

GUIDELINES FOR THE
ASSESSMENT AND
TREATMENT OF SEXUALLY
ABUSIVE JUVENILES



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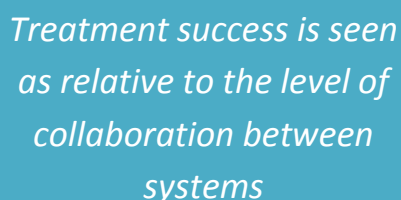
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Purpose

The purpose of these guidelines is to provide guidance for the assessment and treatment of male juveniles, between 11 and 17 years of age, who have come to the attention of law enforcement and may or may not have a sustained sexual offense (i.e. they may be on either formal or informal probation). These youth are referred to as sexually abusive juveniles because the term “juvenile” includes youth involved in the juvenile justice system. Experts in this field have repeatedly urged that such juveniles not be described as “sex offender” because such a label carries misleading implications about their probable future behavior. These implications are not supported by the research. These guidelines are written with the aim of preventing recidivism and promoting the prosocial development of the youth. These guidelines are for professionals conducting the assessment and treatment of this population. The intent of these guidelines is to help reduce sexual violence victimization by providing more effective assessment and treatment as well as by encouraging enhanced collaboration between relevant agencies.

Introduction

FBI crime data (2003) indicated juveniles under age 18 years old accounted for 16% of rapes and 20% of other sexual offenses (Snyder & Sickmund, 2006). The FBI National Incident Based Reporting System (2004) indicated juveniles comprised 35% of those known to police to have committed sexual crimes against minors (Finkelhor, Ormrod, & Chaffin 2009). As of 2007, there were approximately 2,800 juveniles under supervision by the 58 county probation departments in California (California Sex Offender Management Task Force, 2007).



Treatment success is seen as relative to the level of collaboration between systems

Most youth who sexually offend are males. In Finkelhor (2009) et al.’s sample of 13,471 juveniles known to police for committing sex offenses, 93% were males and 16% were children under the age of 12. Research on female sexually abusive youth is sparse, consisting of small samples (Miccio-Fonseca, 2000, 2013; Pratt, Patel, Greydanus, et al. 2001), although sexual offending by female youth has become more common in recent years (Robinson, 2009 Roe-Supowitz & Krysik, 2008). For this reason, at this time, these guidelines address only male adolescents who have come to the attention of law enforcement and may or may not have received a sustained offense. As new data emerges, updates to these guidelines may be offered. Important areas of future consideration are youth with sexually abusive behaviors in

the following categories: those who are not adjudicated, female adolescent perpetrators, young child perpetrators, and youth with low intellectual functioning.

Male sexually abusive juveniles are a heterogeneous population (Righthand & Welch, 2004; Seto & Lalumière, 2010). They come from a variety of backgrounds, and they have unique developmental pathways. They possess unique and individualized strengths and weaknesses. Each sexually abusive juvenile is dependent upon and interacts with a variety of systems on a daily basis. Unlike adult sex offenders, sexually abusive juveniles are dependent on their families or caregivers and are required to go to school. Furthermore, they are heavily influenced by the values of their peer groups and have experienced a high rate of technological change while being involved with technology almost constantly. They are dependent upon a larger community and must conform to the laws and standards specific to the community. These multiple factors should be addressed in order to intervene with the sexually abusive juvenile.

Sexually abusive youth are not simply "small adults."

Sexually abusive juveniles differ from adult sex offenders in many ways in addition to family, school, and peer involvement. These differences can be described from the perspectives of physical and cognitive development, as well as social and familial. They are different in major ways from sexually abusive adults, and are not simply "small adults." Treatment success is relative to the collaboration between the systems upon which the sexually abusive adolescent is dependent (Hunter, 2006; Rich, 2003).

Training and Experience

These guidelines support present standards of training, experience and understanding for those providing assessment and treatment services for this population. For example, the American Psychological Association states in its ethical guidelines, "2.01 Boundaries of Competence: (a) Psychologists provide services, teach and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study or professional experience". Additionally the Association for the Treatment of Sexual Abusers state similar views in their ethical guidelines including the understanding that members have an obligation to receive continuing education and refrain from practice outside the boundaries of their discipline or training, and receive sufficient training before using new techniques and competencies. Clinical staff is assumed to be in compliance with the mandates of their respective licensing agencies when carrying out the recommendations of these guidelines (i.e. The Board of Behavioral Science Examiners; the Board of Psychology).

Current Status

Currently, in California, a variety of intervention strategies exist. Each county is responsible for its own policies and procedures for treating and managing sexually abusive individuals (California Sex Offender Management Board, 2010). Strategies differ widely in sophistication between counties. Some counties have no policies in place which may lead to less methodic and less vigilant management and treatment of these juveniles and may result in higher

California's methods for working with sexually abusive youth are based upon a piecemeal framework which can vary between counties and among jurisdictions.

recidivism, higher rates of victimization, and less support to the youth. Furthermore, in those situations where there are inter-state transfers, sexually abusive juveniles and their families may not be aware that California has different requirements regarding management of sexual abuse cases. In some cases, the tasks required of the juvenile may have already have met in the other state (i.e., juvenile previously completed a treatment program and/or previously completed therapy tasks, such as autobiography).

Accommodations and adjustments in treatment requirements need to be made so that the juvenile

and his family do not feel that services are redundant or that previous efforts were undertaken in vain.

Also, with regard to funding, because each county has its own policies, no clear funding sources exist for sustaining interventions. As a result, each program is required to develop its own funding sources. Typical funding sources include County mental health, probation, or social services department funding, and private pay. Some counties have adequate and secure funding for these services, while others have none. In California, such changes sometimes require relocation to different counties or changes in funding across systems. When these changes occur, interruptions in service occur which can result in exposing the public to greater risk of violence. Furthermore, individual sexually abusive juveniles may fall away from treatment during these transitions.

These guidelines are an attempt to recommend policies that will contribute to more effective management of sexually abusive juveniles and provide standards that will be useful statewide.

Systemic Perspective

Due to the complexity and brevity of the adolescent experience, multiple systems must be engaged in order for treatment and intervention to be successful.

Systems that need to be engaged in order for a given sexually abusive juvenile to be successful might include:

- School: the role of the youth's academic difficulties and strengths upon sexually abusive behavior.
- Peers: the role of an individual's peer group is a strong influence on their behavior.
- Family: the role of family dynamics such as domestic violence, sexual abuse, child neglect or communication difficulties upon sexually abusive behavior.
- Social Services: the role of social factors in the family's ability to care for a sexually abusive juvenile
- Mental Health Services: the role of mental illness upon the behavior of sexually abusive juvenile.
- Probation: the role of supervision upon sexually abusive behavior.
- Other systems such as health care may be included.

Furthermore, good collaboration between these systems can increase the success of interventions with these juveniles.

Collaborative Approach

Beginning in July 2012, California adopted new requirements for registered adult sex offenders and incorporated specifically the Containment Model for managing registered adult sex offenders (California Sex Offender Management Board, 2012). This is an evidence-based approach that represents "best practices" for adult offender management and guides treatment. The state board was careful to note that this approach was not designed for juveniles who have very specific needs considerations that differentiate them from adult offenders.

Due to the complexity of the adolescent experience, multiple systems must be engaged in order for treatment and intervention to be successful.

Not all sexually abusive youth need the same treatment programming; one-size-fits-all treatment programming is much less effective

Collaboration among the important individuals in a juvenile's life is basic for the treatment of this population. The model proposed in these guidelines for sexually abusive juveniles, the *Collaborative Model*, is used to highlight several important factors related to treating this population, beyond the management that the Containment Model proposes. Collaboration in this type of treatment is used in several ways and mirrors characteristics of many of the systems with which the juvenile interacts. Regarding the legal system, the

juvenile courts were set up to be distinct from the adult treatment system and include collaborative elements. Regarding the agencies involved with the juvenile, as with any treatment of teens, including those who sexually offend, collaboration of the various agencies is seen as essential. Also, as described elsewhere, collaboration is seen as the optimal relationship between the juvenile, their family, probation, and the treatment providers. The Collaborative Model emphasizes working together where possible, rather than in an adversarial way, and emphasizes the rehabilitation of the juvenile while also protecting public safety, which goes beyond managing their potential inappropriate behavior in the community.

The Collaborative Model emphasizes working together where possible, rather than from a strictly adversarial model

Collaboration Team

The Collaboration Team involves three core participants¹:

- Juvenile Probation
- Treatment Provider/Organization
- Sexually Abusive Juvenile and their family.

This team works together wherever possible to obtain a "buy in" from the juvenile and their family. Success in building this alliance is strengthened by having consents and orientation to treatment that emphasize that there is a shared goal for all three parties. The shared goal is for the juvenile to lead a pro-social productive life without future legal problems or arrests. Toward this goal, all parties want the juvenile to develop age-appropriate social skills and relationships

¹ Collaboration with auxiliary parties such as case management services, schools, judges, or educational advocacy is also important.

that build towards a prosocial future. The development of this "narrative," also called "therapeutic stance" or "treatment perspective", which describes treatment as beneficial for all parties greatly facilitates a more effective treatment alliance between the provider, juvenile, and family.

The Collaborative approach or "narrative" can help with a more positive treatment relationship and also positively influence all party's views of the juvenile, including the juvenile's own self-image. Sole focus on how a juvenile (or by extension their family) "fouled up" to the exclusion of considering strengths or potential strengths, building pro-social skills, interests and hopes, may miss opportunities to help reduce recidivism and improve future life adjustment for the juvenile. Collaboration between team members is associated with effective treatment outcomes (Lipsey et al., 2010).

Risk, Needs, and Responsivity Principles Applied to Juveniles

There is a limited but growing literature base (Andrews & Bonta, 2006; Lipsey, Howell, Kelly, Chapman, & Carver, 2010; Hoge & Andrews, 2011) which suggests that use of the risk, needs, and responsivity principles of human service can be useful in case planning for juveniles who are involved with the criminal justice system. Consistent with statements made above, Hoge & Andrews (2011) frame the construct of juvenile delinquency as caused by multiple variables that interact and complicate the juvenile's life. These characteristics and environmental factors include the following:

- The juvenile's developmental and mental health history
- The juvenile's family characteristics and circumstances such as abuse and level of supervision by parents
- The juvenile's personal characteristics including cognitive attributes, personality, and behavior
- The juvenile's peers and associates
- The juvenile's involvement with substance abuse
- The juvenile's beliefs and attitudes regarding pro- or anti- social activities

The shared goal is for the youth is to lead a pro-social productive life without future legal problems or arrests

Based on a long history of research on the development of antisocial behavior in adolescents, the application of the human service principles of risk, needs, and responsivity with juvenile treatment and supervision is appropriate (Lowenkamp, Makarios, Latessa, Lemke, & Smith,

2010; Lipsey, Howell, Kelly, Chapman, & Carver, 2010). The principals of this approach help clinicians and supervising officers differentiate and deliver varying levels of therapeutic intervention and supervision based on individualized offender characteristics and needs associated with the risk of further delinquency.

Therefore, a thorough assessment of the juvenile's risk for sexual or other criminal re-offense should be made using the procedures described in subsequent sections in these CCOSO Guidelines. Multi-dimensional and comprehensive interventions strategies can then be developed and implemented with the engagement of the juvenile's parents or care providers participating at every stage of the process (Borduin, Schaeffer, & Heiblum, 2009; Lipsey, Howell, Kelly, Chapman, & Carver, 2010). Interventions should be designed based on the individual juvenile's particular level of risk and specific dynamic, criminogenic, areas of treatment need. Not all sexually abusive juveniles need the same treatment programming; one-size-fits-all treatment programming can be legitimately questioned (Landenberger & Lipsey, 2005).

Those youth who have the highest risk and needs have the greatest room for change, while lower risk youth may be managed at a lower level of care.

Examples of such treatable needs include addressing the juvenile's beliefs and attitudes that support offending behavior, mental health concerns, anger management, substance abuse, and developing a variety of pro-social competencies including problem solving skills, developing positive peer relationships, and empowering his parents to be more effective in their guidance efforts.

Current research suggests that differing levels of intensity and duration of treatment and supervision are required by different juveniles in order to most effectively reduce recidivism while maintaining cost effectiveness (Lipsey, Howell, Kelly, Chapman, & Carver, 2010). Those juveniles who have the highest risk and needs have the greatest room for change, while lower risk juveniles may be managed at a lower level of care. Discerning the juvenile's level of risk for re-offense sexually or otherwise, his particular dynamic needs associated with general delinquency, and a comprehensive case plan that is responsive to the individual and his family clearly represents one aspect of implementation of evidence based practices.

Assessment Guidelines

Assessment of sexually abusive juveniles includes several factors. While assessment of the risk of sexual recidivism is a primary concern, assessment of nonsexual factors is important for several reasons including the high rate of nonsexual recidivism and comorbid psychiatric,

neuropsychological, trauma related, and substance abuse issues in this population (Ralph & Wong, 2013; Seto and Lalumiere,2010).

Professionals (i.e., clinicians, probation officers, social workers, non-clinical staff, youth counselors and medical staff) who assess risk of re-offense for male sexually abusive juveniles should be familiar with current research literature on risk assessment for abusive behaviors. This literature is dynamic and changing frequently so following the emerging issues within this research is important (Prescott, 2006). It is essential to utilize valid and reliable risk assessment tools that have been both validated and cross-validated on sizable culturally diverse samples of juveniles of different age groups. Large samples are necessary for generalizability, in order to have confidence in the results.

Risk Assessment Tools

The juvenile court system relies on the evaluator's expertise and expects that they are employing state of the art risk assessment tools (i.e., tools that have met the standard of being validated and cross validated, demonstrated to have predictive validity and are appropriate for the specific population assessed, related to age and/or gender).

Professionals must consider the scientific status and validity of assessment instruments used for predicting sexual recidivism

Professionals must consider the scientific status and validity of assessment instruments used for predicting sexual recidivism (and instruments for outcome measure), their generalizability and limitations.

Risk assessment is a vital and necessary component of assessment. Risk assessment tools supported by empirical research on at least one independent sample of 100 or more sexually abusive adolescent subjects include:

- *Juvenile Sex Offender Assessment Protocol (J-SOAP-II*, Prentky, Harris, Frizzell, & Righthand, 2000; Prentky & Righthand, 2003; Prentky et al., 2010; Righthand et al., 2005) is an empirically anchored tool (Prentky et al., 2010). It was the first risk assessment tool for sexually abusive youth and is the most extensively studied by independent researchers. A recent study reviewed nine of the studies that utilized the J-SOAP-II and explored its psychometric properties (Fanniff & Letourneau, 2012).
- *Estimate of Risk of Adolescent Sexual Offense Recidivism(ERASOR, Version 2.0*, Worling & Curwen, 2001; Worling, 2004) is an empirically anchored tool . A recent validation study was completed by the authors (Worling, Bookalam, & Litteljohn, 2012). A few

independent researchers have utilized the ERASOR in their studies (e.g., Viljoen, Elkovitch, Scalora, & Ullman, 2009; Rajlic & Gretton, 2010).

- *Juvenile Sexual Offender Recidivism Risk Assessment Tool-II (JSORRAT-II*, Epperson, Ralston, Fowers, DeWitt, & Gore, 2006) is currently the only actuarial tool developed for youth and validated on adjudicated male juveniles ages 12 to 18 ($N = 636$) (however not applicable to female juveniles and/or children under 12). It is the only juvenile risk measure selected by the California state committee charged with choosing state authorized risk assessment tools used for evaluating sex offenders (i.e. SARATSO Committee) as of 2013.
- *Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing Sexually Abusive Adolescents and Children (Ages 4-19) or MEGA^f* (Miccio-Fonseca, 2009, 2010, 2013) is standardized and has normative data (cut-off scores) according to age and gender, making it applicable to broad range of juveniles, including juveniles with low intellectual functioning. Uniquely, it is accompanied by an individualized risk assessment report according to gender and age. *MEGA^f* is also an outcome measure that is useful for assessing juveniles every 6 months.

Consistent with ATSA Guidelines, formal risk assessment should only be done for adolescents with sustained charges

When choosing a risk assessment tool, professionals must consider the scientific status and validity of assessment instruments used for predicting sexual recidivism (and

Unstructured clinical judgment of risk is generally viewed as lacking empirical support and as being, therefore, no better at predicting risk than chance.

instruments for outcome measure), their generalizability and limitations. Risk assessment tools that are standardized and have normative data are more generalizable to the population at large. A tool with normative data (i.e., cut-off scores) with good prognostic ability, provides increased accuracy in risk assessment. Having standardized scores allows for defining risk levels and eliminates guesswork. Normative data allows for a substantially more interpretive and informative risk assessment and therefore provides more guidance.

An essential part of risk assessment validation is that the validation research be replicated and show acceptable levels of prediction for various samples. Also, ideally, this research should be completed on independent samples by researchers other

than the instrument's authors. An instrument's ability to differentiate those who repeat sexually abusive behaviors versus those who do not should be robust and replicated with several populations and at different time frames.

There are other risk assessment tools referenced in the literature and utilized for assessing sexually abusive individuals that lack established validity and reliability (i.e., validation and cross-validation studies on large samples). Professionals are cautioned against using tools for risk assessment that lack established validity and reliability (validation and cross-validation studies on large samples).

Evaluators should note that a large meta-analysis of risk assessment techniques related to adult sex offenders showed that current assessment instruments have modest predictive ability depending upon the population studied and the instrument used (Hanson, Morton-Bourgon). At present, no instrument is able to predict risk with 100% probability. A recent meta-analysis compared J-SOAP-II, ERASOR, and JSORRAT-II-, along with the adult tool Static-99, and found no significant differences between the tools in their ability to predict sexual recidivism (Viljoen, Mordell, & Beneteau, 2012).

It is helpful to understand some statistical concepts when evaluating the utility of a given risk assessment tool. Considering a given instrument's derived Area Under the Curve is important when evaluating the usefulness of a given risk assessment tool (See Appendix for an explanation).

Caution regarding the accuracy of such measures is important given that there may be a tendency for nonclinical professions to overestimate the accuracy of these measures.

Evaluators must remember that the prevalence of nonsexual reoffending for adjudicated male sexually abusive adolescents is higher than that for sexual reoffending

Professionals need to recognize the limitations of risk assessment tools, and not base an assessment solely on the results of any given tool. Professionals completing risk assessments need to clearly state the limitations of risk assessment tools in their reports.

Current research also indicates that sexual arousal to younger children is unusual in juveniles with sustained sexual offenses (Ralph & Wong, 2013; Worling, 2012). Ralph and Wong (2013) report that in treatment with juveniles, primary pedophilic interests are rare, less than 5%. This is an area of research that is still unfinished. While this population seems to be a small part

of the sexually abusive youth population, effective assessment and treatment of this population is still being researched and developed. If such interests are detected or suspected, further assessment should occur to ensure that the concerns are addressed in treatment.

Information to be Included in a Risk Assessment

Due to the complexity of risk assessment for sexually abusive juveniles, evaluations should include multiple sources of information, using multiple methods for assessment involving both quantitative and qualitative assessment methodologies (Miccio-Fonseca & Rasmussen, 2009; Ralph & Wong, 2013). In gathering this information, the evaluator is able to paint a comprehensive picture of the factors contributing to problem behaviors in these juveniles.

Risk assessments should include multiple sources of information on multiple life domains

Interviews with parents/guardians of sexually abusive juveniles should include parental perception of the offense and their concerns about the juvenile's risk for future offending. Assessing parental cooperation with supervision, treatment and intervention is important. One type of treatment, Multi-Systemic Treatment, has identified parental capacity for parenting and hostile interactions between juveniles and their parents as predictive of future delinquent behavior (Borduin, Schaeffer & Heiblum, 2009). These familial dynamics should be addressed in risk assessments.

Evaluators must remember that the prevalence of nonsexual reoffending for male sexually abusive juveniles is higher than that for sexual reoffending (Seto & Lalumiere, 2010). Therefore, public safety is also at risk as a result of nonsexual offending by sexually abusive juveniles. Risk assessment of this population must include an assessment of risk for nonsexual violence including criminogenic factors (Rich, 2011). The protocol for a comprehensive assessment involves incorporating information from multiple domains related to the juvenile's functioning (Miccio-Fonseca & Rasmussen, 2009). Programs vary significantly in the assessment information available. For example, the CCOSO Research Committee (CCOSO, 2012) survey found 58% of residential settings in a state-wide survey had records regarding DSM-IV diagnosis, educational, and cognitive testing, but only 6% of outpatient programs did. Recommended areas of risk assessment include:

- Relevant background and identifying information. All relevant probation, police, educational, mental health, and other records should be required.

- Cognitive and academic functioning and intellectual capacity. This should be assessed through formal cognitive and academic testing, especially with respect to their ability to understand their sexually abusive behavior as well as interventions. This is especially important given the high rates of juveniles with developmental and learning challenges in this population.
- Psychiatric diagnoses including an assessment using DSM IV- TR or DSM V.
- Physical functioning (hearing impairment, visual problems, speech problems, physical disabilities).

(The following should be obtained from records as well as from interviewing the juvenile, parent/guardian, probation officer, or other key informants where possible).

- Social, developmental and medical history and educational history
- Peer relationship history and level of social functioning
- Trauma history
- Mental health and psychiatric history
- Family history, religious values if relevant and current level of functioning
- History of non-sexual problem and delinquent behavior
- History of substance abuse
- Sexual development and interests
- History of sexually abusive behavior
- Details of the current index offense and related sexual offenses
- Environmental concerns (e.g. level of neighborhood violence, or presence of gangs)
- Technology usage patterns and level of supervision (eg. Social media, internet, texting)
- Availability of environmental supports such as pro-social mentors or community organizations
- Amenability to treatment (Rich, 2011; Coffey, 2006).

Addressing pro-social skills deficiencies as well as an emphasis on building on current strengths with an attitude of hope is associated with treatment success.

Interviews with sexually abusive juveniles should be sensitive to developmental factors. For example, the adolescent's ability to take responsibility for offense behavior, understand the harmful effects of their behavior upon their victims requires a level of sophistication

challenging for most teens. A distinction should be made between what is developmentally difficult for the average teen male and what is criminogenic.

Furthermore, accurate assessment of risk should include a review of the sexually abusive adolescent's victim's statement about the crime committed if available.

Because an adolescent is living within a complex system, evaluating the strengths of a given adolescent's current family, school, and neighborhood situation should be part of a risk assessment. Strengths including the presence of resilience factors as well as family, social and academic strengths provide all collaborators with useful information needed for the sexually abusive adolescent's success.

Monitoring and Evaluating Changes in Risk Level

Righthand and colleagues (Righthand, Hecker, and Dore, 2012) suggest that risk assessment of juveniles needs to take place not only before treatment, but at regular intervals during treatment and at termination. Clear and measurable criteria regarding discharge from treatment are important. They have authored and done relevant research with an instrument designed for this purpose, the Juvenile Sex Offense Specific Treatment Needs & Progress Scale. However, a risk assessment needs to be done at discharge even if treatment is completed and successful to ensure that an accurate picture of risk is taken at this important point in the treatment process.

Other instruments for assessing non-sexual recidivism are available. This is important since non-sexual recidivism is identified in some research as occurring. See for example the *Structured Assessment of Violence Risk in Youth, Version 1.1 (SAVRY)* (Borum, Bartell, & Forth, 2003) and the Youth Assessment and Screening Instrument (Baglivio, 2009). However, these instruments do not assess risk for sexually abusive behaviors.

Diagnostic clinical tools are available which are not risk assessment tools but are very helpful in assessing sexual interest, which is important in treatment planning for these youth (*Multidimensional Inventory of Development, Sex, and Aggression* (MIDSA – Auger Enterprises, 2007).

Risk Assessment Considerations

Risk assessments should be sensitive to gender and sexual orientation issues and the adolescent's language and cultural milieu (Miccio-Fonseca, 2013). If necessary, a certified translator should be used when the adolescent or their family does not speak English and the examiner is not fluent in the family's language.

Evaluating the strengths of a given adolescent's current situation should be part of a risk assessment

Structurally, assessments regarding risk of recidivism should include review of the sexually abusive adolescent's current records, parental interviews, interviews with other professionals who are working with the sexually abusive adolescent and face-to-face interviews with the sexually abusive adolescent (Miccio-Fonseca & Rasmussen, 2009; Rich, 2011).

Treatment Guidelines

Sexually abusive juveniles are treated in a variety of settings including outpatient, residential, and secure detention. The following elements of treatment have been demonstrated to be predictors of treatment success and reduced recidivism and would likely be relevant in all of those settings:

- Individualized treatment: Treatment individualized to each sexually abusive adolescent's needs. Factors such as the type of treatment, duration, setting, and intensity of treatment should be customized. (Blasingame, 2012; Andrews and Bonta, 2007). Treatment that does not match the needs and risk level of the juvenile is associated with adverse outcomes in the general probation population (Hoge & Bonta, 2010) and is likely to also be the case with juveniles with adjudicated sexual offenses (Epperson, 2012).
- Treatment focused on non-sexual recidivism factors and co-morbid factors: Curriculum and treatment addressing non-sexual and associated conditions and recidivism contribute to treatment success (Borduin, Schaffer, and Heiblum, 2009; Lipsey, Howell, Kelly, Chapman and Carver, 2010; Ward, Mann, & Gannon, 2007)
- Treatment focused on prosocial skill building as well as hope and strength based approaches: Addressing pro-social skills deficiencies as well as an emphasis on building on current strengths with an attitude of hope is associated with treatment success. (Lipsey, Howell, Kelly, Chapman and Carver, 2010; Ward, Mann, & Gannon, 2007; Worling & Langton, 2012)

- Supportive relationship between treatment staff and juveniles: Positive treatment outcomes have been seen in treatment programs that have fostered positive relationships between treatment staff and the sexually abusive juvenile (Leversee and Powell , 2012; Norcross and Lambert , 2011)
- Prosocial treatment interventions are important: Lipsey, Howell, Kelly, Chapman, and Carver (2010) in studying the general probation population, not just those who sexually offend, identified Prosocial/Case Management oriented treatments as more effective. They emphasized social skill building, counseling services, victim restitution, and coordinated case management services. Those that emphasized a prosocial approach—including restorative, skill building, counseling, and case management services—produced about a 10% or higher level of reduction in recidivism.
- Interventions that fit the individual juvenile’s needs are more important than the type of intervention used: Lipsey, Howell, Kelly, Chapman, and Carver (2010) noted that programs that fit the needs of juvenile were more likely to result in 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 well-known programs. Addressing pro-social skills deficiencies as well as an emphasis on building on current strengths with an attitude of hope is associated with treatment success. Providing an adequate amount and quality of services was associated with better treatment outcomes. Their reviews suggest that not only well-known "name brand" programs were effective (CBT, ART, MST, etc.), but other approaches were as well.
- Intervention modality is less important than good program design: Reitzel and Carbonnel (2006) conducted a meta-analysis of nine studies of juveniles who sexually offended with a total sample size of 2,968 primarily male youth. Every study included

Interventions that fit the individual youth’s needs are more important than the type of intervention used.

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 juveniles). Effectiveness was not limited to cognitive behavioral programs, but was evident with other models. Lipsey,

Howell, Kelly, Chapman, and Carver (2010) noted that higher-quality of designs were associated with a better treatment effect.

One area of focus, which should be considered in treatment, is the role of technology in the juvenile's day to day activities. Current and emerging technologies seem to be more quickly adopted by adolescents and children, often, than by their adult caregivers and treatment providers. Incorporating the role of these emerging technologies into the individualized treatment of sexually abusive juveniles is recommended. This is an area that needs further research to understand the role of this technology on the juvenile's risk or treatment success. This topic will likely be addressed further in future versions of these guidelines.

Treatment for sexually abusive youth is a different model than usual adolescent outpatient psychotherapy.

Orientation and Consent for Treatment

It is important to spend significant time regarding orientation to treatment and developing consent for treatment (Blasingame, 2012; Worling, 2012). Treatment for sexually abusive juveniles is a different model than usual adolescent outpatient psychotherapy. An important difference is that treatment with this population has two goals, public safety and the treatment needs of the juvenile. Developing a consent for treatment process and an orientation to treatment that discuss both of these issues is essential. For example, a Consent for Treatment form that allows regular contact with probation regarding exchanging important information is essential. When appropriate, noncompliance or non-attendance with treatment would be seen as a violation for probation departments. Developing a treatment consent process which is specific while also being flexible regarding various possible contingencies is essential.

It is essential to acknowledge the stress that the youth and their families likely experience, while not minimizing the harm done to victims.

Many sexually abusive juveniles who enter treatment require less probation supervision due to the characteristics of their case (i.e. informal probation). For example, juveniles who have engaged in sexually inappropriate behavior that is seen as posing low risk for future inappropriate behavior might require minimal probation supervision. In these cases, minimal probation involvement might be appropriate given the circumstances of the case and the principals of Risk,

Need Responsivity outlined above. In these lower risk situations, less information should be released to probation than in more severe sexual abuse cases.

Most sexually abusive juveniles and their families are significantly stressed by all that has come before when starting treatment. This includes the arrest, possible detention, and litigation regarding the offense. The juveniles and family understandably are cautious, even fearful, and often defensive. This should be regarded as a normal and understandable response to this quite difficult situation. It is essential to acknowledge the stress that the juveniles and their families likely experience, while not minimizing the harm done to victims. For those appropriate for outpatient treatment, families typically can be reassured that the "worst is over" and the goals of probation, treatment providers, the juveniles, and family are the same. These goals would be for the juveniles to live a good prosocial life, have no further problems with probation, and get "back on track" with a normal and healthy adolescence. Developing a balance between opportunities for normal adolescent growth and development, and having the juvenile avoid high risk situations requires careful collaboration with all parties as is appropriate for the individual case.

If individual treatment goals have been reached and the youth's risk for re-offense has been minimized, all parties should work towards termination of sex-offender specific treatment.

An essential part for many treatment settings is a "Safety Plan" which is developed collaboratively between probation, treatment provider, and the juvenile and their family early

The key feature of effective treatment outcome, often overlooked in discussions of the treatment for sexually abusive juveniles, is the role of probation

in treatment. The purpose of this plan is not only to ensure public safety, but also the safety of the juvenile and avoiding situations where the juvenile might be at risk for being inappropriately blamed. This should be an extension of the usual "conditions of probation" with more specific elements describing conditions relevant for juveniles with sexual offending, such as no unsupervised contact with younger children, no contact with victims, no use of pornographic materials, and so forth.

The key feature of effective treatment outcome, often overlooked in discussions of the treatment for sexually abusive juveniles, is the role of probation. Lipsey (2009) has identified intensive supervision levels as associated with better outcomes for the general probation population, and likely true for sexually abusive juveniles

who are on formal probation. Weekly contact with probation officers, probation visits to school or work sites, and visits to the home, are desirable. Also the use of a "collaborative model" as opposed to an adult-oriented "Containment Model" is seen as beneficial (see discussion above). This means that close and regular collaboration between the treatment providers and probation officers is essential and should be based upon the individual characteristics of the case.

Treatment Completion

Treatment is seen as the beginning of a long-term commitment by the sexually abusive juveniles and their family to ensure that the abusive behavior does not recur. However, as the juvenile participates in treatment, they will typically complete enough of the program to warrant transitioning out of the current treatment program and into a lower level of care. The timing of this transition should be considered by all members of the treatment team as well as probation, when appropriate. When considering this transition, the sexually abusive juvenile, their family and other involved parties (such as probation officers) should review the juvenile's individualized goals, which were established at the beginning of treatment as well as the juvenile's level of risk for re-offense. If these goals have been reached and their risk for re-offense has been minimized, all parties should work towards termination of sex offender-specific treatment. At this point in treatment it is important to recommend additional ongoing treatment for other conditions such as ADHD, general delinquency issues, or substance abuse since these may be factors contributing to both sexual and nonsexual recidivism.

Polygraphy

While CCOSO supports the use of polygraph in the Containment Model (Flinton, 2010) used to manage adult sex offenders, the inclusion of this information gathering technique in the treatment oriented collaborative juvenile offender model is provisional.

The provisional inclusion of this information gathering technique is based upon several concerns in the field about using this technique with the adolescent population. CCOSO recommends that individual practitioners, mental health workers, probation officers and polygraphers be aware of and address these concerns prior to using this technique with male sexually abusive juveniles. The primary concerns include:

Polygraphy should only be used with a full understanding of the issues surrounding its use with this population

- Validity

While several articles address the validity and reliability of polygraph with the adult population (Hindman & Peters, 2001; Krueger, 2009; Grubin & Masden, 2006; Committee to Review the Scientific Evidence on the Polygraph, 2003) concerns about the theoretical underpinnings of polygraphy as well as its validity and reliability are highlighted. Furthermore, these sources are based almost exclusively upon the adult population and do not cover the juvenile population. While some articles do address the use of polygraphy in the adolescent population (Hindman & Peters, 2001), the question of validity and reliability is not suitably addressed to include polygraphy as a recommended mode of information gathering.

- Child Abuse Reporting

Additional child abuse cases discovered during polygraph examination must be reported to appropriate law enforcement or child protection agencies as required by California state law.

The impact of these additional child abuse reports upon a given juvenile's ongoing court process should be considered prior to the administration of the polygraph. For example, if a new sexual abuse case arises as a result of their polygraph process, this case could have implications in future evaluations for new offenses either sexual or non-sexual.

- Current Research

Individuals working within the collaborative model of treating sexually abusive juveniles should remain aware of ongoing research about the use of polygraphy with this population. This is a controversial use of the tool, so further research needs to be forthcoming. Tracking the research activities by way of the American Polygraph Association (polygraph.org) and the California Association of Polygraph Examiners (californiapolygraph.com) is an effective way for keeping up with current research.

Polygraph use is associated with higher disclosure of victims and other relevant information. However increased disclosure occurs during the course of treatment as well (Worling, 2012). There is no current research demonstrating that the use of polygraph is associated with better treatment outcomes, but this is also true of many areas assessed in these juveniles. Prescott (2010) urges caution, and notes, "The use of polygraph examinations with juveniles, to the present, remains empirically unsupported and potentially counterproductive" (p. 7). Many practitioners are concerned that the

use of polygraphs helps maintain an antisocial and pessimistic narrative regarding these juveniles, for example, that these juveniles will lie or minimize regarding offenses, and the only way to obtain this information is regarding coercive rather than consensual methods. This is an area of practice that merits further research.

- Current Practice

In a recent survey those providing treatment to male sexually abusive juveniles in California, 19% of providers who responded were using polygraphs in practice (CCOSO, 2012).

The reader should also know that The California Association of Polygraph Examiners (personal correspondence, May, 2011) has endorsed the use of polygraph with the sexually abusive juvenile population as long as American Polygraph Association Post Conviction Sex Offender Testing Guidelines are followed. Also, many practitioners work with sexually abusive juveniles find the polygraph to be a useful tool for gathering information.

As a result of this information, CCOSO recommends caution. Consultation with applicable professional standards should occur prior to use of this technique with this population. If polygraph is to be used, the reader is encouraged to understand the controversy surrounding its use with this population.

Summary

These guidelines for the assessment and treatment for sexually abusive juveniles were written with the goal of preventing future recidivism and promoting the prosocial development of juveniles. The guidelines emphasize the physical development, cognitive, and social factors unique to the adolescent populations distinct from the adult population. Having practitioners who have experience, training, and credentialing consistent with current standards of care is required.

A collaborative approach is recommended involving juvenile probation, treatment provider organizations, and the sexually abusive juveniles and their family. Where possible a collaborative relationship with the parties including the juveniles and their family should be implemented.

A comprehensive assessment of the juvenile should be conducted which includes an assessment of factors which contribute to sexual recidivism. The assessment should also

include comorbid psychiatric, neuropsychological, trauma related, and substance abuse factors. Part of this should include use of adequate research regarding their appropriateness for this population. Assessment should also occur during treatment and at discharge so that adjustments can be made to treatment and discharge plans. The use of instruments to assess for sexual recidivism which have adequate scientific research is important.

Treatment methods used should be consistent with evidence-based practice regarding specific methods, intensity, and duration. The guidelines note that a variety of treatment approaches have been shown to be effective. Consent for treatment is an important step to ensure appropriate collaboration with probation but also respecting the privacy of the juvenile. While polygraph is used by many practitioners, there is a diversity of opinion regarding their effectiveness and suitability.

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Appendix

Area Under the Curve (AUC)

Accuracy of risk assessment tools is generally determined through a statistic referred to as the Area Under the Curve (AUC). AUC refers to how accurate a given test is for identifying a characteristic of an individual. It refers to “the probability that a randomly selected recidivist has a higher value on a risk-assessment instrument than a randomly selected non-recidivist” (Duwe & Freske, 2012, p. 2). As a result, *the AUC is the percent of individuals that are correctly classified by a test* and ranges from 0 to 1. An AUC value of .50 means that 50% of individuals are correctly identified and is the same as being selected by chance (flip of a coin). Above .50 means better than chance and below .50 means worse than chance.

Most research on current juvenile risk assessment tools has found modest AUC values of .65 to .70. However, recent research gives cause for optimism as progress is being made in improving the accuracy of risk assessment tools. Several studies in 2010-2012 using the ERASOR have shown a Total score AUC between .71 and .74 (Worling et al., 2012; Chu et al., 2012, and Rajlic & Gretton, 2010). Also, the MEGA cross-validation showed an AUC of .71 (Miccio-Fonseca, 2013). AUC's over .71 are considered "larger than typical" in the child psychiatry literature (Kraemer, Morgan and Leach, et al., 2003). However, it should be noted that even with an AUC of .70, 30% of non-recidivists would have a higher score than recidivists.

A recent meta-analysis compared three of the risk assessment tools (J-SOAP-II, ERASOR, JSORRAT-II), along with the adult tool Static-99, and found no significant differences between the tools in their ability to predict sexual recidivism (Viljoen, Mordell, & Beneteau, 2012). Also this study found modest predictive validity of these youth oriented tools, with aggregated AUC scores ranging from .64 to .67.