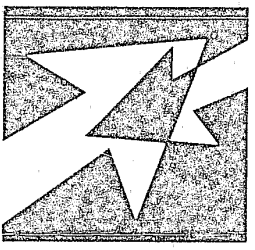

TRANSFER OF KNOWLEDGE WORKSHOP

PROVIDING A CONTINUUM OF CARE FOR THE Adolescent Sex Offender

MENT OF THE YOUTH AUTHORITY
OF CRIMINAL JUSTICE PLANNING
September 1987

Additional copies may be obtained from:
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PREFACE

The Department of the Youth Authority, in cooperation with the Office of Criminal Justice Planning, is conducting a series of Transfer of Knowledge Workshops on a variety of subjects that are of importance to the prevention of delinquency, crime and violence.

A Transfer of Knowledge Workshop is not a typical workshop or training event. Based on the belief that there currently exists in California sufficient knowledge and expertise to solve the major problems of crime and delinquency facing our communities, acknowledged experts are brought together to share information and experiences. They present and/or develop program models or action strategies that are then made available to interested individuals, programs, and communities.

The Transfer of Knowledge Workshop on Providing a Continuum of Care for the Adolescent Sex Offender and the resulting publication are dedicated to understanding the extraordinary impact that sex offenders have on their victims and on the community at large. It is also focused on the unique problems in identifying, placing, treating and supervising the adolescent sex offender. The primary objectives of this workshop were to broaden knowledge in this relatively new field and to develop realistic action plans to create an appropriate and comprehensive intervention effort for the young sex offender by the juvenile justice system.

ACKNOWLEDGMENTS

Many individuals, organizations, and agencies contributed to the development and completion of this publication. The Department of the Youth Authority wishes to thank Dr. Steven Bengis of New England Adolescent Research, Inc., of Holyoke, Massachusetts for his skillful and resourceful role as both keynote speaker and workshop moderator. His pioneering work in developing the "Continuum of Care" concept was the core idea of this Transfer of Knowledge Workshop.

The planning committee was made up of representatives from the Youth Authority, the Los Angeles County Sheriff's Department, the California Sexual Assault Investigators Association, the Bay Area Juvenile Sex Offender Treatment Network, the Los Angeles Sex Offender Treatment Roundtable, and several private clinicians. Their many hours of hard work and dedication to task proved that cooperation among those along the intervention continuum can be both successful and rewarding.

We also wish to thank James Rowland, former Director of the Youth Authority. His vision and dedication to resolving the problems in treating young sex offenders have helped to put California in a position of leadership in this area and made this Transfer of Knowledge Workshop possible.

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INTRODUCTION

During the last decade there has been increasing focus on the problems caused by adolescent sexual offenders in the community. The rising number of reported sexual assaults by this age group comes at a time when research is telling us that the adolescent sexual offenders of today are likely to be the adult offenders of tomorrow without appropriate intervention. However, no single part of either the criminal justice system or the therapeutic community is able to provide a complete and effective intervention. The answer to the problem of adolescent sexual offending lies in a systems intervention which provides a continuity of supervision, treatment, and public protection. This idea is the core of the design for this workshop.

This workshop was conducted over three days in Ontario, California, in September 1987. Participants came from diverse professional disciplines along the entire intervention continuum. They brought with them a wide range of experience from law enforcement, the courts, social service agencies, community-based service groups, and the therapeutic community. After a keynote address by Dr. Steven Bengis, a national authority on providing a continuum of care for the adolescent sexual offender, the participants were divided into two types of working groups. The first type was a grouping of individuals who were from similar disciplines. These groups analyzed the system as it exists in California, listing both strengths and weaknesses. Then the participants were divided into five multi-discipline groups. Each group focused on a specific area of the intervention continuum, and produced recommendations and action plans for change. Those recommendations and plans are contained in this text.

During the three days the participants heard several panel discussions. In these discussions individuals from model programs and from representative sections of the intervention continuum presented their view and findings. The panel members were workshop participants as well. Their presentations, along with Dr. Bengis' keynote address, are summarized in this publication.

BACKGROUND

Assessment and treatment of the adolescent sex offender is a relatively new field. Attention focused on the juvenile and adolescent offender subsequent to work with adult offenders after the discovery that most adult offenders started acting out their sexually aggressive behavior while they were quite young (12–16 years of age).[1] Research has shown that many of these young offenders will, if left untreated, become habitual adult offenders. Aggressive sexual acting out by young people is no longer seen as merely adolescent sexual curiosity. Therefore, it is important to have a comprehensive intervention sys-

[1] A. N. Groth and C. M. Laredo, "Juvenile Sex Offenders: Guidelines for Assessment", (International Journal of Offender Therapy and Comparative Criminology), Vol. 25,No. 1, 1981, pp. 31–39.

tem to address the young offender, which includes a team of treatment, custodial, and law enforcement professionals.

The public has become more aware of the problems associated with sexual aggression during the last 10–15 years. Media attention is focusing on sexual aggression, the women's movement, and demands by women to be safe from sexual assault. Public awareness centered at first on the victims of these offenses, and it is still largely concerned with victims' issues. However, there has been increasing attention given to the treatment of the perpetrators of sexual crimes.

As a result of stronger public sentiment against sex crimes, there have been increasing arrests, prosecutions, and commitments to long periods of incarceration for sex offenses. Police departments and district attorneys have become more sophisticated in their efforts to successfully apprehend and prosecute perpetrators. As evidence of this, the Bureau of Criminal Statistics reports that in 1983 there were 2,575 felony arrests of sex offenders under the age of 20. This represents 24% of all the sex-related arrests in the state (10,729). Juvenile arrests (i.e., of those under age 18) for sex offenses in California during the same period numbered 1,850—more than in the prior five years. In 1983 nearly 50% of the arrests for forcible rape in California were of persons under age 25, with nearly 25% of those arests being in the 18–22 year age group.[2] A substantial number of these arrests have and will continue to result in a commitment to the Youth Authority.

In response to these statistics, increased attention has been focused on the pervasiveness of sexual aggression by adolescents. Fay Honey Knopp, a noted researcher and activist in this field, writes that part of this attention by therapists came from the rapid increase of treatment programs for adult sex offenders in the 1970's.[3] The suspicions of many therapists in the field were confirmed when the adult rapists and child molesters began to share their personal histories. These histories consistently contained stories of pubertal and prepubertal sex offenses. In clinical studies of over 1,000 sex offenders over a 16-year period, Dr. A. Nicholas Groth found that the typical age of inception of sexually aggressive acting out for these adult offenders was between 12–16 years of age.[4] It was soon realized that the behavior of a significant number of serious adult sex offenders is patterned on acts that begin near the age of puberty.

Studies have also found that sexual aggression by adolescents is grossly underreported.[5] The offender seldom self-refers to clinicians, due either to

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[2] Statistics from the Bureau of Criminal Statistics as reported in the California Youth Authority Sex Offender Task Force Report—January, 1986.

[3] Fay Honey Knopp, "Remedial Intervention in Adolescent Sex Offenses: Nine Program Descriptions", p.4, (Safer Society Press, Syracuse, NY), 1985.

[4] A. N. Groth and C. M. Loredo, "Juvenile Sex Offenders: Guidelines for Assessment", (International Journal of Offender Therapy and Comparative Criminology), Vol. 25, No. 1, 1981, pp. 31–39.

[5] Knopp, p. 8.

feelings of wrongdoing or, more likely, to fear of adverse legal and social repercussions. The families of offenders tend to minimize, deny, or ignore the existence of the behavior or the need for treatment. In addition, juvenile justice and mental health agencies were reluctant for many years to regard the adolescent offender's behavior as significant. Dr. Groth writes:

> Unfortunately, all too often, such behavior is dismissed as merely sexual curiosity or experimentation, situational in nature, and due to the normal sexual aggressiveness of a sexually maturing adolescent. What should be a priority in our efforts to combat the serious problem of victimization is neglected. No intervention is made at a crucial stage in the early development of the sex offender, at a point where he first begins to exhibit the symptoms of his pathology, and at a time when his assaults have not become an ingrained behavior pattern, when he still may be accessible and responsive to treatment and rehabilitation.[6]

The extent of the underreporting of sexual assaults by adolescents is seen in another important study, conducted by Finkelhor in 1979.[7] Dr. Finkelhor's research, involving 796 male and female students from predominantly white, middle-class backgrounds, found that a large percentage of the students were sexually victimized. The sexually aggressive behavior ranged from exhibitionism and fondling to oral sex and rape. One-third of the women who reported such victimization indicated that their assailant was a male youth betrween the ages of 10 to 19. Of the men who reported similar victimization, almost 40% reported their assailant as a male youth aged 10–19. Again, these statistics come from an experimental group whose ethnic and socioeconomic environment is thought by most of us to be among the safest from these types of assaults. This and other studies not only tend to confirm the findings of Knopp and Groth, but also indicate the degree to which most sexual assault goes unreported.

As a primary provider of rehabilitative treatment for adolescent sex offenders committed by California's juvenile courts, the Youth Authority takes a leadership role in the implementing effective treatment for this population. It also has a major responsibility to protect the public from offenders who are currently unsafe for community-based treatment. However, no agency within the juvenile justice system works in a vacuum. For better or worse, the intervention system involves a series of component agencies and treatment professionals, all of whom must work cooperatively if successful intervention with the sex offender is to be achieved. At best, the effectiveness of intervention efforts that are not coordinated with other parts of the intervention continuum tend to be minimal. In the worst case, noncoordinated efforts can minimize or even encourage the thinking errors which are at the root of the offender's sexually aggressive behavior. Disjointed service is little or no ser

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[6] Groth and Loredo, p. 31.

[7] D. Finkelhor, "Sexually Victimized Children", (The Free Press, New York), 1979, pp. 74–81.

vice at all, and for this reason the Youth Authority has invited professionals from throughout California to examine the current state of the intervention system for young sexual perpetrators.

This model sequences services from the point of first contact with the criminal justice system through Aftercare. In turn, each component needs to function cooperatively with the other parts of the system. By way of example, those involved in the Investigation component can ensure complete police reports that accurately outline all of the offending behavior that occurred. Complete victim statements and witness statements are also very helpful during subsequent treatment. Prosecution needs to be both firm and specific to the sexual offense. No favor is done to the offender who is not prosecuted for the behavior he committed. The disposition should balance the protection of the victim with the protection of the rights of the offender. Those involved in assessment should be aware that typical mental health assessments are not appropriate with the adolescent sex offender, and are of little help to judges prior to sentencing.

Each of the components outlined above must be present for an intervention system to be effective. No one component or group of components can function alone and hope to be effective. Specialization is important in providing services to sex offenders, because specific training in sexual offense dynamics is a necessary adjunct to one's own professional training. An intervention system such as this not only treats the offender, but helps to prevent sexual victimization by eliminating the offending behavior. Dealing with sexual abuse by concentrating solely on treating victims is tantamount to treating diarrhea by building outhouses. Real prevention has to include specialized sex offender intervention. The time to start is now!

PANEL DISCUSSIONS

Systems Issues in Providing a Continuum of Care

Summary of a Panel Discussion Involving Representatives from Different Components of the Intervention Continuum

Sgt. Toby Tyler—Law Enforcement

If law enforcement does not do its job properly, no one else gets a chance!

Sex crimes investigations are initiated by the patrol officer. Often the officer's own emotions get in the way of an accurate investigation. The officer's personal outrage at what happened to the victim can cause a "tunnel vision" to occur. This can prevent the officer from getting information as to how long the offenses have been going on, or whether or not the perpetrator has at some time been a victim of sexual or physical assault. The officer's own emotional baggage may keep him/her from doing a thorough investigation.

The P.O.S.T. minimum training standards for peace officer training include nonmandatory guidelines for training sexual assault investigators. Therefore, law enforcement academies are not required to provide such training. In the San Bernardino Sheriff's Academy there are 12 hours devoted to this specialized training. A licensed social worker takes up to 4 hours of this time to explain sex offender treatment. This is quite a bit more than the average in academies across the state.

Traditionally law enforcement does not look favorably on treatment. In California officers have experienced disillusion with facilities such as the Norco substance abuse program and the old Mentally Disordered Sex Offender Program at Atascadero State Hospital. Both programs had highly publicized failure rates and high re-offense rates. Officers are wary of trusting the new modes of treating sex offenders. However, we need to recognize that sex crimes affect not only the current victim, but future victims as well as society as a whole. And the only long-term preventative measure is effective treatment of the identified sexual offender.

Nancy Stretch—Prosecutor

Historically, prosecutors and law enforcement are bunched together. Typically prosecutors are anti-treatment. They make their decisions on information that is basically second-hand; i.e., from the victim and from witnesses. They do not typically talk to the perpetrator. They see their role as primarily to protect the community by removing the perpetrator from its midst.

San Francisco County uses a vertical prosecution model for prosecuting sexual offenses. Most large jurisdictions in California use this model because it is clearly more efficient. If a county needs money to implement vertical prosecution there are funds available. In smaller areas OCJP and other agencies have funds for specialized training for prosecutors handling sex cases.

The prosecutor's role usually ends with the disposition. However, prosecutors can legally follow up on their cases prior to the perpetrator's release to see what treatment progress has been made. Sometimes institutions are stingy with information in their efforts to protect the privacy rights of the per-

petrator. In San Francisco the Youth Authority established a specialized parole program for sex offenders. The parole agent assigned to that program became the conduit for information between the district attorney's office, the probation department, and the Youth Authority. This made information concerning treatment and public safety easier to share.

San Francisco has also developed an inter-agency protocol for handling sexual offenders and their victims. Each agency has agreed to specific interventions and cooperative strategies. The process helped each part of the system understand what the other part does. Cooperation is difficult when each professional guards his own turf. They have to be willing to learn each other's language, as well as each other's role and function. Sometimes others ascribe more power to the district attorney's office than really exists.

Judge Daniel Weinstein—The Judiciary

When Judge Weinstein first came to the bench, he had no real experience with sex offenders. As a result the first two cases he encountered, though their behavior was similar, received very different treatment. Both offenders were arrested for molesting a younger sibling. In the first case the probation officer wrote a very judgmental report recommending placement in the Youth Authority without much regard to a valid risk assessment. Not knowing any better Judge Weinstein sent him to the CYA. In the second case a different probation officer took a completely opposite view, and saw the offender as more a victim than a perpetrator, and therefore recommended community treatment. Both offenders looked relatively similar, and yet probation recommended dispositions that were polar opposites.

As Ms. Stretch indicated, several individuals in San Francisco's probation and mental health departments got together and helped develop a common intervention protocol. Now sex offenders are handled by probation officers with specialized training. These officers coordinate treatment with specific therapists from the Department of Mental Health. They also communicate with the Department of Social Services and the Prosecutor's Office. Disposition reports now represent the combined thinking of all of these professionals.

There has to be communication between the Bench and the treatment providers, regardless of whether the treatment takes place in the community or in a closed custody setting. In turn, the Bench has to give treatment providers the leverage they need in order to provide effective treatment. By way of example, Judge Weinstein recommended that all juvenile sex offenders should be given suspended time as leverage to be used in community treatment. Young sex offenders should be kept under the court's jurisdiction until the age of 18, and in some cases to the age of 21 if possible. There should be regular progress reports to the bench concerning progress in treatment. The juvenile court (unlike adult court) can require parents to cooperate in their child's treatment through the use of the contempt power.

If the problem of juvenile sex offending is as bad as the professionals are saying it is, then the judges need to help lobby in their communities for

change. They have to come down from their bench and go into the community, using the prestige of their office to advocate for needed services. When judges go with the professionals to speak to the Rotary Clubs and to the Legislature they can really help make a difference.

Noreen Grella—Department of Social Services

The system in California is currently faced with one of its biggest challenges: defining "child abuse" and the services to be provided to the victims. Current legislation has been enacted to define child abuse as "serious physical harm" to the child victim. However, much of the child molest and other sexual abuse of children does not involve gross physical harm, but does impart serious psychological trauma that is in some cases crippling. Serious physical abuse is only a small part of the child abuse that occurs in California. A lot of counties supported this legislation because it effectively legislated away their responsibility to provide treatment services to child victims. Social service agencies will no longer be able to work with those sexually molested by others unless there is evidence of serious physical harm.

Social workers in the system who do sex offender assessments are generally not adequately trained. There are not yet training standards for mental health providers to work with sex offenders. Training exists for law enforcement personnel, even if only in the police academies of large jurisdictions; but few schools of social work have similar training. This is an absolute outrage! Additionally, though there are state-mandated standards for minimum numbers of credentialed social workers in county agencies, these agencies typically operate grossly understaffed through the use of waivers. This is because it is hard to keep credentialed employees at current wage scales. The average child welfare worker in Los Angeles County has only two years of experience.

Ms. Grella runs a treatment program called PACT (Parents and Children Together). It is the only program in Orange County which provides treatment services to abusive families. The senior social workers in that program are the only social workers employed by the county whose job descriptions include treatment for abused children. There are 18 interns who make up the rest of the treatment staff.

As a member of the State Advisory Group of the Office of Criminal Justice Planning, Ms. Grella stated she knows there is money available in the State Agency Category to sponsor demonstration projects, and feels that if the Youth Authority chose to, it could propose a pilot project which would operate under the principle of "continuum of care" for funding under this category.

Gary Lowe—Closed Custody Treatment

Prior to starting specialized treatment for sex offenders at the CYA's Preston School of Industry several years ago, sexual offenders received the same generic mental health treatment services as anyone else. The sexual offense dynamics were generally not addressed, and sex offenders were released with only somewhat better social skills, and the authorities wondered why they were re-offending at such an alarming rate.

In 1984 the Youth Authority established a task force to look at the adolescent sex offender with reference to what services were needed and what should be provided. At that time most therapists who worked with sex offenders were doing so in isolation. The CYA brought these isolated therapists together in two regional training conferences held that same year. Through these conferences, networks were formed which made it possible to share information between therapists and others who worked with sex offenders. This helped professionals self-educate and also expanded the numbers of professionals who were willing to work with sex offenders. One of the results of the task force's report was the goal of the CYA to provide offense-specific treatment to all offenders in the Youth Authority. Additionally the CYA established specialized parole caseloads to provide appropriate supervision and treatment to sex offenders after their release.

There are still some problems within the Youth Authority. There are some psychologists who still think it appropriate to keep therapy information confidential from living unit staff. Some treatment staff believe that the offender has to be motivated or self-referred to be appropriate for effective treatment. This is not borne out in our clinical experience with offenders at the Oak Lodge Program.

Effective treatment takes time. An average length of stay at Oak Lodge is two years, and is going up. Though commitments are increasing, there has not been a concomitant increase in resources or special treatment beds. The problems experienced by closed custody treatment programs are similar to those in other settings in that there appears to be a lack of coordination of resources. However, this TOK process is a good place to start to reverse this trend.

Some treatment assumptions shared with other treatment programs from around the country are:

- Sex offense specific treatment should be available in all CYA institutions. They should be interfaced with law enforcement, special education, and child protective services.
- Adolescent sex offenders require a specialized treatment approach.
- Offense specific treatment should be mandated. It should include interdisciplinary and multi-modal approaches.
- Aftercare protects our investment in treatment. Without appropriate aftercare, treatment is generally invalidated upon the offender's release and perhaps should not be attempted. Aftercare should be mandated in the court order or the parole board's release order.

Identification and Assessment

Summary of a Panel Discussion Involving Representatives from the Identification and Initial Assessment Phases of the Intervention Continuum

Sgt. Beth Dickenson—Sexual Assault Investigation

Law enforcement agencies are usually the first component of the intervention continuum to come in contact with the offender. Often sex offenders have avoided detection because the law enforcement officers investigating the

case fail to recognize the seriousness of the offender's behavior. They have dismissed the behavior either as "children playing 'doctor' " or as "boys will be boys." This is particularly true of "nuisance" crimes such as exhibition or peeping. Through proper training and self-education, law enforcement officials can become sensitized to the seriousness of offender behavior. Additionally, as we start to recognize that some juvenile sex offenders have also been victims of sexual offenses, officers may be able to identify adult sexual offenders in the young offender's environment.

In a recent study by the FBI Behavioral Sciences Division in Quantico, Virginia,[1] the offense behavior of 41 adult serial rapists was examined and it was found that:

- These 41 rapists had been responsible for over 1200 sexual assaults as adults (in addition to over 100 as adolescents).
- 56% of the rapists had been victims of sexual assaults. Another 12% had witnessed a significant sexual act (e.g., a rape of a parent).
- 48% of those who had earlier victimized the rapists were male; 32% were female; 10% had been victimized by both males and females.
- 51% of the rapists exhibited offending behavior which was a direct reenactment of their own sexual abuse during their adolescence.
- 68% of these rapists had histories of voyeurism as adolescents.

The investigation process starts with the initial complaint. The subsequent investigation determines if there is enough evidence to believe a crime has been committed. If there has been and the offender is a minor, the question is whether to detain the offender. In deciding this question officers should look at the offender's:

- Criminal history
- Level of denial
- Family history (there is also a need to assess the parents' attitude)
- School history
- Violence content in the offending behavior
- Concern for the victim

After the investigation has been completed, the investigator has wide discretion over how to disposed of the case. "Counsel and Release" is a disposition that is unfortunately used often with nuisance crimes. This is a dangerous practice for law enforcement. Not only is there a possibility that a future perpetrator is being ignored, there is no follow-up referral of the nuisance offender to appropriate treatment. The investigator also has the option of:

- Referring a sex offender to a treatment facility without prosecution
- Releasing offender to his parent(s) and referring the case to the District Attorney for prosecution
- Detaining the minor and referring the case for prosecution

In Los Angeles County the sex crimes investigators typically interact with the probation department, the district attorney's office, parole, and commu-

[1] Roy Hazelwood, Special Agent–FBI, and Dr. Ann Burgess of the University of Pennsylvania

nity treatment providers when investigating sex offenses by young people. Some agencies do not have this level of involvement. There is much room for improvement in how law enforcement processes these cases. The key to reducing the escalation of sex offenses and further victimization by juveniles and adolescents is early identification, intervention, and responsible disposition of juvenile sex offender cases.

Dr. Dee Shafer—Risk Assessment

Dr. Shafer is currently the Director of the Juvenile Sex Offender Treatment Program of the Ventura County Department of Mental Health. This is one of the three pilot sex offender community treatment programs funded by the Legislature through SB 890 in 1986. The assessment process she discussed is that which is used in the Ventura program.

After a referral is received from the probation department of a minor who has had a true finding for sexual offending, a psychological evaluation is done by program staff who are therapists specializing in sex offender cases. After the evaluation is completed, it is sent to the juvenile court judge who then makes the disposition. If the minor is on probation, he is mandated to treatment within the program. Regular contact (often daily) is maintained between the probation officer and program staff, and regular progress reports are sent to the court. All adjudicated sex offenders with probation sentences of six months or longer, are given outpatient treatment within the program. Unfortunately, the probation department does not have specialized sex offender caseloads, and the voyeurs and exhibitionists are not treated by the program. This would make the program more efficient.

In assessment for treatment staff look at the nature and severity of the sexual offense, as well as the psychopathology of the offender and his family. Staff try to assess dangerousness in terms of the likelihood of re-offense and the violence potential of the offender, using the following process:

- Make a thorough psychological evaluation with emphasis on sexual history and deviation, as well as any possible victimization of the offender
- Collect the police report, prior psychological evaluations, probation reports, and victim statements
- Interview the offender and his parents
- Get a detailed sexual history, criminal history, and history of prior treatment
- Look for psychological difficulties in addition to the sexual acting out. Determine if the offender is a substance abuser
- Examine the offender's family dynamics
- Examine the offender's current level of functioning with siblings, school mates, family, and peers
- Conduct psychological testing using the MMPI, a Risk Assessment Instrument, and the Jesness Inventory at minimum

It should be noted that there is a lack of really useful clinical tests for sex offenders. Primary information comes from clinical interviews with the sex of-

fender and from environmental sources. The assessor should keep these things in mind during the interview process:

- Intensity of the deviancy (how large a role does the deviancy play in the offender's life?)
- Developmental patterns (are they limited or advanced?)
- Sex offender's relationship to the victim
- Offender's motivation for offending
- Check for a history of victimization (who, how often, to what extent?)
- Distorted sexual socialization
- Victimization of siblings or significant others
- Presence of hardcore pornography in the offender's environment
- Sexual repression or over-stimulation (This leads to heightened interest in sexuality, and often to thinking errors.)
- Other sorts of sexual deviancy besides the present offense
  Masturbatory behavior and fantasies (Interviewer should ask these questions in several different ways in order to overcome offender's hesitancy)
  Exhibitionism or voyeurism
  Stealing underwear
  Ritualism
  Prostitution (Is the offender the buyer or the seller?)
  Other psychopathologies that could be associated with victimization (i.e., significant periods of amnesia for early childhood events; indication of post-traumatic stress syndrome; multiple personality)

In assessing dangerousness the offender's degree of sexual deviancy, and other complicating factors such as family problems and substance abuse are looked at. The environmental factors are examined to see if they have changed since the time of the offense. Staff also look at the offender's motivation for treatment and his impulse-control development. The offender's violence potential is examined separately. The home environment is looked at for models of violence, and themes in fantasies and artwork are examined for violence content. Motivation for treatment can be misleading. Sometimes the most motivated child is the one with the least problems. One must be careful in being too conservative in making amenability judgments.

Commissioner Ben Schaffer—Juvenile Court Process

In Los Angeles County during 1985, a little over 2% of the juvenile court referrals were for sexual offenses (c. 800–850). Prior to a hearing, the juvenile court has several options at its disposal:

- *Dismissal*—Determination is made that there is no need for further services. The family is so shocked by the offense that they are appropriately mobilized to seek therapy for the offender. This is extremely rare!
- *Informal* Supervision—The offender is informally supervised by probation without being declared a ward of the court. An agreement is made between the parents and probation on how to work on the problem. The court is then out of the picture. This is sometimes appropriate, and sometimes a convenient way of avoiding the issue.

If neither option is utilized, there is either an admission of guilt by the minor or a fact-finding trial. If a true finding is made, the judge then asks the probation department for a pre-sentence report and also a psychological evaluation. The quality and specificity of both of these reports largely depend on the training and motivation of the professional. Unfortunately, there is quite a disparity in the quality of the reports submitted. After the reports are received and the arguments from the attorneys are heard, the judge must make a disposition in the matter. The following are the dispositions open to the court.

- *Probation without wardship being declared*—This probably provides the least intensive supervision, and has the least leverage on the ward's subsequent behavior.
- *Probation with a declaration of wardship and with conditions of probation.* This is usually preferable. However, in order to mandate treatment, there needs to be appropriate treatment resources within the community as well as funding sources for this treatment. Also the size of probation caseloads becomes a factor in determining whether or not the ward would be properly supervised.
- *Probation and placement outside the home in foster care or residential treatment*—This is commonly called "Suitable placement." However, what is an appropriate placement for a juvenile sex offender? Are the facilities in the community willing to accept the minor? Are the facilities able to provide appropriate treatment? Does probation have sufficient resources to follow through with the case effectively?
- *Probation and detention in a probation camp, juvenile hall, or similar facility.* These are settings for fairly delinquent youngsters. Is this an appropriate placement for sex offenders? Will there be meaningful treatment?
- *Order to place in specific county-run programs*—Is it appropriate for the judge to order an individual minor into a specific program, thereby taking all discretion away from probation? Can the chief probation officer comply with the order?
- *Commitment to the Youth Authority*—This is the end of the line for juvenile court alternatives. Should the judge refer to the Youth Authority as a last resort, or because they have the best programs available, or both?
- *Remand to Adult Court*—This would involve a fitness hearing. Current statutes result in most 16–17 year old violent sex offenders going to the adult court if the district attorney so requests.

Judges look to the mental health professionals and to probation officials for guidance. They are the experts in terms of knowing the availability and appropriateness of treatment resources.

Treatment Programs in Residential, Outpatient, and Closed Custody Settings

Summary of a Panel Discussion Involving Representatives from Typical Treatment Programs for Sex Offenders and Child Victims of Sexual Abuse

Betty Van Order—Child Abuse Intervention Project—Ventura Juvenile Hall

The goal of this program is to reduce the recidivism of those who have been victims of child abuse, and who come under the jurisdiction of the Ventura County Corrections Services Agency. The program is funded through an OCJP grant. Prior to the initiation of the program, the probation department had no policy nor program to intervene with child abuse victims.

The program works with youth committed to the Ventura Juvenile Hall, the Juvenile Restitution Project (a work-release program), and at Colston Youth Center (a secure county detention and treatment facility). The program has an advisory board for input from representatives from throughout the intervention continuum. There are representatives from law enforcement, the county's Juvenile Justice/Delinquency Prevention Commission, Child Protective Services, the Child Abuse Council, the probation department and the Youth Authority.

Direct services to minors are provided by outside treatment providers who contract with the county through the RFP process. Services are provided on two levels:

- *General education program on victimization provided to all minors at juvenile hall*—A cycle of five 30–45 minute presentations is made to the minors. Cycles are staggered to coincide with the turnover rate of minors. Topics include child abuse, sexual abuse, communicating with authority figures, passive, aggressive, and assertive behavior, and handling emotions. Pre- and post-tests are given to ensure comprehension. This portion of the program helps identify abused minors.
- *Short-term, intensive skills-building training groups*—These are small groups designed to increase understanding of how physical, emotional, and sexual abuse of children influence one's own behavior. It also develops specific skills to break up the cycle of violence among the participants. This is not therapy, but a skills-building group. There is a total of nine meetings which are held twice weekly. Some of the subjects covered are anger control, communication skills, empathy and relationship skills, male/female roles, cycles of violence, and the connection between violence and delinquency.

Ms. Van Order screens all of the minors for the program. Minors answer a survey on health problems, suicide ideation, and history of victimization. Anyone who answers yes to these questions are placed into the skills-building groups. The program was also offered to minors placed on probation at home. However, it was much harder to elicit cooperation from the minors

when they were not a "captive audience." The program is now being offered as a part of the curriculum in the continuation schools, and this may help to better target the probationers placed at home.

Problems with the Program

- Difficult to find good counselors who can work with delinquents.
- Counselors tend to burn out within 9–10 months.
- Minors tend to act out initially as they are afraid to address sensitive issues.
- The turnover of the juvenile hall population keeps minors from completing all sessions.

Benefits from the Program

- Recidivism has been reduced, though not as much as expected.
- The program served 723 minors with 3769 service units last year.
- Total cost of the program for last year was only $22,000.
- Probation staff are becoming increasingly aware of the extent and impact of child abuse.
- Probation department is now more involved on committees and other groups involved in child abuse prevention.

Margaret Rose—Dorothy Kirby Center—Los Angeles County Probation Department

At Dorothy Kirby Center there is not a discrete treatment program for sex offenders. Rather, offenders are combined with similarly emotionally dysfunctional youth. However, there are offense-specific therapy groups for sex offenders. Staff coverage on the living unit consists of a social worker, three probation officers who are custodial staff, and a Ph.D. or M.D. consultant to the social worker. The social worker is in charge of the treatment program on the living unit.

Therapy consists of daily group therapy. The population is coeducational. Individual therapy is provided as needed. There is a weekly sex offender specific group. Approximately 33% of the male population on the living unit are sex offenders.

The group at large benefits by having sex offenders placed with them and treated with them. The high emotional content of dealing with sexual material decreases and disclosure increases. The sex offender benefits by experiencing the more normalized environment of a co-ed population. The dynamics of the emotionally disturbed minor are similar to that of adolescent sex offenders.

Attitudes of staff have changed since the program started. Staff are still caring, but are also more demanding and require increased accountability of the minors. Female staff are a necessary and valuable component to the program. Issues of physical risk for female staff parallel those of male staff. A lot of appropriate transference takes place as the female staff often becomes an idealized maternal figure for the offender. There has to be acknowledgment that the issues raised by the presence of female staff are germane to the issues concerning females generically. This can be used to change offender behavior and attitudes. Having male/female co-therapists can help to minimize burnout for the staff.

The role of the chaplain needs to be addressed. Sometimes the teachings and counseling of the chaplain can increase the defenses of the sex offender.

Care should be given to address the needs of clerical staff who read and type sex offender files. These employees are rarely trained to emotionally handle sexually offending behavior, and this can and does cause increased stress for the clerical staff.

The major drawback to the program is the length of stay. Typical time in custody is only eight months. Many offenders can either "wait you out" during that time and not participate in treatment, or may be discharged just as they begin effective work. Probation officers should negotiate for more custody time with the judge during sentencing.

Bill Bosic—Olivecrest Residential Treatment Center

The Abuse Cycle Division of the Olivecrest Treatment Center is the component that provides sex offender specific treatment in a residential treatment facility. It is one of a very few such facilities in the state. The program was initiated three years ago at the direction of the Riverside Probation Department. It started with six beds, and now has grown to 30.

The program has a length of stay of two years. It is operated in two phases. Phase I involves continuous supervision of the minor at all times. Staff ratio is two staff (male and female) on duty during awake hours for every six residents. Treatment includes weekly individual therapy by a Ph.D. psychologist. Sex offense specific group therapy is provided two hours weekly by William Breer, a psychologist nationally recognized for his expertise in treating adolescent sex offenders. There are weekly values clarification groups and weekly family therapy. Family therapy usually starts six months into the program. Phase II involves gradual reintegration into the community. There are also two-hour treatment team meetings held weekly. One hour is a general meeting, and one hour is for in-service training.

There are three ways for a minor to move through the program.

- Successful completion
- Disciplinary removal
- Administrative release. In this case the minor has complied with all behavioral issues, but is still considered to be at high risk for re-offense. So far the program has had three administrative releases; two of the three have re-offended.

The program has had eight successful graduates, with none re-offending. Most graduates look for alternative placements to the family upon release (seven out of eight did so). Apparently the graduates were able to recognize unhealthy family dynamics after treatment.

The program is licensed by the state under the psychiatric model. This reflects both the level of treatment and the level of funding. Referring agencies include the probation department, Mental Health, and the Department of Social Services. The program services San Bernardino, Riverside, and San Diego Counties. The program is divided into five different facilities, each of which houses six clients. The reason is that if you have over six beds in your

program, a public hearing is mandated. Generally, the public becomes hypersensitive about sex offenders placed nearby, regardless of how well the offenders are supervised.

Screening interview criteria requires the ward to at least admit his involvement in the presenting offense. Minimization is expected.

The minor has to demonstrate that he sees he has a problem, and wants to work on it. The program is usually an alternative to incarceration, and so the minor must demonstrate cooperation in order to be admitted.

Behaviors that will discharge a minor include violent acting out, sexual acting out, and leaving the area of supervision. Originally the program sent sex offenders to open schools, but this did not work well for either the school or the offenders. Now the school program is conducted at the living unit site. Because aftercare is a non-allowable expense through the licensure contract, aftercare services are not available except on a voluntary basis.

Richard Embry—Valley Child Guidance Clinic—Outpatient Treatment

This outpatient treatment program began in response to the Youth Authority's Sex Offender Training Seminar held in Anaheim in 1984. The program has treated 60 minors, all of whom were placed either at home on probation or on placement orders at open placements in the San Fernando Valley. The program has served as the outplacement treatment component for some open residential programs.

The original design called for parallel groups for the offender and the offender's family. This has not yet been achieved; however, there is a conjoint family meeting after every three weeks of group therapy. The worst offenders seem to come from the families with the most dangerous dynamics. In these cases it is appropriate to try to intervene to separate the child from the family. However, in most of the cases we see the family is not in bad shape. It is in these instances that family therapy is important.

The program calls for a long-term treatment commitment. There are no figures to substantiate any minimal length of treatment. However, it is clear that longer-term therapy is more effective than shorter-term therapy. Eighteen months is currently the average length of treatment. The program works with low to moderate risk offenders. It is felt that working with higher risk offenders would be an implicit sanctioning of keeping excessively dangerous offenders in the community.

Treatment Issues

- Program treats male sex offenders ages 14–17.
- Therapy primarily in group treatment design. Ninety-minute groups held once per week.
- Originally worked with molesters only. Some rapists introduced in aftercare from Dorothy Kirby Center. It was found that, contrary to current opinion, rapists and molesters could be mixed selectively. The separation criteria should be based on offense dynamics and not on the penal code violation.

- Male/female co-therapists are used. This helps to bring out necessary transference issues, and helps to control burnout among therapists.
- Program is housed within a delinquency treatment program. This is probably a significant part of the program's success. Therapists focus on the offender's victimizing of others as well as on his own victimization. They also focus on related delinquency issues and on self-destructive behavior. They work in cooperation with the probation department. This enhances the program's credibility.

Observations on Outpatient Care

What makes it unique?

- Offense specific treatment forces the offender to look at his own culpability for the offending behavior. It limits his denial, but also recognizes the difficulty for the offender in disclosure.
- The offender's attitude toward treatment changes during the life of the group. As the offender's rapport with the group stablizes, he learns to deal effectively with the shame and get more in control of his life.
- Feelings education early in treatment gives the offender a vocabulary to work with in exploring his feelings.
- Sex education is provided early on. This is focused on relationship-based consensual sexual behavior. It includes information on physiology and on arousal patterns.
- Social skills training develops pro-social behavior. It includes dating skills, practice with appropriate initiation skills, and role playing in telephone and interpersonal conversations.
- Goal of treatment is understanding the psychosocial context of the offense. Gives a complete and comprehensive answer to "Why did you commit your offense?" This orients the offender toward self-management and self-monitoring.
- Develops empathy toward the victim. This empathy increases as minor moves toward self-understanding.
- Teaches minor to work effectively with authority figures.
- Helps offenders work through their own victimization issues. Not all offenders are also victims. However, offenders who have been victimized tend to have higher frequencies of offending, be more intrusive to the victim, and be more highly emotionally disturbed.
- Develops a sense of the offense cycle. It develops in the offender the notion of high risk behaviors and environments, and the need to develop alternatives for managing these behaviors and environments (relapse prevention therapy).

Where does it fit?

- Outpatient treatment providers have the difficult role of coordinating services between minors, parents, foster home parents, probation/parole officers, and police officers.

- Typically the program is either the first or the last treatment intervention for offenders. It is the first treatment for lower risk offenders, and the last treatment intervention for those on aftercare status.

Probation and Parole

A Summary of Panel Presentations on Model Programs in Probation and Parole

John Isaacson—Solano County Probation Department—Specialized Probation Caseload

Mr. Isaacson established a specialized sex offender probation supervision program in Solano County. The program employs a vertical supervision model in which the offender receives all probation services from the same probation officer. Typically, several probation staff are involved with a juvenile sex offender from the time of his arrest through his ultimate discharge from probation. It is believed that probation services for sex offenders should be delivered from one probation specialist. This specialist would be assigned to the offender from the arrest throughout the supervision process.

The program also operates on the assumption that sex offender intervention should involve a county-wide, interagency approach. Too often turf issues and mis-communication interfere with effective service delivery. Regular meetings and coordination between staff from different agencies involved in the intervention process help to resolve problems.

In Solano County the juvenile court judges are able to rely on the probation department for consistently accurate and appropriate information in presentenced reports for sex offenders. Community protection is the primary focus in the sentencing decisions. The more disordered and violent offenders are referred to the Youth Authority. Indicators of offenders who are inappropriate for community treatment would include:

- Offenses that contain physical violence, threats, or use of a weapon
- Clients who have already been involved in community treatment and have re-offended
- The offenses are escalating in either frequency or severity

Those sex offenders who remain in the community on probation are relatively non-violent.

The probation specialist is involved with the case at intake. That officer decides whether home detention is appropriate prior to appearance in juvenile court. The alternative is detention in juvenile hall. The decision is based on the risk assessment of the minor for re-offense prior to his court appearance. If the decision is made to keep the minor at home, the minor is required to see the probation officer weekly and to participate in weekly sex offender counseling sessions which are assigned by the probation officer. The offender does not have to admit his involvement at this point in order to participate in the counseling sessions as he has not yet appeared in court. Meanwhile, a psy-

chological assessment is made immediately by one of a cadre of psychologists who look at offense specific dynamics as well as traditional psychological indicators.

Once the minor is adjudicated and the minor is given probation, the minor is required to participate in treatment at the Community Treatment Center. This is a specialized sex offender treatment program specializing in relapse prevention therapy. The probation officer participates as a co-facilitator in therapy sessions, and also attends school review board meetings to check up on the minors under supervision. Frequent contact with the family of the offender is typical. The probation officer also meets at least once monthly with the minor's individual therapist for treatment updates. The job of community supervision of the minor is made easier by implementation of both specialized treatment and specialized supervision. Typical length of treatment on probation is two years.

The program has supervised 27 juvenile sex offenders in the last 18 months. During that time there has only been one known re-offense by one of these minors. The only real problem that has been experienced to date occurs when the minor's family moves out of county. There is generally not a specialized probation caseload available in the new county for the offender.

Dennis Dulay—California Youth Authority—Specialized Parole Caseloads

Some 700 sex offenders are incarcerated in Youth Authority institutions. Almost 300 sex offenders are currently on parole. This accounts for about 10% of CYA institution and parole populations. There are currently 11 specialized sex offender parole caseloads throughout the state. Each employs the vertical supervision model described in the Solano County program. These caseloads are all modeled after the pilot sex offender parole program in San Francisco. Currently only two of these caseloads are assigned only sex offenders. The rest are assigned other high risk or addictive parolees that benefit from intensive supervision as well as sex offenders.

Supervision by the parole agent starts at intake. After the offender is committed to the Youth Authority's institutions, the parole agent completes a thorough community assessment report. Here the agent contacts the offender's family and school, as well as the probation and police departments, the victim, and the victim's family. These contacts result in a complete offense and treatment history so that institution staff are not "re-inventing the wheel." The parole agent follows the offender throughout the institutional stay of the offender, making periodic contact, either in person or by telephone.

When the offender is ready for release, the parole agent completes a thorough re-entry plan which includes a current risk assessment, community aftercare treatment plan, victim impact statements, and treatment resources. This information is included with the more typical re-entry information such as employment resources, school placements, and the like. The offender is usually placed back with the family or on independent placement, as out-

of-home placements are far and few between. The offender is then seen by the parole agent at usually twice the rate of the typical parolee, and is required to continue in sex offense specific therapy as a condition of parole.

In order to better supervise sex offenders on parole, a better classification system should be developed to use with young sex offenders. This system should be applicable systemwide—to law enforcement, the courts, probation, custody, and parole. Such a classification system would avoid duplication of effort and enable those in each part of the system to use similar language when working with the offender. The classification system should be sensitive to offender risk and needs assessments, and be applicable to a variety of treatment and supervision settings. It should be understandable to the offender and to all those who work with the offender. In addition minimum training standards should be developed for those who work with sex offenders. These should include residential facility workers and foster care operators. A common language should also be developed to be used by all those who work with sex offenders. Finally, minimum standards need to be developed for service delivery. These are not "ordinary" cases, and need to be handled differently. The benefits for all of this would be better supervision for the offender, revivification for the case worker, and increased public safety.

Fran Hinostro—California Youth Authority—Specialized Out of Home Placement

Mr. Hinostro supervises a Youth Authority-operated group home for emotionally dysfunctional parolees. The name of the program is Turnabout and is located in San Diego. Turnabout is a seven-bed re-entry program; two beds are for women and five are for men. Three of the five beds for males are used exclusively for sex offenders. The major goal of the group home is to assist the parolees in developing independent living skills. Referrals come from all over the state. Primary consideration is given to those who are emotionally disturbed.

Program Advantages

- Daily contact with parole agent. Parole agent has dual role of enforcer of parole conditions and treatment person.
- Parole agent available to respond 24 hours per day.
- Frequent drug and alcohol testing of clients.
- Frequent contact between parole agents and therapists.
- Regular and requisite psychological therapy for clients.
- Parole agent begins contact with parolee up to six months prior to release to initiate appropriate re-entry planning. Pre-release furloughs are sometime used.
- Primary focus is surveillance and accountability. The parole agent continually conducts room searches, and monitors social contacts, job choices, peer relationships, etc.
- Major tool used with parolees is unused available confinement time as an "or else" factor.

- Participation in sex offender therapy mandatory. Participation in drug/alcohol therapy is also required if appropriate.
- Clients are required to save at least half of their earnings if employed for moveout expenses.
- 83% success rate for program to date.

Problems Encountered

- There are not enough out-of-home placements for sex offenders available. This creates an excessively long waiting list for beds.
- The NIMBY ("Not In My Back Yard") Syndrome. Although such facilities are desperately needed, no one wants such a facility near them.
- Need for more funding to hire competent staff.
- Need for more standardization on what is important in aftercare programming.
- High burnout rate for staff.
- Need for ongoing research to ensure quality of intervention.

Pre-Pubescent Offenders

A Summary of Panel Presentations on Treatment Issues
for the Pre-Pubescent Sex Offender

Dr. Toni Johnson—Children's Institute's S.P.A.R.K. Program

S.P.A.R.K. stands for "Support Program for Abuse Reactive Kids." Clients seen in this program are children between the ages of 4–13 who have been sexually abused. The children come from a variety of referral sources: C.P.S, probation department, teachers, and parents worried about age-inappropriate sexual acting out of their children. The S.P.A.R.K. program does not accept children into treatment who were merely "playing doctor." Clients accepted for treatment are typically re-enacting episodes of sexual abuse which they have suffered.

The program is primarily a group treatment program, but also provides family and individual therapy as staff are available. All of these clients benefit from family therapy. Clients are divided up by sex and by age. However, very small children (4–7) need not be separated by gender. Older children are also separated by offending behavior. There are victims groups and offender groups, and the program is starting support groups for siblings of offenders. A cognitive/behavioral approach is used. Psychoanalytic approaches are not effective with these children. The program has treated 47 boys and 13 girls to date between the ages of 4–13.

Current Program Statistics

Boys

- Family status—Only 7 intact families out of 47 boys seen. 28 boys from single female head-of-household. Average number of children per family is 2.5.
- Socio-economic status—53% came from middle income families. 47% came from lower income families.

- Ethnicity of clients near that of L.A. County.
  Caucasians—44% (LA Co.—45%)
  Blacks—28% (LA Co.—15%)
  Hispanics—28% (LA Co.—28%)
  No Asians seen
- Offending behaviors in order of frequency are:
  Fondling
  Attempted genital penetration
  Sodomy
  Oral copulation
  Vaginal intercourse
- 46% were involved in sibling incest.
  11 cases of brother-sister incest. Average age difference was 4.5 years. This was non-consensual activity. 12 cases of brother-brother incest. Average age difference is 3 years. In 3 cases there was some degree of mutual consent, but there was high level of compulsivity to the behavior.
- 49% of the boy offenders had been sexually abused.
  19% had been physically abused.

Girls

- Female offender's behavior tends to cause more physical damage to their victims than do male offender's behavior.
- Girls usually have more victims than boys. Girls have as many as 15 victims. Most victims for a boy is 11. The offenders can usually tell you the names of all of their victims.
- 100% of the girl offenders had been sexually abused.

Boys and Girls

- Age at time of first known perpetration—8 years, 9 months. Mean age at entrance to program—9 years, 7 months.
  Half of minors are in the 4–9 year age range, and half are 10–12 years old.
- Average age of victims of all offenders—There were two peaks on the graph at ages 4 and 7. Average age for victims of girl perpetrators is 4.4 years. Average age for victims of boy perpetrators is 6.9 years.
- All of the offenders knew their victims quite well.
- The younger the age of the offender, the more likely it was that the offender had been sexually abused.
  In 4–6 year olds 72% were sexually abused.
  In 7–10 year olds 42% were sexually abused.
  In 11–12 year olds 35% were sexually abused.
- Physical abuse, when combined with sexual abuse showed an impact on 86% of the 4–6 year old offenders.

Eugene Porter—Therapist in Private Practice

Most of the pre-pubescent clients seen by Mr. Porter offend in day care and school settings. The first question to be answered before treating the child is whether or not the child can be treated effectively and safely and still be al-

lowed in the day care/school setting. To get to the answer, one must realize that the locus of control for a child this young is external. The child has not usually developed sufficient internal behavior controls at this age.

The initial step would be to create a team or network of intervenors to help with behavior control. The team might consist of parents, teachers, and Child Protective Services workers. These networks are very difficult to assemble. Families are often incredibly dysfunctional and either unable or unwilling to cooperate. There is often hysteria in the school or day care setting in which the offender acted out. There is often typically an inability of the government intervenor (e.g., Child Protective Services) to understand what type of intervention could be most effective.

There is usually no probation or juvenile court leverage for children this age. However, leverage may be placed on the parents through the courts in order to keep the child in treatment. Generally the therapist must work with the families in these cases. It is essential to work with the mother-child bonding in order to work with the very young child.

Often the pre-pubescent offender will not have been overtly sexually abused, but is clearly sexually pre-occupied. The child can model behavior seen by adults, on the television, or on the video tape recorder. Exposure to explicit sexual behavior, either directly or through pornography can be problematic for the young child without the means to adequately and appropriately process the stimuli. The extent of the impact on the child of exposure to sexual material largely depends on how the parents handle it. Two extremes tend to fall out here—extremely permissive and extremely controlling parental styles. Part of the solution, therefore, is education of the parents on how to handle their child's exposure to sexual material.

Therapy for very young children usually involves individual counseling. It will also usually involve the parent(s). Conflicting messages of how violence is used and when violence is appropriate can also cause problems with these children. The following are general considerations in treating pre-pubescent sexual offenders:

- The younger the child, the better the prognosis for positive behavior change.
- The locus of behavior control for very young children is external.
- Impact of victim treatment is much more profound with a very young child than it would be with an adolescent. The child has not yet had the time to habituate ineffective coping mechanisms for his own victimization.
- Knowing clear consequences for behavior is very important in treating the young child.
- Modeling appropriate exercise of power/control, anger, etc., with the therapist is also very effective.
- There is a need to re-direct the sexual energy in the child. Parents will try to eliminate the sexual energy, and this never works. Kids are usually willing to take on more developmentally appropriate behavior if the option is presented. For example, a child may agree to masturbate by himself in private once in a while instead of with others or in public view.

Jerry Tello—Cross Cultural Issues

Mr. Tello's particular remarks are focused on the Latino population, but may be generalized to many other cultural minorities. Part of the problems encountered when treating children of some groups, particularly migrant worker populations is disenfranchisement. There is a feeling of separation among members of these groups from authority figures. In addition, survival issues for the family as a whole can eclipse problems with very young children.

Issues of violence for parents from different cultures may be very different. This is particularly true for families from Third World countries. Violence may have been a necessary part of the family's survival strategies, and therefore may be seen as more appropriate. These feelings are also prevalent in inner-city cultures.

In terms of risk factors, many scales examine locus of control. In multi-cultural families there may not be a lot of external locus of control. The locus will come from within the family or group. There will also be evidence of protection of group members from external authority figures. This may keep inappropriate behavior from coming to the attention of the intervenor.

Working with the family is vital with the very young child. If the family is too dysfunctional, then the therapist needs to help create a safe environment for the child. Understanding the dynamics in multi-cultural families can help the therapist work with the families in creating the safe environment.

RECOMMENDATIONS

Following are the recommendations offered by each of the multi-discipline work groups. As indicated earlier in this booklet, each multi-discipline group was assigned one area of the intervention continuum to examine, analyze, and develop recommendations and action plans. The recommendations were to be as specific as possible, naming the responsible change agents and time lines where appropriate. The recommendations are given for each of the following five sections of the intervention continuum:

- Investigation/Prosecution
- Assessment and Disposition
- Residential and Outpatient Community Treatment
- Closed Custody Treatment
- Aftercare

Investigation/Prosecution

A. *Training, Awareness, and Education*
   1. Sex offender specific training should be provided to those involved in the investigation/prosecution process.
      a. Should include law enforcement field officers, investigators, prosecutors, public defenders and judges.
      b. Should involve cross training among agencies (e.g., "ride along").
      c. Should include role clarification for individuals along the system.

2. Public awareness films re: adolescent sex offenders should be shown in schools to parents, teachers, and students.

B. *Administrative Procedural Changes*
   1. Vertical handling of sex offender cases
      a. Should include investigation, prosecution, probation, Child Protective Services, juvenile court judges, and parole.
      b. Should include mandated training for all of the above comparable to P.O.S.T. certification.
         —Funding should be shared by state and local government.
   2. Regionalization of sex offender investigations for smaller counties.
      a. Involve specialized multi-jurisdictional DA/investigators to handle cases.
      b. Centralization of the investigation and prosecution process of smaller counties by region.
   3. Develop protocol for victim and offender interviews for law enforcement and district attorneys.
      a. Use expertise of law enforcement and DA's combined with input from treatment professionals.
   4. Non-statutory procedural recommendations
      a. Adequate compensation for medical/evidencing exams.
      b. Law enforcement and DA staff assignment should allow for rotation to new assignment.
         —When staff requests transfer
         —When staff are "burned out"
         —To provide for sabbaticals
      c. Probation reports should include views of DA

C. *New Staffing Needs*
   1. Vertical handling staff
      a. Vertical approach requires specific staffing needs to meet caseload standards.
      b. A federal, state, local partnership should be established to share costs.
      c. Should provide for aftercare coordinator.

D. *New Services*
   1. Law enforcement/probation direct referral for intervention and therapy.
      a. Non-prosecutable offenses; some 1st offenses.
      b. Help prevent lower risk kids from "falling through the cracks."
      c. (Use LA County Sheriff's Diversion Program as model?)
   2. Research projects
      a. Profiling offenders
      b. Evaluation of treatment
      c. Public awareness
      d. Computer linkages between agencies

E. *Statutory Changes*
   1. Mandate disclosure of crime reports and investigative reports to therapist and aftercare provider.
   2. Confidentiality protection to be lifted in the case of AIDS offender.
      a. Allows authorities to notify victims.
   3. Expand statute of limitations to provide for disclosure by a victim under 18.

Assessment and Disposition

A. *Training, Awareness, and Education*
   1. Publication of a resource directory
      a. Statewide standards established for the resources listed.
      b. (Bay Area Network Directory as model?)
      c. One agency mandated to be responsible for interagency cooperation.
         —County agency for countywide system; State agency for statewide system.
         —Agency to provide staff hours for preparation, update, and monitoring.
   2. Periodic training of juvenile court judges and commissioners re: JSO issues.
   3. Education of Judiciary & Youthful Offender Parole Board on special issues re: offender treatment options, female offenders, prepubescent offenders.
   4. Education of public and juvenile justice system re: need for money to fund outpatient treatment.

B. *Administrative Procedural Changes*
   1. Standardization of assessment techniques, probation report content, mandatory psych reports, etc.
      a. Probation reports to include:
         —current offense
         —prior history
         —criminal, institutional, dependency, treatment
         —victim's statement (or parents of victim)
         —school records
         —parental attitudes
         —offender's attitude re: offense
         —family functioning
         —family ability to pay for treatment
         —mandatory psychological report
      b. Development of protocol for juvenile offender assessment to include offender victimization information (if any), and utilize guidelines for assessment currently being developed by National Task Force.
      c. Assessment report by trained, state-certified (see legislative) experts. Use of a valid risk assessment instrument.

2. Two-year time commitment for juvenile court judges and commissioners. (referees)
3. Information availability and sharing.
   a. Collaborative approach on assessment and dispositions by agencies/individuals involved.

C. *New Staffing Needs*
1. Staff for developing, monitoring, and updating resource directories (see above).

D. *New (or expended) Services*
1. Court-ordered family and JSO participation in treatment.
   a. Where available and where appropriate.
2. Court review of community-based treatment at conclusion of treatment.
   a. Should include planned aftercare and transitional supervision.
3. Mandatory aftercare for JSO's released from residential facilities.
   a. Both from CYA and community residential placements.
   b. Should involve both therapy and transitional supervision/monitoring.
4. Development of jointly funded (local and CYA) residential facilities.
   a. Would include post-CYA youth and medium risk probationers.
   b. Six beds or less to minimize public concern and fit existing zoning regulations.
   c. Stringent safety guidelines as to location, supervision, etc.

E. *Statutory changes*
1. Training and certification requirements for JSO assessors.
2. Mandatory Psychological reports.
3. Funding legislation for outpatient treatment for JSO's.

E. *Other recommendations*
1. Longitudinal study of validity on risk assessment instruments.
2. Study of feasibility of sentencing guidelines for juvenile offenders.
3. Study of treatment needs and sentencing alternatives for the very young offender (under 13 years of age).
4. Study of treatment needs, sentencing alternatives and processing inequities re: female offenders.
5. Study of treatment needs, sentencing alternatives for mentally retarded offenders.

Residential and Outpatient Community Treatment

A. *Training, Awareness, and Education*
1. Development of standards for staff training/education.
   a. outpatient clinicians
   b. residential clinicians
   c. residential line staff
   d. certification standards for treatment staff

   —basic education

—specialized offender treatment education
—minimum number of supervised hours treating JSO's
—continuing education

2. Promote regional networking efforts.
   a. Ideally should be county-based.

B. *Administrative Procedural Change*

1. Secure adequate leverage from courts/parole boards for effective treatment.
   a. Specialized intensive treatment probation/parole supervision (specialized caseload model).
   b. Vertical probation supervision.
      —Intake through disposition through termination.
   c. Family cooperation mandated (as needed).
      —By juvenile court or by parole board.
2. Mandated waiver of confidentiality between treatment program and supervision personnel.
   a. Waiver secured at time of referral.
   b. Maximum access by treatment staff to:
      —police reports
      —arrest records
      —probation reports
      —prior evaluations
      —Treatment records
      —School records
      —DSS investigations, etc.
   c. Create environment of mutual exchange of information between therapists and law enforcement agencies.
3. Develop Interagency Protocols
   a. Agencies identified for protocol:
      Agencies could include:
      —juvenile courts
      —schools
      —district attorney
      —probation department
      —law enforcement
      —public defender
      —Dept. of Social Services
      —community mental health
      —medical/health department(s)
      —victim services
      —private service providers
      —parole department
   a. Define case flow
      —Roles for each agency
      —Case flow procedures

—Information gathering/dissemination
c. Standards for providers
d. Review process

4. Develop early Intervention programs.
   a. Referrals to community-based treatment prior to adjudication.
      —Low to medium risk offenders.
      —Not as alternative to adjudication.
      —Conditional on offender admission.
5. Provide all sex offenders with treatment, regardless of risk level.
6. Develop adequate residential treatment and community aftercare programs.
   a. Waiver of confidentiality between residential treatment and aftercare staff.
7. All JSO's remain on formal probation supervision until after completion of treatment.
   a. Special supervision given to older adolescent (over 18).
   b. Administrative commitment to continue funding treatment when AFDC cutoff is reached.

C. *New Staffing Needs*
   1. Staffing patterns should be balanced culturally to service population.

D. *New Services*
   1. Community Needs Assessment for Adequacy of Placement Facilities.
      a. Alternatives in JSO continuum of care:
         —residential (open/secure)
         —day treatment
         —specialized foster care
         —outpatient
         —self-help netv· ·rks
         —alternative placements (emancipated offenders)
   2. Community Needs Assessment
      a. Identify gaps in service.
      b. Identify existing resources to fill needs.
      c. Alternative funding sources.
      d. Inter-regional cooperation protocol.

E. *Outpatient Program Component Recommendations*
   1. Male/Female co-leaders for group therapy.
      a. Group treatment is treatment of choice, along with adjunctive individual treatment.
      b. Family participation in treatment mandated when appropriate.
         —When placement plan calls for family reunification or if offender remains in family during treatment.
   2. Primary mandate is protection of victims and community.
      a. Continuous risk assessment throughout treatment program.
      b. Treatment decisions based on community protection/risk of reoffense.

3. Treatment Issues to be addressed:
   a. Full disclosure of offense
   b. Full responsibility for victimizing
   c. Deviant sexual arousal
      —Including other paraphilias
   d. Human sexuality education
   e. Identifying/managing feelings
   f. Relationship skills training
   g. Identifying and managing psychological stressors
   h. Identifying offense cycle
   i. Victim empathy
   j. Substance abuse
   k. Prior victimization
      —Sexual abuse
      —Physical abuse
      —Emotional abuse
   l. Other delinquent behavior
4. Maximum leverage needed in treatment mandate (the "or else" factor).
   a. Particularly important for adolescent offenders.
   b. Reliance on family cooperation/leverage with prepubescent offenders.
5. Community programs need to be involved in case management/supervision decisions.

F. *Residential Program Component Recommendations*
1. Non-public/on-site school placement for all residents.
   a. Until clinical team (including Probation) recommends public school placement.
2. Public school administrators must be notified at offender's registration of status.
3. VD testing (including AIDS test) as part of health examination for admission to residential treatment.
4. Treatment issues same as in outpatient program.

G. *Other Issues*
1. Research
   a. Risk assessment criteria.
   b. Pilot project to develop protocols for use of penile plethysmograph with JSO's.
   c. Pilot project to develop protocols for aversive conditioning.
   d. Develop nationally accepted assessment standards.
2. Statutory
   a. Training and certification standards as research provides validation.
   b. Changes in limitations for licensing residential treatment facilities.
   c. Increase parole time to more than one year when indicated for treatment purposes.

Closed Custody Treatment

A. *Training, Awareness, and Education*
   1. Inaugurate comprehensive public education effort.
      a. Build systemwide constituency for adequate treatment programs.
         —Creative "marketing" of closed custody needs to public and law makers.
      b. Target specific groups of decision-makers.
         —Legislators
         —Judges
         —Youthful Offender Parole Board
      c. Develop resource sharing models for smaller counties.
      d. Clearly define the task of closed custody treatment facilities for the public.
         —Removal of dangerous perpetrator from society.
         —Decrease danger to the community.
         —Modify offender behavior through effective treatment.
         —Increase offender receptivity to aftercare supervision and treatment.
         —Offer offense specific treatment to perpetrator.
         —Treatment specific to level of risk presented by offender.
         —Minimize risk to future generations.
         —Provide better knowledge base through empirical studies.
   2. Develop a political power base (statewide coalition)
      a. Lobby for increased funding, more and better facilities, and better trained staff.
   3. Enhance training budget for sex offender specific training for all JSO treatment staff.
      a. Basic training in sex offender issues for all institution staff.
      c. Increase staff awareness of the significance of the needs of sexual offenders.
      d. Sensitize to issues and the significance of specific behaviors.

B. *Administrative Procedural Changes*
   1. Set standards for length of custody required by sexual offenders.
      a. Ensure adequate time for effective treatment.
      b. Reduce "waiting time" to enter specialized programs.
      c. Ensure adequate time for aftercare supervision and treatment.
   2. Deal with victim/victimization issues in general population during therapeutic sessions in all closed custody facilities.
   3. Monitor media (TV, movies) watched by offenders while in custody for violent and deviant material.
   4. Provide resources for treatment of lower to medium risk offenders.

C. *New Staffing Needs*
   1. Ensure appropriately trained male and female staff on specialized sex offender treatment units.
      a. Co-ed staff important at all levels, but vital in treatment process of offenders.
   2. Ensure sufficient number of treatment programs to treat all of the offenders who are incarcerated.
      a. "Warehousing" offenders is counterproductive to treatment needs of offenders.

D. *New Services*
   1. CYA needs to fulfill its commitment (financial) to provide sex offender specific aftercare for all offenders.
      a. Recognize that closed custody treatment does not exist in a vacuum.
      b. Aftercare must be mandated for all JSO's.
   2. Need to educate mental health providers regarding higher risk offenders.
      a. Recognize addictive/compulsive nature of acting out.

E. *Statutory Changes*
   1. Increased community resources for low risk offenders (in lieu of incarceration).
   2. Replicate Ventura County's Victim Education Program.
      a. Juvenile Halls
      b. Camps
      c. Ranches
      d. Dependency facilities
   3. Periodic training for Youthful Offender Parole Board
      a. Members to be provided with training re: resources and treatment needs of sex offenders.
      b. Members could be involved in any effort to establish a Statewide coalition.

F. ***Research***
   1. Study could be done linking lack of resources to decreased public safety and high task costs to community.
   2. Study how existing resources can be reallocated to enhance services.
   3. Offender profiling studies.
   4. Longitudinal studies re: JSO response to treatment and supervision.

Aftercare

A. ***Protocol for formalized aftercare to be developed in the following areas:***
   1. Adequate assessment tools.
      a. Validated and standardized
      b. Cumulative
      c. Focused on risk to reoffend
   2. Specialized caseloads with appropriately trained caseworkers.

3. Caseload population standards based on risk assessment.
   a. Focus on workload of caseworker rather than caseload.
4. Standards for minimum time in aftercare program.
5. Length of program participation based on risk to reoffend.
6. Protocol should focus on all disciplines in the system's continuum.
7. Strategies for developing out-of-home placements in the community.
   a. Alternative placement programs should have standards set for:
      —Staffing
      —Staff training and development
      —Treatment of offenders
      —Staff/client ratio based on risk
      —Community education
8. Minimum standards for frequency of contact between aftercare and other service providers.
   a. Information sharing
   b. Responsible parties articulated by protocols
9. Development of transitional release facilities.
   a. Program design based on offender risk, needs, and program released from.
10. Establish minimum length of aftercare treatment.
    a. Option to extend by multi-disciplinary treatment team.
11. Mandated wardship for offender.
    a. No informal probation.
12. Treatment design to be determined by multi-disciplinary team.
    a. Group therapy to be treatment of choice.
    b. Family therapy (when appropriate).
    c. Individual therapy (as conjunct to group therapy).
13. Minimum standards for psychological treatment contracts awarded based on:
    a. Sex offender specific training
    b. Education
    c. Experience with sex offenders
    d. History with client
    e. Cost

		Gary Lowe, LCSW CYA Program Manager Oak Specialized Counseling Program
	Overview of Group Task Process	Richard Embry, LCSW Asst. Clinical Director Valley Child Guidance Clinic Lancaster
3:00–3:15 p.m. Diamond Room	Break	
3:15–4:30 p.m. Parlor A Parlor D Parlor E Conference 1	Small Group Session 1—Single Discipline Groups 1. Judiciary/Law Enforcement 2. Probation/Parole 3. Community Treatment/ Victim Services 4. Residential Treatment	
4:30–4:40 p.m. Diamond Room	Break	
4:40–5:30 p.m. Diamond Room	Report Back to Large Group	Moderator Richard Embry
5:30–6:30 p.m. Opal-Ruby Room	Hospitality Hour/No Host Bar	
6:30–7:30 p.m. Opal-Ruby Room	Dinner Panel Discussion "Identification and Assessment Issues"	Moderator Richard Embry Dee Shafer, Ph.D. Program Director Juvenile Sex Offender Treatment Program Ventura Co. Mental Health Hon. Ben Schaffer Juvenile Court Commissioner L.A. Superior Court Sgt. Beth Dickinson Child Abuse Detail L.A. Sheriff's Dept.
8:00–9:00 p.m. Poolside Suite	Relevant Videos "Victim to Victimizer" "Aids Information for Law Enforcement"	

Tuesday, September 22

7:30–8:00 a.m. Diamond Room	Continental Breakfast	

8:00–9:30 a.m. Diamond Room	Panel Discussion "Treatment Program in Residential, Outpatient, and Closed Custody Settings"	Moderator Don Cotton, Ph.D. Psychologist Private Practice San Francisco Bay Area Margaret Rose, LCSW Consultant to Dorothy Kirby Center L.A. Co. Probation Dept. Richard Embry, LCSW Betty Van Order Sr. Deputy Prob. Ofcr. Juvenile Offender Child Abuse Intervention Project William Bosic, M.B.A. Director Olive Crest Treatment San Bernardino Co.
	Overview of Group Task Process	Jeff Bodmer-Turner
9:30–9:45 a.m. Diamond Room	Break	
9:45–11:45 a.m. Parlor B Parlor D Parlor E Conference 1 Conference 2	Group Session 2 1. Investigation and Prosecution 2. Assessment and Disposition 3. Residential and Outpatient Community Treatment 4. Closed Custody Treatment 5. Community Supervision and Aftercare	
11:45–Noon	Break	
12:00–1:30 p.m. Opal-Ruby Room	Luncheon Panel Discussion "Programs in Probation and Parole"	Moderator Bill Greer, Consultant Cal. Youth Authority Dennis Dulay Program Specialist Cal. Youth Authority John Isaacson Probation Officer Solano County Fran Hinostro Parole Agent II San Diego Network Cal. Youth Authority

1:30–3:00 p.m.	Group Session 3 (Continuation of Group Session 2)	
3:00–3:15 p.m. Diamond Room	Break	
3:15–3:45 p.m. Diamond Room	Report Back to Large Group	
3:45–5:00 p.m.	Group Session 4 (Continuation of Group Session 2)	
5:15–6:30 p.m. Poolside Suite	Hospitality Hour	
6:30–7:30 p.m. Period-Onyx	Dinner Panel Discussion "Pre-pubescent Offenders"	Moderator Beryl Davis, Ph.D. Psychologist Los Angeles Toni Johnson, Ph.D. Assistant Director Child Sexual Abuse Center Children's Institute International, L.A. Eugene Porter, MFCC Private Practice Berkeley Jerry Tello, LCSW Coordinator Trng. & Tech. Asst. Cal. Consortium of Child Abuse Councils Los Angeles
8:00–9:00 p.m. Poolside Suite	Relevant Videos	

Wednesday, September 23

7:30–8:00 a.m. Diamond Room	Continental Breakfast	
8:00–9:15 a.m. Diamond Room	Small Group Reports Discussion of Recommendations	Facilitator Steven Bengis
9:15–9:30 a.m. Diamond Room	Break	
9:30–11:20 a.m. Diamond Room	Reports (continued)	
11:20–11:30 a.m. Diamond Room	Wrap-up	Ronald W. Hayes
11:30–12:30 p.m. Atrium	Luncheon	

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ADOLESCENT SEX OFFENDER TRANSFER OF KNOWLEDGE WORKSHOP

Ontario-Hilton Hotel
September 21–23, 1987
Sponsored by California Youth Authority
Office of Criminal Justice Planning

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