Juveniles who sexually offend: A view from 2016

This blog, like last weeks by Jon Brandt (New Research: Juvenile Sexual Recidivism < 3%), is linked to a recent publication by Michael Caldwell on the declining rates of juvenile sexual recidivism. Kieran

When I first started working with juveniles who sexually offend (JSO) in 2001, the focus was on sexual deviancy and compulsions. Our knowledge about this population has increased since then, and this population has likely changed as well, all of which has implications for practice and policy. The following is a personal view of how things look in 2016.

Knowing the prevalence rates of outcomes is an important starting point for assessment. Caldwell's (2016) article cited a weighted mean sexual recidivism rate of 2.75% for JSO youth, and a nonsexual recidivism rate of 30.00%. Measures of both sexual and nonsexual recidivism should be included in JSO assessment. The latter is a more recent development, and warranted given the high prevalence level noted by Caldwell and others. Nonsexual crimes also cause harm to victims.

Caldwell's study also suggests that the results from sexual risk measures, given a base-rate of 2.75%, may need to be qualified. For example, if a risk measure puts youth in the highest risk level, with say a risk of twice the base-rate of 3%, 94% of these "high risk" would be predicted to not sexually reoffend.[i] One study (Borowsky, Hogan, Ireland, 1997) examined rates of sexual offending behaviours reported in non-forensic, community samples, and found this rate for juveniles to be 4.8%, higher than the base-rate reported for reoffending of 2.75% by Caldwell. These considerations suggest decisions regarding out of home or secure placement, let alone civil commitment, may not be justified based primarily on findings from risk measures of sexual recidivism.

Developmental outcomes are also important to assess. These include psychiatric factors (depression, anxiety, etc.), neuropsychological conditions (ADHD, autistic spectrum, learning and intellectual disabilities, etc.), substance abuse, violence and trauma related conditions. The high prevalence of these conditions in this population, and also the availability of evidence-based treatment approaches to address them, argues for the inclusion of such factors in assessments. Also neighborhood, socio-economic, ethnic, cultural, and family factors are also important.[ii]Prevalence rates of psychiatric conditions in outpatient setting are likely lower than in residential or secure settings.

In 2001, the priority as I recall it for JSO youth was treating what was assumed to be an underlying sexual pathology. For most of these youth, however, I found there wasn't evidence of a pattern of enduring sexual deviancy. While there are such youth, they are rare in my experience. Impulsivity, poor judgment, supervision problems, and sometimes a history of sexual victimization, seemed to be the best explanations, rather than a primary disordered sexual behavior pattern.

This led me to believe that treatment approaches which promoted better social judgment and skills, along with family education, and a psychosexual education component, was optimal for most JSO youth. The theory and techniques of Moral Reconation Therapy and Aggression Replacement Training provided the framework for approaches to promote more mature social judgment and skills. One recent study (Ralph, 2016), documented deficits in prosocial reasoning for JSO youth, and three previous studies (Ralph, 2015a; Ralph, 2015b) documented the effectiveness of these approaches with JSO youth, including reducing sexual misbehavior.

In 2001, evidence-based practice with JSO youth wasn't in widespread use in my experience. Now it is a major consideration in treatment, and in California, some probation departments require evidence-based practices to obtain funding. In my view, evidence-based practice should include an evaluation of outcomes for treatment programs. You should be able to track your therapeutic outcomes so you can see not only if a given client improves, but also whether the program as a whole shows positive outcomes. Every surgery center in the USA has to do outcome studies (mortality and morbidity), and so should JSO treatment settings. In my experience highly committed, but rarely is any program evaluation done in JSO programs to document these admirable efforts.

Worling, Littljohn, and Bookalam's (2010) study on a 20-year follow-up from the SAFE-T program in Toronto is probably the best known example of such research. A more modest effort was my own recent follow-up study of 129 youth in a residential JSO program (Ralph, 2015b).

The ultimate outcome to be tracked for JSO interventions had been sexual recidivism. This may not be the best measure to use in an era of recidivism less than 3%. Is a good program now one that reduces recidivism from 2% to 1%? Other outcomes might be tracked including non-sexual recidivism, reduction in psychiatric symptom ratings, and increases in prosocial reasoning and skills. Righthand's (2005) treatment progress scale is a useful tool with some normative information available. Examples of such measures are also found in my recent article (Ralph, 2016).

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