO programs who believe they are providing excellent services with good outcomes should be encouraged to demonstrate this. The Research Committee of the California Coalition on Sexual Offending, for example, has offered program consultation on developing an evaluation component to help program managers find resources to do program evaluations.

Research methods and EBP based on them are designed to be a tool to improve JSO program effectiveness, and not too ambitious an ideal that inhibits the development of thoughtful and effective treatment methods. The consideration of what are appropriate scientific and research methods has been an area of professional debate. Sanson-Fisher, Bonevski, Green, and D'Este (2007) note that alternatives and trade-offs with the use of randomized trials have been discussed in the public health and social service fields. This issue has also been raised with respect to the treatment of those who sexually offend (Marshall and Marshall, 2007) and follow up discussions. Importantly, having methods developed from randomized trials be disseminated on a wide scale basis at present hasn't resulted in widely implemented category #1 EBPs for JSO treatment. If a given scientific approach to developing EBP hasn't been productive, then other scientifically valid options might be considered. As an epidemiologist and psychologist, I am aware that there are always different options available for scientific research.

Modifications to this "traditional" model might be considered. Washington State, through its Institute for Public Policy (2007), evaluates the effectiveness and cost effectiveness of different treatment methods on a state-wide (and sometimes national and international) basis. This is similar to what hospitals are required to do; that is, track outcomes relative to national norms (Joint Commission, 2012). Minnesota (Listiak, 2011) has a state-wide system for evaluation which addresses whether programs have adequately described their model, used appropriate client selection, and adequately implemented the model, among other factors. Public policy is presently based on those findings and the relevant agencies believe the methodology is scientifically appropriate. This approach would fall in category #4 above, but wouldn't qualify for the CEB4CW #3 since peer-reviewed journal submission is not part of this approach. By CEB4CW standards this approach would be rated as "NR Not Able to Be Rated", as there is insufficient research to be rated. There is a diversity of opinion in this area regarding what are appropriate methods and standards of scientific evidence, which will be a future source of professional discussion.

An opinion articulated by program evaluation professionals is that emphasis should be on evaluating a particular program since the overall program performance is the key factor, and not simply the presence or use of EBP. EBP may be just one component of an effective program, and not necessarily the most important one. For example, Serran, Fernandez, Marshall, and Mann (2003) indicate that "therapist features" have an influence on correctional patients' behavioral changes. **Lambert and Barley (2001) address** these issues in their "common factors" model. In

their view, 15% of improvement in psychotherapy patients is due to "Technique"; that is, the use of a specific model of treatment (e.g., cognitive-behavioral therapy). They attribute 40% to "Extratherapeutic" factors—factors outside of treatment which influence outcomes, 15% to "Expectancy" factors—the patient's optimism and hope that the treatment will or can be successful, and 30% to "Common Factors"—aspects of the client-therapist relationship that contribute to a positive therapy outcome.

Program evaluation would also address another issue: Even though the program is using EBP, this doesn't assured that the practices are appropriate or effective with a given population. Can you be assured that EBP produces desirable outcomes for your program if you don't evaluate outcomes? Lipsey (2009) notes that juvenile probation interventions are most effective when they are designed for specific populations, address relevant treatment goals, and are rigorously implemented. For example, if a juvenile program uses EBP consistent with the criteria described in #1, #2, or #3 above, but is applied to populations or for treatment goals for which it was not designed, and did not rigorously implement the program, this in fact would not be adequate EBP. However, this could be addressed by using program evaluation to track outcomes. This is similar to what Washington State did in evaluating Dialectical Behavior Therapy (DBT) for youthful probationers (Washington State Institute for Public Policy, 2006). DBT had been used originally for suicidal borderline women, and to reduce suicidal behaviors and psychiatric symptoms. It hadn't been evaluated for use with male adolescents to reduce recidivism, however. They conducted a program evaluation showing a 15% reduction in felony convictions using DBT for juveniles. Their approach is a viable model for finding effective treatment methods.

Treating professionals often find practical difficulties with implementing EBP. One funding agency, for example, requested the use of EBP for treating female juvenile offenders, but there are no established EBP for this group. The costs, training, supervision, and evaluation of results of some EBP make them practically prohibitive to use, especially in a climate of declining funding. For example, Aggression Replacement Training (Goldstein, Glick, & Gibbs, 1998) in California entails considerable program costs and time for the State sponsored training, as well as the follow-up supervision and fidelity and outcome monitoring. From a public health perspective, we would ideally have interventions that are effective, inexpensive, easy to implement, and available to most of the programs serving populations at risk.

There are some relative easily implemented and inexpensive EBPs, such as the Seeking Safety program (2010) that can be used for trauma with adolescents. A number of emerging methods have the promise of being effective, but also affordable and practical for the average program. Some practitioners with adult sexual offending populations provisionally report that Eye Movement Desensitization and Reprocessing (EMDR) may show a significant treatment effect on trauma in as little as three sessions (Land, 2012). Practitioners have also suggested that taking selected elements of EBPs, such as the MST model (Borduin, Schaeffer, & Heiblum, 2009), if carefully adapted, could be effective, and more readily implemented with adolescents than the "franchised" model (Blasingame, 2011). These innovative approaches could be tested with program evaluations in a fashion similar to how Washington State evaluated DBT. Finding cheaper and easier approaches that can be robustly implemented has long been a goal for public health, such as the development of a polio vaccine (Aylward, 2006) or teen family planning

programs (Ralph & Edgington, 1983). This might be a model for treatment research in the JSO field.

Cortoni (2010) notes that most practitioners use models that "make sense" to them and that they can "do." She emphasizes that clinician acceptance is a powerful factor for what is actually used. She points out, for example, that the relapse prevention model gained popularity in spite of limited evidence of effectiveness, because clinicians could understand it and use it. Cortoni advocates using methods that are effective—that is EBP. Evaluating methods of successful "real world" programs, rather than university -based studies, might also likely provide examples where clinician acceptance had been addressed.

Conclusion

The use of EBP in the treatment of JSO youth has been increasingly important, but various opinions exist regarding what this specifically means. ATSA and the California Sex Offender Management Board both endorse EBP treatment, but don't provide definitions for this. This article provides a definition of EBP which may be useful for JSO programs. Expanding the present "traditional" model to include program evaluation as a scientifically viable method is suggested as an improvement over what exists now. Efforts such as the CEB4CW, while admirable, have not produced many or easily implemented EBPs for JSO program. Washington's and Minnesota's statewide program evaluation plans are models for what might be done in this regard.

Challenges exist for JSO program managers wanting to use EBP, including finding EBP that matches their population, assessing whether a given EBP produces a cost/benefit ratio to justify implementation, does the EBP meet with clinician resistance, and is the cost and ongoing "hassle" of implementing EBP too great? Also, JSO program managers should focus on appropriate selection and screening of clients, how well the overall program is designed to fit the needs of their population, how well implemented the program is, and whether important program process and outcomes are evaluated. As Lambert and Barley's (2001) model suggests, EBP is important, but it is just one factor in promoting therapeutic outcomes and other factors, such as the quality of the patient-therapist relationship, may have a greater effect.

In summary, the use of evidence regarding improving JSO treatment outcomes is not an issue of just using EBP. It likely requires more comprehensive consideration of program design, implementation, fidelity tracking, and evaluation of outcomes.

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