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PILOT JUVENILE SEX OFFENDER TREATMENT PROGRAM

PETE WILSON
Governor

142212

OFFICE OF CRIMINAL JUSTICE PLANNING

FINAL EVALUATION REPORT

State of California
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**Report to the Legislature
in Response to
SB 890 (Seymour, 1985)**

**Administered by the
Office of Criminal Justice Planning**

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FINAL EVALUATION REPORT

PILOT JUVENILE SEX OFFENDER TREATMENT PROGRAM

FOREWORD

Breaking the cycle of pain.

This report is about the cycle of pain resulting from sexual violence – the lifelong cycle of repeated sexual crimes by offenders who often begin early as juveniles, many of whom have themselves been victims of abuse. It is known that many youthful offenders continue to offend over time, with increasing frequency and seriousness. The costs for this persistent cycle are enormous – the physical and emotional pain suffered by victims and families, as well as the financial burden to society for victims services and offender incarcerations.

The devastating cycle of abuse may be broken for many offenders by an innovative treatment program for the young sex offenders – the Pilot Juvenile Sex Offender Treatment Program. This program was established in California by Senate Bill (SB) 890, sponsored by Senator John Seymour (R.-Orange County). Through an effective partnership of state, county and private agencies, this program continued for the four years from 1986 to 1990. This report evaluates the program's efforts to help young offenders break their patterns of sexual abuse to prevent a lifelong career of sexual violence.

Inevitably, this program evaluation report on the three pilot projects will remind us of the physical and emotional pain suffered by over 400 victims sexually traumatized by the offenders treated in this program, as well as the pain to the families of both victims and offenders.

The youthful offenders treated by this program and their victims came from all social-economic elements of their communities. The range of sexual violence of these offenders was similar to that committed by adult offenders. Some of the offenders were themselves victims of sexual violence; more often they were victims of physical and emotional violence – a "victim to victimizer" link which is not yet completely understood.

By intervening early in the deviant developmental years of these young offenders, the three projects attempted to help these offenders cultivate healthy and responsible behavior, through community-based programs of intense treatment and monitoring. The programs were designed to prevent young offenders from continuing their offense pattern through their adult years and compounding their numbers of victims from the 400 to 4,000, ultimately to save society the emotional and economic costs of additional victimizations, to avoid the expenses of lengthy incarcerations, and to reduce the potential of new victims becoming victimizers.

Sincerely,

G. ALBERT HOWENSTEIN, Jr.
Executive Director

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This evaluation report would not be possible without the cooperation and assistance of the individual staff members in each of the three projects who took the extra time and effort to provide the documentation of their clinical work.

Special acknowledgement is due to Ms. Kathy Ludricks, who, as this evaluator's administrative assistant, conscientiously monitored the submission of project data forms, meticulously entered all the data and ensured that reports were submitted on schedule both to the projects and the Office of Criminal Justice Planning. Without her special skills and commitment, the wealth of information generated from this program would not have been as readily available.

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EXECUTIVE SUMMARY:

ABSTRACT

This report evaluates the results of the first legislatively funded pilot program in California to develop comprehensive community-based treatment for juvenile sex offenders. The program was aimed at early intervention and the prevention of continued sexual violence.

The four-year Pilot Juvenile Sex Offender Treatment Program established a comprehensive model of court-ordered treatment with a public safety focus in three California counties. The model involved treatment and monitoring of offender behavior in the community to prevent further sexual violence.

The three projects accepted a total of 277 sentenced juvenile sex offenders – 79% of those referred by the courts. The full course of treatment averaged 20 months and included over two hours per week per offender in individual and group therapy. Offender behavior was monitored in the course of program activities and through collaboration with probation officers, family members, and others familiar with the offender.

The treatment approach was primarily focused on personal accountability and "relapse prevention". That is, offenders learned to take full responsibility for their actions, to acknowledge their own patterns of offending behavior, to recognize the early warning signs in those patterns and to take corrective actions for gaining self-control and avoiding reoffenses.

The pilot program was successful and resulted in a very low recidivism rate for young offenders while in treatment (2.5% for new sex offenses). Those who reoffended with new sexual crimes had a distinctive profile which differed significantly from those who reoffended with non-sexual offenses and those who did not reoffend. A new Juvenile Risk Assessment Scale developed by this program was effective in identifying offenders at-risk for sexual reoffending.

The annual cost of this community-based program per offender was 6% of the cost of the specialized treatment program in the California Youth Authority. Twenty-two juvenile sex offenders could be treated in the community for the same cost as one offender in institutional treatment with parole aftercare.

The findings from this study support the position that early, direct, and intensive intervention works. A comprehensive outpatient program of treatment and supervision based on the most current understanding of the juvenile sex offender, is an effective and inexpensive model with which the state can begin to confront a serious public safety problem.

EXECUTIVE SUMMARY:

PROGRAM DESCRIPTION

Community Safety Issues. Juvenile sex offenders commit the same range of sex crimes as adult offenders, victimizing children and adults from all segments of society. Nonetheless, there has long been a reluctance on the part of law enforcement and juvenile justice workers to "label" a juvenile with a sex offense. As a result, juvenile sex offenders often do not get charged until they have committed additional or more serious offenses. Even so, an average of 1,464 juveniles in California are charged annually with sex crimes and 80% of the charges are sustained. The majority are sentenced to probation in their communities, which all too often have inadequate, if any, treatment to offer. Because many do not receive adequate treatment, a certain percentage of them will continue to reoffend. Without intervention, these juvenile sex offenders can become entrenched in a pattern of sexual violence that continues into their adult years. Treatment, which is usually too little and too late, is provided mostly to those who have "graduated" to the most serious and compulsive patterns of offenses.

Cycle of Violence. Adult sex offenders often report having started their crimes as teenagers, sometimes even younger, particularly if they themselves were victimized. With no effective treatment intervention, they continued committing sex offenses, even after spending time in jail and prison. Similar to the alcoholic, there is no cure for the compulsive, or habitual, sex offender. Such offenders, however, can learn how to stop offending through specialized treatment with an emphasis on self-control of behavior, relapse prevention, and social skills development.

Legislative Intent. A special pilot program to provide such specialized outpatient treatment for juvenile sex offenders was created through California Senate Bill 890, sponsored in 1985, by Senator John Seymour. The Pilot Juvenile Sex Offender Treatment Program targeted the 89% of juvenile sex offenders sentenced to probation in their communities. In 1986, pilot projects were established in Fresno, San Joaquin and Ventura Counties and were funded for four years. The three projects accepted 277 juvenile sex offenders into treatment. Based just on reports, these 277 offenders victimized over 400 people.

Program Goals. The goal of the Pilot Juvenile Sex Offender Treatment Program was to provide early intervention to these young sex offenders before they became ingrained in a potential lifelong pattern of sexual violence. The program had a primary focus on public safety and prevention of further victimization through an intensive and comprehensive approach to treatment intervention.

Treatment Approach. The comprehensive intervention approach used by the three pilot projects combined treatment services with close monitoring of the offender. Treatment consisted of multiple types of therapy. In the course of treatment, therapists learned that three-fourths of the juvenile sex offenders were themselves victims of sexual, physical and/or emotional abuse. Although victim issues were addressed, the program staff consistently held the offenders responsible for their actions and insisted that the offenders understand, monitor, control and change their behavior.

Evaluation of Program Effectiveness. The legislation included an innovative provision for an evaluation of the program's effectiveness and listed questions to be answered in this final evaluation report. Information was collected on the offenders' characteristics, the treatment services provided, and all reports of their "at-risk" behaviors. The evaluation focused on treatment outcome, particularly offender reoffense patterns. The program's evaluation design did not include controlled or comparison studies. In answering the legislative questions, however, the results provide a baseline for further development of the program model.

The responses to the legislative questions, summarized in this report, describe: 1) the offenders treated; 2) the services provided; 3) the cost of the program; 4) the impact of combining services; and 5) treatment outcomes.

New Risk Assessment Measure. The Juvenile Risk Assessment Scale developed by this program promises to help identify offenders at high risk to reoffend. The offenders who reoffended with new sex crimes had been rated higher risk at admission than the non-reoffenders. Thus, the scale identifies those higher-risk offenders accepted into the program who require more intensive treatment and monitoring. Continued study and revision of the scale is needed.

Treatment Success. This study showed that the intervention approach used in this program is effective and efficient with potential for considerable long term social benefit in terms of abuse prevention and public safety. The

program provided an important first step towards interrupting the sexual abuse cycle and preventing the development of career sex offenders.

Recommendations. Recommendations in the following seven areas are presented at the end of the report to provide direction for future development of this intervention model:

1) Expand the pilot juvenile sex offender treatment model.
2) Develop specialized probation caseloads for juvenile sex offenders.
3) Expand treatment focus to include other anti-social behavior.
4) Develop options for extended and after-care treatment services.
5) Develop residential placement options.
6) Support risk assessment efforts and long term recidivism studies.
7) Provide recognized experts in program development and evaluation.

EXECUTIVE SUMMARY:

RESPONSES TO THE LEGISLATIVE QUESTIONS

SB 890 required that the final evaluation report address five key evaluation questions. The following are the legislative questions and summaries of the evaluation findings.

1. NUMBER OF JUVENILE SEX OFFENDERS TREATED.
The number of defendants who participated in the counseling programs during the pilot program.

Of the 350 sentenced juvenile sex offenders who were referred to the pilot program during the four years of funding, a total of 277 offenders received treatment services. Of these, 93 juvenile sex offenders successfully finished the complete course of treatment which consisted of more than two hours per week for an average of 20 months. Thirty offenders were still in treatment when funding ended. While the remaining 154 did not complete the entire treatment program, many had nearly completed their treatment by the time they left. Offenders did not complete treatment because their probation ended, they were not physically available for treatment, or they were referred back to the courts as unamenable for participation in the program.

The 277 juvenile sex offenders in this program had victimized 402 people, ages 1 to 34, in their referring offenses. The primary charges for which they were sentenced were the same as those committed by adults: PC 647a -- Annoying and molesting a child (29%), PC 288a -- Oral copulation (24%), and PC 288 -- Lewd or lascivious acts with a child under 14 (20%). The levels of violence most often used in these offenses were coercion (34%) and force (24%). Most often, the offense involved one victim, who was usually female, who averaged 8 years of age, and knew or was related to the offender.

The typical offender was male, white, and an average age of 15 years with no disabilities. Ethnic compositions of the project caseloads were generally close to those of their communities.

Three-fourths of the offenders acknowledged that they themselves had been in some way victimized. A third of the offenders reported that they were victims of sexual abuse. The juvenile sex offenders were twice as likely to reveal their history of victimization later in treatment than at their admission interview.

2. NATURE OF THE TREATMENT.
The nature of the treatment provided to participants in the counseling program.

Treatment provided in this program had two major focuses: 1) changing the offender's behavior through therapy; and 2) protecting public safety through monitoring the offender's behavior. Therapy provided the insight and skills for the offenders to understand and control their behavior. Monitoring the offenders in the community provided a basis for assessing their level of risk.

Therapy services consisted of individual, group and, when possible, family therapy sessions. A variety of supplemental therapies were also provided, such as social and personal skills development groups and victim awareness sessions. The clinical approach for the three projects was predominantly based on cognitive-behavioral and relapse-prevention treatment models. In summary, cognitive-behavioral therapy focused on how thoughts and feelings direct a person's actions and how those thoughts and feelings can be reshaped. Relapse-prevention therapy focused on identifying offenders' patterns of sexual violence, their individual vulnerabilities and warning signs, along with effective corrective actions.

Monitoring services, in addition to the multiple offender contacts each week, included networking with other agencies, collateral contacts with those familiar with the offender and, on occasion, home visits.

3. COST OF THE PILOT PROGRAM.
The cost of the pilot program, including data concerning the amount of the cost recovered from participants in the counseling program.

The annual cost per offender for the three projects averaged $4,123, which included both direct and indirect costs. The average cost per week for each offender was $80.

These early intervention efforts with juvenile sex offenders may provide maximum leverage of fiscal resources by avoiding the considerable institutional and social costs accrued as a result of untreated offenders who reoffend as older juveniles and, later, as adults.

The cost-effectiveness of the program becomes apparent when its costs are compared to the $23,725 annual cost for a Juvenile Hall commitment, $31,064 for a California Youth Authority (CYA) commitment without specialized treatment, and $65,000 for a CYA commitment with specialized treatment.

The pilot program's $4,123 annual cost per offender is 17% of the cost per year in a juvenile hall facility, 13% of the cost per year of a basic program in the CYA and 6% of the annual cost of a special treatment program in the CYA.

Expressed differently, the annual cost of one offender in special treatment at the CYA would pay a year's treatment in the community for 16 juvenile offenders.

The cost differences are compounded by the length of time required by the alternatives to early community-based treatment. Offenders in the CYA facilities have an average stay of 22 months and five years of aftercare parole services. The cost of a full course of treatment in the pilot program, which averaged 20 months, was $6,871, while the costs would be $88,950 for a full Youth Authority sentence, or $151,166 if specialized treatment was provided within the institution. Twenty-two offenders could receive the full course of community treatment for the cost of one offender's complete treatment through the institution and parole.

Half of the program cost was provided by SB 890 funding; half was provided by other in-kind county support services. These costs did not include any of the residential placements which were provided or any supervision services by probation. No fees were collected from these juvenile offenders or their families.

4. RESULTS OF COMBINED SERVICES.
The results of combining counseling services to child intrafamilial and pedophiliac sexual abusers.

While pedophilia patterns can be identified in some of the juvenile offenders' behavior, the criteria for diagnosing juvenile pedophilia are very narrow. Projects tailored their treatment for those few believed to be potential pedophiles on a case-by-case basis. No significant differences were found as a result of combining treatment services to intra-family offenders and offenders with pedophilia offense patterns.

5. RESULTS OF TREATMENT ON RECIDIVISM.
The results of the treatment provided to participants in the counseling programs, including data concerning recidivism by participants, other criminal offenses committed by participants, and failures to participate in the counseling programs.

Low Recidivism Rate. The offenders in the program were monitored closely for acting out behaviors during their 15 month average participation in treatment. Only 2.5% of the offenders in treatment were involved in a new sex-related arrest (n=7/277). The rate for non-sexual reoffenses involving rearrest was 11.2% (n=31/277). The non-sexual reoffenses were primarily for substance abuse and property crimes which did not involve violence. The combination of the two rates was 13.7%. Each of the three projects provided effective treatment for maintaining a similar low rate of sexual reoffense.

While there were no differences in the sexual reoffense rates, the projects varied in their arrest rates for non-sexual reoffenses. The variation in the non-sexual offense rates may be related to differences in the amount of pro-active intervention used, the frequency of offender contacts and the frequency of specialized skills-development sessions.

New Findings on the Reoffender Profile. The profiles of the two reoffender groups were very different. The sexual reoffenders in this study were notably younger, with a higher risk profile than both those who did not reoffend and those who reoffended with non-sexual offenses. The sexual reoffenses occurred earlier in treatment. At least half of these reoffenses could have been prevented with increased monitoring of the offenders' homes, because children had been brought into the homes by caretakers. Some reoffenders were able to continue treatment after spending additional time in juvenile hall.

The reoffenders with non-sexual offenses were more often older, had been in treatment longer, and were not as clearly identified by the Juvenile Risk Assessment Scale ratings. Their behavior often involved non-contact crimes involving property, substance abuse or a combination of the two. The issues contributing to these offenses may have been quite different from those which were the specific focus of the core sex offender treatment. The non-sexual reoffense rates were lower in the projects which used more skills-development group treatment sessions and proactive interventions (e.g., probation sanctions for treatment non-compliance). Offenders in these projects may have benefited from the increased supervision and external controls provided by more frequent treatment contacts and more active probation intervention. They may have developed more internal controls through the more intensive focus on skills development.

Baseline Results. These evaluation findings provide a baseline. There were no readily available results from comparable programs with which to compare recidivism rates, although several other outpatient studies are currently being conducted which have not yet reported their findings. Long-term effectiveness of treatment can best be determined through longitudinal follow-up studies. No such studies have been done as yet.

EVALUATION REPORT

PILOT JUVENILE SEX OFFENDER TREATMENT PROGRAM

BACKGROUND

Basic assumptions

There are a number of important assumptions that provide the context for the development of this program and the context within which the program was evaluated.

Dynamics. In the mid-1980s', new approaches to reducing sexual violence in our society began to emerge. Researchers such as Nicholas Groth, Gene Able and David Finkelhor found that the sex offender's behavior is fueled by a habitual, at times compulsive, deviant sexual arousal pattern, which often begins in early adolescence or even earlier. The sexual abuse pattern involves exploitation, manipulation, and/or physical violence.

For reasons not yet completely clear, sexual violence serves as the young sex offender's highly maladaptive attempt to vent rage or to compensate for unmet primitive narcissistic needs. These might include the need for acceptance, affection, and control. The offender is inclined, at times driven, to act-out these needs through a pattern of deviant sexual behavior -- as the means to resolve anger, to become complete, to feel wanted, or to feel in control.

This behavior is probably influenced initially by significantly, even profoundly, negative experiences in the offender's development. Such experiences might be related to emotional neglect, to physical, sexual or emotional abuse, or to overwhelming exposure to an environment permitting or promoting violence and sexual aggression. Beyond these early developmental factors, many routine aspects of our society and culture, including many images in the media, provide an environment which reinforces the pattern of sexual violence.

Offense Cycle. There are three important potential aspects to sex offending which need to be addressed by an intervention program for the juvenile offender: 1) many offenders themselves have been victims; 2) offending is often repeated and may be a lifelong pattern of compulsive behavior; and 3) juvenile sex offenders commit offenses which are often as serious as adult offenses.

It is known that many juveniles who were sexually abused have abused others. This is not to say that all victims become offenders, nor that all offenders

were victims. However, a percentage of both juvenile and adult offenders have histories of being sexually abused as young children. Younger offenders are more likely to have documentation of such victimization. Offenders who have been sexually victimized often replicate the abuse with an offense pattern that is similar to the way they were victimized. Therapists note that this pattern may be an attempt to identify with the aggressor, to regain a sense of control. More study is needed to understand this important victim-to-victimizer linkage.

It has been found in offender treatment programs that the referring, first documented offense often was not the first occurrence of such behavior. Although there can be the mistaken assumption that juvenile sex offenders do not engage in serious sexually aggressive behavior, the experiences of treatment providers offer another perspective. While some juveniles are referred for first-time, less serious offenses, others are referred for multiple offenses and/or offenses that involve the use of force and physical violence. The victims of juvenile offenders may be infants or elderly persons, males or females, family members or strangers. They may have been victimized through use of manipulation, physical or emotional coercion, even a weapon.

Juvenile sex offenders who are referred by the courts for treatment may have committed a number of offenses, offenses which are often as serious as those committed by adult offenders. Sexual offense histories match the pattern of compulsive behavior: once initiated, the behavior becomes habituated through repetition and reinforcement. Sometimes, fantasies, planning and rehearsal become part of the offenders' ritualized behavior. The offense pattern may be highly specific for the juvenile offender who is predatory, while the opportunistic offender may exploit any occasion available. Sometimes, the pattern is characterized by increasing frequency and/or violence of successive offenses.

The dangers are clear in ignoring the juvenile sex offender. The problem does not go away and can only get worse. The longer sex offenders remain untreated and continue abusing new victims, the more likely there will be other potential offenders. Once an offender establishes an abuse pattern, the pattern of sexual violence may be lifelong. Despite the age, a juvenile sex offender may be establishing a pattern of sadistic sexual aggression. Therefore, it is imperative to intervene early to help the juvenile offender break the cycle of abuse.

Intervention Goals. Given these dynamics, any effective juvenile sex offender intervention must address the following treatment goals. The measure

of success in meeting these goals is a low rate of reoffense both during treatment and through the years thereafter.

1) Help abusers control their behavior, using external controls until internal controls are developed.
2) Interrupt and replace the deviant sexual arousal pattern and offense cycle.
3) Help abusers recognize intense needs and find appropriate ways to meet them.
4) Foster development of a mature ego.
5) Help abusers develop compensatory social skills.
6) Intervene as early as possible in the sex offender's development.

California Response. Social control of sex offenders needs to begin as early as possible, with as intensive a program as possible. This approach was recommended by the 1986 report of the Sex Offender Task Force sponsored by the California Youth Authority. The task force summarized its findings as follows:

> It is widely held that the special problems of adolescent sex offenders have tended to be ignored and neglected and often responded to in an inappropriate manner. Intervention is rarely made at the crucial point where the young offender first exhibits abnormal or abusive sexual behavior. This behavior is usually ignored or excused until it develops into a violent act of rape, sodomy or sexual homicide. Public outrage and costly incarceration without appropriate treatment is the usual response, which is too little and too late. In failing to address the serious problems of these young offenders in a timely and appropriate manner, we may help to perpetuate continuing cycles of sexual misbehavior and abuse.

The California Sex Offender Task Force recommended several measures, including: more appropriate intervention as early as possible; comprehensive treatment of incarcerated offenders; careful treatment of paroled offenders after their release into the community; and development of community-based programs for juvenile offenders sentenced to local probation. This last measure might well stop the current pattern of benign neglect which allows young offenders to drift through the system until they "graduate" to more serious sex offenses, offenses which fall under the jurisdiction of the California Youth Authority where they might first get help.

Previously, California had few options for treating sex offenders. Depending on their age and legal options, offenders were sent to state hospitals, confined in youth facilities, jails or prisons, or released on parole or probation into communities which had few resources for structured outpatient treatment. Only those sent to state hospitals or to the Youth Authority's specialized treatment facilities received a structured treatment program. Those sentenced to youth facilities, jail, prison or put on probation usually went untreated.

Legislative intent

In 1985, the California Legislature passed, and Governor George Deukmejian signed into law, a measure designed to provide a special community-based comprehensive treatment program for juvenile sex offenders.

SB 890 (Chapter 637, Statutes of 1985), introduced by Senator John Seymour, authorized the development of the Pilot Juvenile Sex Offender Treatment Program to treat juvenile sex offenders convicted of specified sex crimes. Offenders would be eligible if they were sentenced to probation, could be safely treated in the community and would benefit from treatment. (See Appendix A)

SB 890 authorized the Office of Criminal Justice Planning (OCJP) to administer the Pilot Juvenile Sex Offender Treatment Program and select three counties to participate in the program. The bill provided four years of funding for treatment services to all juveniles who were not committed to the California Youth Authority and who were wards of the juvenile court pursuant to Section 602 of the Welfare and Institutions Code for specified sex offenses (listed below). The statute did not prevent any other confinement or conditions of probation that might be imposed.

The following sex offenses were eligible for treatment under SB 890:

PC 261	Rape
PC 264.1	Rape in concert with others by force or violence
PC 266	Enticement for prostitution of child under 18 years
PC 285	Incest
PC 286	Sodomy
PC 288	Lewd or lascivious acts with child under 14 years
PC 288a	Forced oral copulation
PC 289	Penetration of genitals or anus with a foreign object

In addition to the specified Penal Code sections, OCJP included the following offenses with Senator Seymour's approval:

PC 220	Assault with intent to commit an offense (sexual)
PC 243.4	Sexual battery
PC 647a	Annoying and molesting a child
PC 664	Attempt to commit an offense (sexual)

The following four legislative guidelines, which the counties had to demonstrate in their application for participation, were established for the Pilot Juvenile Sex Offender Treatment Program: 1) counties will provide a statement indicating the need for juvenile sex offender treatment; 2) projects will insure inter-agency participation; 3) projects will provide only qualified counselors; and 4) projects are expected to participate in evaluation.

In addition to the statutory guidelines, OCJP included additional requirements recommended by an advisory committee with the concurrence of Senator Seymour. The requirements specified that the local county department of mental health was permitted to subcontract the treatment program. Projects needed to secure an enabling resolution by the county board of supervisors and to provide letters of support from key community services. Projects were also required to demonstrate a comprehensive treatment approach, have appropriate offender/therapist ratios, not use interns without supervision, and have staff participate in two training sessions per year.

Program purpose

The Pilot Juvenile Sex Offender Treatment Program addressed the needs of juvenile sex offenders most likely to benefit from community treatment and supervision – those who had been released into the community, often after a brief juvenile hall incarceration, who needed a structured intervention program to help them avoid repeating their sexual offenses. Without this program they would have gone untreated.

The program reflected a growing recognition of the importance of treating young sexual abusers early. The pilot program's Request for Proposals states: "Historically, sex crimes committed by juveniles have not been considered serious offenses. This behavior is now recognized as a harbinger of lifelong patterns of conduct. Early identification and treatment are essential to correct these patterns and to prevent further sexual assaults against adults and children."

SB 890 created three county-level pilot projects for the treatment of juvenile sex offenders. The program's goal was to fill the treatment gap for

juvenile offenders released into these communities. Success in meeting this goal might facilitate the development of similar programs in other counties. The model would provide the state with a non-institutional intervention alternative, as well as comprehensive outpatient treatment and monitoring at less cost and with minimum risk to the community.

Evaluation questions

The legislation required that OCJP administer the program and provide an evaluation of the three projects. The evaluation report was required to address the following five questions:

Number of sex offenders treated. The number of defendants who participated in the counseling programs during the pilot program.

Nature of the treatment. The nature of the treatment provided to participants in the counseling program.

Cost of the pilot program. The cost of the pilot program, including data concerning the amount of the cost recovered from participants in the counseling program.

Results of combined services. The results of combining counseling services to child intrafamilial and pedophiliac sexual abusers.

Results of treatment on recidivism. The results of the treatment provided to participants in the counseling program, including data concerning recidivism by participants, other criminal offenses committed by participants, and failures to participate in the counseling program.

EVALUATION METHOD

Design

To provide this information, program staff collected data about the offenders' offenses, clinical characteristics and their demographic characteristics. They also recorded the type and frequency of treatment services provided, the degree of offender compliance and the number of reoffenses. The program evaluation was designed to give baseline data on the offenders served and the treatment provided, and a summary of offenders' progress during the program, as directed by SB 890.

Current thinking about sex offenders is that many remain at risk to reoffend throughout their entire lives and need specialized skills to recognize the factors and situations which increase that risk, much as the alcoholic learns

to avoid situations which promote drinking. The true test of a program's effectiveness is whether or not offenders reoffend after completing treatment. Unfortunately, there were no provisions in this program for an extensive post-treatment follow-up of the offenders treated, or for comparison with a control group. Despite these limitations, the data collected to answer the mandated evaluation questions can provide a baseline for more comprehensive program development and evaluation.

OCJP also required that the evaluator develop data collection instruments, procedures and forms; provide technical assistance and training to the pilot program on how to conduct the evaluations; analyze data on the three pilot projects; and prepare a comprehensive report on the pilot program data and operations which will comprise the substance of the OCJP report to the legislature.

Evaluation measures

For the program evaluation, several sets of forms, developed specifically for this program, were used in addition to several established measures. (see Appendix C). An intake form was developed to obtain demographic data on the juvenile sex offenders and their offenses. A monthly service form tracked the frequency and modes of services provided. Special incident forms provided information about reoffenses and other behavioral problems. The Kempe National Adolescent Perpetrator Network's Uniform Data Collection System forms were used to provide standardized clinical information at the beginning, middle and end of treatment. A Juvenile Risk Assessment Scale was developed in conjunction with the three projects to measure risk levels at the beginning and end of treatment. Juvenile Risk Assessment Scale ratings were assigned by the therapist based on a review of the offender's offense(s) and prior criminal and clinical history, as well as clinical judgments about the offender's current attitudes and behavior.

Three standardized psychological tests were used in addition to these forms: the Minnesota Multiphasic Personality Inventory (MMPI), the Millon Adolescent Personality Inventory (MAPI), and the Adolescent Version of the Multiphasic Sex Inventory (MSI). Projects tested offenders at admission and discharge with these tests as the pre and post measures, if the offender was available for testing and staff resources were also available. The MMPI and MAPI provided a number of clinical scales to compare groups of offenders treated in this program. The MSI provided specific sex offender scales used to

measure levels of denial, acceptance of responsibility for offense, sex information and sexual attitudes.

The data was collected and analyzed to provide the pilot projects and OCJP administration with ongoing reports on project activities and progress in meeting treatment objectives. These reports included listings of offender status, monthly service summaries, and quarterly progress towards objectives.

PROGRAM DESCRIPTION

Overview

The three counties funded for the Pilot Juvenile Sex Offender Treatment Program under SB 890 were Fresno County, San Joaquin County, and Ventura County. These counties were selected through a competitive bid process from California counties responding to the request for proposals. Fresno County includes urban and rural areas in California's inland valley. San Joaquin County is rural and also an inland area. Ventura County is an urban/rural area on the California coast.

Each of the three projects provided a comprehensive, structured program of both therapy and monitoring, with a public safety focus. While the projects differed to some degree in their particular focus of treatment, the therapy component typically included individual, group and family therapy along with social skills and education groups. Monitoring services typically included collateral contact with probation officers, family members and other members of the offenders' network. As needed, project staff conducted home visits and other forms of supervision to monitor offenders' day-to-day adjustment.

Start up for the pilot program and development of the evaluation design took longer than expected. Each project spent considerable effort in developing their treatment system, establishing referral relationships with the courts and probation, setting up offender records, hiring staff, and procuring specialized resources. Data collection forms, clinical test selection and data set designs went through several revisions in consultation with the projects.

During the first two years, all pilot projects were involved in extensive in-service staff training. Because of more complex treatment issues and longer probation terms, many offenders were found to require treatment well beyond the initial program guidelines which recommended 18 months of therapy.

Each of the pilot projects required some modification of their pre-existing services to conform to the legislative and administrative mandates. Fresno

County's project, while experienced in providing services within the juvenile facilities, had to develop the outpatient clinic program. The project in San Joaquin County, while experienced with residential treatment and victim services, had to develop an outpatient program for the juvenile offenders. The Ventura County project consolidated existing services for juvenile offenders and adult sex offenders, developing a county-wide network specifically for treating juvenile sex offenders.

One of the legislative intents of SB 890 was to maximize inter-agency interaction. System-wide networking was identified as particularly necessary in treating sex offenders. Coordination and consistency of intervention in the pilot program were effectively provided through inter-agency staff networking. Network meetings often involved probation officers and victim treatment service teams who were objective monitors of the offenders' progress.

Each of the projects maximized their inter-agency cooperation as required by SB 890. This was done formally with letters of support from key county agencies. In all projects, this cooperation was implemented with scheduled meetings. The particular nature of the cooperation and the types of agencies involved in networking varied from one project to another based on the organizational structure and philosophy of the project and local governmental policies.

Profile of the three pilot projects

A brief summary description of the three pilot juvenile projects is provided in Appendix B. The summaries identify each project and how they were organized and staffed.

Each of the three pilot juvenile sex offender treatment projects were comprehensive and provided the range and intensity of treatment currently accepted as standard in sex offender treatment. The projects did vary in staffing patterns, organizational structure, background experience, philosophical orientation, and supplemental services, but all focused on providing "core therapy" services to deal with the complex underlying causes of the offender's behavior. The projects predominantly used specific techniques to help the juvenile offender recognize and interrupt the chain of events which might lead to another offense.

Fresno County. The Fresno County project had a staffing level of 2.6 Full Time Equivalents (FTEs'), which included two psychologists. The project relied

more heavily on psychological testing and collateral contacts than did the other two projects.

The project's clinical orientation was cognitive-behavioral with educational components and process-oriented group and individual sessions. This involved the use of individualized treatment plans for each offender, addressing issues specific to each sex offender.

The Fresno County project staff were concerned about the resistance and denial of offenders and their families. Additional trainings and orientations were required for new probation officers and court personnel whenever the probation department had staff changes. Also, the Fresno County project had many families with limited resources living in outlying areas who had difficulty traveling to therapy.

Project highlights included establishing inter-agency cooperation among county services, and establishing a group for parents of victims and offenders. The project reported that groups for the juvenile sex offenders were particularly effective as cohesive units for treatment.

San Joaquin County. The San Joaquin County project had a staffing level of 2.5 FTEs' and used licensed Social Workers and Mental Health Counselors. The project used the most therapy groups and skills development sessions of the three projects.

The project's clinical orientation developed over the four years as therapists relied more on techniques which encouraged the offender to recognize the motivations, stressors and signs leading to the offense and to take full responsibility for their actions. The project helped offenders to learn alternative behaviors and improve social skills in a variety of groups. The project held family sessions to reduce the denial and minimization within the family and to encourage family members to provide an appropriate setting to keep potential victims safe.

In San Joaquin County, project staff were concerned that data collection detracted from clinical services and that probation department involvement in treatment was limited by case overloads. Some probation officers stated that they were not supportive of treatment. Some parents resented the time demands of the project and resisted involvement in the treatment process. There were few resources available for the after-care services needed.

Project highlights included having the pilot program offenders and the agency's residential offenders (when other funding was available) meeting together in treatment groups. This enriched the group process for both types of

offenders. Offenders demonstrated improved recognition and avoidance of high-risk situations, such as babysitting. Hypnotherapy was used to help process past victimization issues. Responsibility meetings with the offender, victim and family were conducted when possible and therapeutically beneficial for the victim. These meetings provided an opportunity for the offender to take responsibility for the sexual abuse and for the victims and family to express their feelings and questions directly to the offender. Offenders participated in mock responsibility meetings with counselors rather than the victim, when the victim was unavailable or not clinically appropriate. The project instituted shared-perception sessions in which adolescent sex offenders were confronted about their attitudes and behavior by victims or victim advocates.

Ventura County. The Ventura County project had a staffing level of 1.9 FTEs' and used psychologists, social workers and, when needed, a consulting psychiatrist. This was the only project to use psychiatric medication services. However, such services were not often indicated and were used in relatively few cases, usually for conditions unrelated to the offense behavior. This project provided more family therapy and case management sessions than the others.

The Ventura County project focused on both treatment and case management. The latter involved monitoring and facilitation of offenders' adjustment in the community through fairly close contact with important members of their networks (e.g., parents, guardians, probation officers). The treatment orientation had a mixture of cognitive-behavioral, behavioral, educational, and psychodynamic approaches. The emphasis was on offenders' establishing control over offending sexual behavior by accepting responsibility for it, understanding its roots, warning signs and consequences, and developing self-control strategies and alternative behaviors.

Limited staff resources reduced the project's ability to serve offenders in remote or inaccessible areas of the county who had difficulty traveling to therapy. Post-treatment follow-up monitoring and support services were needed but not possible due to limited resources. Gaps in county placement resources included the lack of a placement setting between secure residential and group home (i.e., open residential with on-grounds school) and the lack of specialized foster care. Offenders placed on informal probation often did not receive specialized treatment because unsentenced cases were not eligible for program services.

Project highlights included established bicultural and bilingual services (English-Spanish), and implementation of a multi-family therapy group. The multi-family therapy group included offenders, parents and siblings from several

families. At times, the group included victims. The project also established effective working relationships with local residential facilities, as well as with the courts and probation office.

Types of treatment

The three pilot projects screened 350 juvenile sex offenders and accepted 277 of those referrals for treatment. Program services totaled nearly 29,000 hours over the four years. During that time, over 36,000 treatment sessions and case meetings were provided.

Services to screen offenders referred for treatment included interviews with the offender, the offender's family, the probation officer, and psychological tests. These services totaled over 1,400 hours and averaged four hours for each offender referred.

For the 93 offenders who successfully completed the full recommended course of treatment, treatment spanned an average of 20.4 months and comprised an average of 161 treatment service hours and 198 sessions per offender.

For all 277 treatment offenders, including those who did not complete treatment because of the termination of the program, termination of their own probation, relocation with their families or a revocation, the average length of treatment was 13.7 months and 120 hours of treatment services per offender.

Each of the three projects provided therapy through an array of treatment modalities. These included individual, group, case management, networking sessions, collateral sessions with families, family therapy, home visits, psychological testing, and skills groups. The program's treatment hours totaled 7,253 hours in Ventura County, 9,669 hours in Fresno County, and 10,589 hours in San Joaquin County.

The pilot projects described the primary content of both individual and group psychotherapy sessions as focused on helping the offenders acknowledge and understand their offense behavior, their predisposition to offend and their responsibility for the offense, and to gain control of their behavior. With the therapist's guidance, the offenders identified the circumstances prior to the offense, recognized the emotions involved (such as anger, resentment, and emptiness), and the ways they actively precipitated the offense. Relapse-prevention and cognitive-behavioral approaches were extensively used in individual and group sessions.

Relapse-prevention therapy focused on the offenders' pattern of sexual violence and identifying corrective actions. Using relapse prevention

techniques, the offenders were helped to identify the situations in which they were at risk to reoffend. They were helped to identify their own vulnerabilities, their warning signs and their resources for overcoming the situation, and to rehearse the interventions needed to prevent a reoffense.

Cognitive-behavioral therapy focused on how thoughts and feelings direct a person's actions and how to reshape those maladaptive thoughts and feelings to change behavior. With a cognitive-behavioral approach, the offenders were helped to recognize their deviant sexual fantasies and "errors" of thinking. They learned and practiced ways to inhibit the fantasies and behavioral patterns that reinforce the offense behavior.

Both group and family sessions focused considerably more on the offenders' interactions with others. Group sessions provided offenders an opportunity to recognize the offense patterns of other members, helping them to recognize it in themselves. Group and family sessions also provided opportunities to confront the offender with victim reactions, to identify and correct dysfunctional interactions and to reinforce appropriate social and communication skills.

Treatment services provided

The distribution of treatment services by mode of treatment varied among the projects (Table 1). Fresno and Ventura Counties provided more individual sessions than group therapy sessions; while the San Joaquin County project provided a third more group sessions. Of the three counties, the Fresno County project provided 80% of all the testing sessions and the majority of collateral sessions. Ventura County provided the most family therapy sessions. San Joaquin County provided over 2,000 skills group sessions on nine specialized areas, such as relapse prevention, anger management, victim empathy, and self esteem. The other projects reported a minimal use of separate skills groups, but incorporated skill development into their weekly group therapy sessions. The groups sessions for those projects functioned to provide both skills training and group psychotherapy.

Table 1
Treatment Services Provided

	Pilot Juvenile Sex Offender Treatment Program:			
	Fresno	San Joaquin	Ventura	Total
Total Offenders in Treatment:	101	92	84	277
Individual therapy sessions	2,706	2,023	2,295	7,024
Group therapy sessions	2,402	2,996	2,103	7,502
Case management meetings	3,627	2,774	6,050	12,451
Networking meetings	165	470	143	779
Collateral sessions with offender's family	1,072	242	301	1,617
Family/couples therapy	655	540	814	2,009
Home visits for case management	1	1	13	15
Medication sessions	0	0	41	41
Other treatment sessions	104	51	209	364
Psychological testing while in treatment	643	94	80	817
Skills groups	94*	2,237	0*	2,331
Total Treatment Services:				
Number of sessions	11,469	11,428	12,049	34,946
Number of therapy hours	9,669	10,589	7,253	27,511

* NOTE: The Fresno and Ventura projects reported skills training as included with their group therapy sessions.

Cost of the program

The average annual per offender cost for the three projects was $1,623 of program funding and $2,500 of local indirect costs, for a total of $4,123. The averages for individual projects varied from $3,883 in Fresno County to $4,030 in San Joaquin County and $4,190 in Ventura County. The combined average weekly offender cost was $80, which included individual, group and family sessions as well as the other services described above. Some services were provided while offenders were in the local youth facilities. The additional probation services required by this program and any needed residential services are not included in this cost. Local indirect costs included the services provided by other agencies such as support groups, skills groups and educational classes. Most of the offenders did not have resources to pay for the treatment services and, as a result, no offender fees were collected according to OCJP accounting staff.

There are three major costs in treating the juvenile sex offender: treatment, supervision and residential care. The program paid only for the treatment and supervision services provided by program staff and described in this report. Additional costs not funded were the supervision expenses for specialized case management by probation officers and residential costs for maintaining some offenders in a more structured facility such as a group home. Future programs must consider these additional resource needs to insure that

adequate support is available for the comprehensive treatment of the juvenile sex offender.

Projects expressed preference for probation officers assigned to a specialized caseload of juvenile sex offenders. Such probation officers were more familiar with the program, the treatment issues and community resources. Similarly, project staff identified the need for specialized group homes for some offenders, especially if their victims were still in the home. As a result of additional studies, the cost per offender-year could be adjusted for the most effective length and intensity of treatment required for the different types of juvenile sex offenders.

The cost for the program's comprehensive treatment was lower than other alternatives for these offenders. The annual per offender institutionalization at the California Youth Authority (CYA) costs an average of $31,064. Specialized treatment at CYA costs an average of $65,000 per year. Incarceration at county juvenile facilities costs an average of $23,725 per year and intensive parole supervision (with minimal treatment) costs $6,400 per year. The annual treatment cost in the pilot program ($4,123) was 6% of the annual cost of institutionalized treatment.

Cost differences are compounded when the length of treatment is considered. The cost of a full 20 month episode of treatment in the pilot program averaged $6,871, whereas the cost for an average stay of 22 months in the CYA's specialized treatment facility ($119,166) plus five years of parole aftercare ($32,000) totaled $151,166. One treatment episode at CYA would pay for 22 juvenile sex offenders' treatment in the community. Intervention at the earliest stage of identification of the juvenile sex offender would save $144,295 just in correctional costs if that same offender went untreated, escalated in sexual violence and finally required specialized CYA placement. There would be many more additional costs with the additional offenses; including the costs of law enforcement and criminal justice services, victim services, and the indeterminate impact of the trauma on the victim and community.

The differences in cost between community-based and institutional services are very real. Those higher costs are clearly justified with the difficult sex offender who needs to be treated within an institution. The attempt of this pilot program, however, was to provide a previously unavailable alternative for the younger, less difficult offender who does not require that higher level of intervention and custody.

OFFENDER POPULATION

This section addresses the following topics: A) target population, B) juvenile offender referrals, C) offender population treated, D) demographic profile of offender population, E) history of victimization, F) offense profile of offender population, G) profile of offender victims, and H) clinical profile of the juvenile sex offender.

As a group, the 277 offenders referred to the pilot program treatment had victimized a total of 402 known individuals, ages 1 to 34, both male and female. There is no way to document the total number of victims generated by these offenders in any previous offenses prior to this referral. The primary charges for which they were adjudicated at referral include: PC 647a – Annoying and molesting a child (29%); PC 288a – Oral copulation (24%); PC 288 – Lewd or lascivious acts with a child under 14 (20%); and PC 243.4 – Sexual Battery (13%). The levels of violence used most often in these offenses include coercion (34%) and force (24%).

Target population

Criminal justice records indicate that few juvenile sex offenders are actually charged with the sex crime they commit. When sex crime petitions are filed and found true, most of those offenders will remain in their communities on juvenile probation, often without access to a comprehensive treatment program. In the mid-1980s', the only comprehensive treatment programs available were in the California Youth Authority facilities which served only the most disturbed offenders. SB 890 was designed to address three aspects of this problem by encouraging accurate charging for sex offenses, offering a less expensive outpatient treatment option for those who qualified and could benefit from community treatment, and making treatment compliance a condition of probation.

Many law enforcement specialists report that juveniles are undercharged for their sex offenses. The number of sex crimes is underreported because either the arresting officers do not charge the offender (informal diversion) or the charges are disguised by non-sex offense Penal Codes (such as burglary instead of rape). The failure to correctly charge juveniles with the actual sex offense, usually to avoid labelling them, may actually perpetuate, if not reinforce, the juvenile's pattern of sexual violence. Intervention should be as early and effective as possible to stop the habituation of sexually violent behavior. SB 890 encouraged a higher public safety standard by ensuring that those referred to

treatment were actually charged, adjudicated and held accountable for their sex crimes, and that their responsibility to participate in treatment was enforced through the terms of their probation.

The pilot program addressed the large population of juvenile sex offenders who remain in their communities. A review of California Department of Justice data for 1984 to 1987 shows that 89% of juveniles who had petitions sustained for sex offenses remained in the community under probation. In the three pilot project counties, 75% of the petitions filed were sustained. Of the petitions sustained, the average rate for the three pilot project counties was 93% for those who remained in the community under probation (Table 2). Of these, a small percent were required to serve time in the local youth guidance facilities.

In comparison, the state's average was 89% for adjudicated juvenile sex offenders remanded to probation within their own communities. The survey by the 1984 Juvenile Sex Offender Task Force, sponsored by the California Youth Authority, found that community outpatient treatment programs for juvenile sex offenders were sparse and rarely comprehensive, and that inadequate programs did more harm than good. The same was also found for programs within county juvenile facilities. By means of SB 890, the three county pilot projects would develop exceptions and test the viability of a comprehensive community treatment alternative.

Table 2
Juvenile Sexual Offense Incidence Pattern for 1984 - 87: 4 year summary

	Pilot Juvenile Sex Offender Treatment Program:				
	Fresno	San Joaquin	Ventura	Total	%
Population 1987	579,400	437,200	620,300	1,636,900	
Child Sexual Abuse Reports:	560	563	396	1,519	
Juvenile Petitions Filed:	68	50	33	151	
Total Sustained:	49	39	25	113	
Youth Authority and Adult Remands	3	3	2	8	7 %
Juveniles retained in the community	46	36	23	105	93 %

Juvenile offenders referred

In the four years of the pilot program, 350 juvenile sex offenders were referred for treatment. These offenders were assessed to determine if they met the criteria for treatment set forth in the legislation. Additionally, offenders needed to demonstrate "amenability", that is the motivation and ability to safely participate in and benefit from the program. The 79% acceptance rate indicates that the projects developed effective communication with their referring

probation departments about the type of offenders who were appropriate to participate in this pilot outpatient program. There were only slight differences among the three projects in their acceptance patterns. The reasons for non-acceptance, as shown in Table 3, were either 1) an issue of qualification – whether the juvenile was adjudicated, charged with one of the mandated Penal Codes and under the jurisdiction of the local county's probation office; or 2) an issue of amenability – whether the juvenile could be treated safely in the community. Of the 350 referrals, 33 individuals (9%) were found not to qualify, and 29 individuals (8%) were found not to be amenable to treatment.

The non-accepted cases were rated as higher risk and more violent in their crimes. Demographic characteristics of those not accepted indicate that they were older than those accepted, had offended against older rather than younger victims, used more extreme violence (e.g., a weapon) and were more likely to have serious developmental disabilities.

Table 3
Pilot Program -- Numbers of sex offenders referred

	Pilot Juvenile Sex Offender Treatment Program:				
	Fresno	San Joaquin	Ventura	Total	%
Total Referrals:	127	112	111	350	
Accepted treatment cases:	101	92	84	277	79 %
Not accepted for treatment:	26	20	27	73	21 %
Reason not accepted:					
Not Eligible:					
Not adjudicated	3	3	0		
Out of county offender	2	3	2		
Transferred or moved	0	4	4		
Sentenced to Youth Authority	7	1	4		
Subtotal				33	9 %
Not Amenable:					
(refuses, denies, or too violent)	10	8	11	29	8 %
Non-English speaking (no bilingual services)	1	0	2	3	1 %
Program funding soon to terminate	3	1	4	8	2 %

Offender population treated

A total of 277 (79%) of the 350 referrals were accepted into the pilot program. These offenders were analyzed by the type of discharge from treatment at the end of the funding. One-half of those accepted for treatment had successfully completed treatment or were still in treatment at the end of the funding. Another 26% were not available to complete treatment because their probation ended or their families relocated. Less than 25% were non-compliant with the treatment program and required proactive intervention which resulted in removal from the program and a recommendation for placement in a more

restrictive environment such as a residential program or the Youth Authority. Not all reoffending offenders were discharged in this category; some spent time in juvenile hall before returning to the program and a few completed the treatment.

Demographics of offender population

The demographic characteristics of the juvenile sex offenders in the pilot program, as described in Table 4, gives a composite picture of the offender as more frequently male, white, averaging 15 years of age, and with no disabilities. Two-thirds of the offenders were under 16 years of age. A total of 16 (6%) developmentally delayed offenders were accepted, but the more severely developmentally delayed offenders were not accepted because the projects could not meet their special needs. Ethnic compositions of the offenders for each of the projects were generally close to those of their communities. Hispanics comprised one-third of the accepted cases and Blacks 10%.

Table 4
Demographics of offender population

	Pilot Juvenile Sex Offender Treatment Program:				
	Fresno	San Joaquin	Ventura	Total	%
Total Offenders in Treatment:	101	92	84	277	
SEX:					
Female	1	0	2	3	1 %
Male	100	92	82	274	99 %
RACE:					
American Indian	3	1	1	5	2 %
Asian	1	2	1	4	1 %
Black	15	5	7	27	10 %
Filipino	1	3	1	5	2 %
Hispanic	40	26	26	92	33 %
White	40	55	47	142	51 %
Other	1	0	1	2	1 %
AGE GROUP:					
Age 8-11	4	1	0	5	2 %
Age 12-15	64	57	50	171	62 %
Age 16-17	29	33	30	92	33 %
Age 18+	4	1	4	9	3 %
AGE AVERAGE:	14.7	15.0	15.1	14.9	
AGE RANGE:	(10-19)	(11-18)	(12-19)	(10-19)	

History of victimization

The juvenile offender's own victimization is believed to have a significant role in the development of offending behavior. In this group of offenders, summarized in Table 5, 75% acknowledged some form of victimization, either sexual, physical or psychological. The category of psychological abuse in this study combines emotional abuse, neglect,

abandonment and rejection. Psychological abuse was most often associated with parental alcoholism. Histories of abuse were obtained mostly by self-reports or reports of family members.

In terms of sexual abuse, 34% of the offenders acknowledged sexual abuse and another six percent acknowledged some non-contact sexual trauma. Nearly 50% of those sexually abused were also victims of other forms of abuse.

Forty-three percent of the 208 offenders eventually identified as abused did not acknowledge the abuse at admission. This is consistent with other studies which suggest that juvenile offenders are reluctant to discuss their abuse until trust can be established with staff. However, those with multiple forms of abuse or more extensive abuse histories were more likely to be identified at admission, either because they were less likely to use denial or because the abuse was more likely to be noted in other case material.

Table 5
Victimization history of offenders

	Pilot Juvenile Sex Offender Treatment Program:				
	Fresno	San Joaquin	Ventura	Total	%
Total Offenders in Treatment:	101	92	84	277	
Abuse or neglect history:					
Any type of abuse	83	64	61	208	
Percent of treatment cases	82%	70%	73%	75 %	
Victimization by abuse combination:					
Sexual, Physical and psychological	14	7	10	31	11 %
Mix of two: sexual, physical, or psychological	30	23	14	67	24 %
Sexual alone	13	11	16	40	14 %
Physical alone	19	13	9	41	15 %
Psychological alone	7	10	12	29	10 %
No abuse identified	18	28	23	69	25 %
Frequency for each type of abuse: (more than one type of abuse may be identified)					
Sexual abuse	37	29	27	93	34 %
Sexual trauma or suspected abuse	7	3	6	16	6 %
Physical abuse	50	37	28	115	42 %
Psychological (emotional, neglect, rejection)	16	11	23	50	18 %
Difference in timing of abuse acknowledgement: (Percents are of 208 abuse cases)					
If abused, acknowledged at admission	39	41	38	118	57 %
If abused, acknowledged during treatment	40	24	26	90	43 %

Offense profile of offender population

The offense profile of the juvenile sex offender in the pilot program, as described in Table 6, provides a composite picture of the juvenile offender as more frequently adjudicated for Penal Code 647a (annoying and molesting a child), for charges involving one victim, who was usually a female averaging 8 years of age.

Over one-third of the offenders used force or the threat of force in their offense and another one-third used coercion and manipulation in their offense. Only four of the offenders used or threatened to use a weapon. This rate of weapon use was lower than that of referrals not accepted by the program. Weapons were associated with assessments of high risk levels considered unacceptable for community treatment.

Table 6
Sex Offending Profile

		Pilot Juvenile Sex Offender Treatment Program:				
		Fresno	San Joaquin	Ventura	Total	%
Total Offenders in Treatment:		101	92	84	277	
PENAL CODE OF REFERRING OFFENSE:						
PC 647a	Annoying and molesting a child	50	21	8	79	29 %
PC 288a	Oral copulation	23	26	20	69	25 %
PC 288	Lewd or lascivious with child under 14	2	9	43	54	20 %
PC 243.4	Sexual Battery	8	24	4	36	13 %
PC 286	Sodomy of a child	13	2	2	17	6 %
PC 261	Rape	1	0	3	4	1 %
PC 289	Penetration with foreign object	0	0	3	3	1 %
PC 264.1	Rape in concert with force	1	1	0	2	1 %
PC 285	Incest	0	1	0	1	0 %
PC 220	Assault with intent to commit a sex crime	0	0	1	1	0 %
PC 266	Enticement for prostitution	0	0	0	0	0 %
PC 664	Attempted sex crimes	0	0	0	0	0 %
Misc--	Accepted as program exceptions: (statutory rape, indecent exposure, etc.)	3	8	0	11	4 %
USE OF FORCE:						
Coercion and manipulation		24	63	10	97	35 %
Threatened Force		15	4	19	38	14 %
Used force		49	14	4	67	24 %
Threatened use of a weapon		1	1	1	3	1 %
Used a weapon		0	1	0	1	0 %
Unclear what force was used		12	9	50	71	26 %
PRIOR OFFENSES:						
Prior Criminal Offenses (non-sexual)		37	24	28	89	32 %
Prior Sex Offenses		10	7	12	29	11 %
NUMBER OF VICTIMS (this conviction):						
1		81	60	56	197	71 %
2		16	21	19	56	20 %
3		4	5	5	14	5 %
4 to 7		0	6	4	10	4 %
RANGE:		(1 - 3)	(1 - 7)	(1 - 7)	(1 - 7)	
AVERAGE NUMBER OF VICTIMS:		1.2	1.6	1.5	1.5	

Curiously, one-quarter of the offenders' use of force was not reported by the projects. If not known, this might significantly reduce the projects' ability to identify relapse prevention strategies. There may have been limited access to police reports in those projects, or the use of force was not clearly established.

The known criminal justice histories of these offenders reveals that 34% had prior non-sexual offenses and 10% had prior sexual offenses.

Profile of offenders' victims

The juvenile offender is usually an average of eight years older than the victim and does not reside in the same home as the victim, but is either known or related to the victim – allowing access to the victim. As described in Table 7, the juvenile offenders treated in this program were most likely to have had some prior interaction with their victims; only six of the offenders victimized a stranger.

Clinical profile of the juvenile offenders

Clinical descriptions of the offenders were provided by several clinical assessments: a diagnosis using the psychiatric Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R); admission and discharge Global Assessment of Functioning Ratings (G.A.F.); and by admission and discharge Juvenile Risk Assessment Scale. A series of psychological tests was also used to assess offenders' treatment needs and their progress in therapy.

A DSM-III-R diagnosis identified several dimensions of the offenders' disorders based on behavioral criteria assessed by the mental health professionals. These included level of offender's stress and their success at coping with the stress. The G.A.F. ratings described the offenders' overall level of functioning by means of a 100 point scale. The Juvenile Risk Assessment Scale ratings estimated the level of risk for further sexual-acting out based on the clinicians' assessment of the offenders' histories and their current attitudes and behavior.

Although both the DSM and the Global Assessment Scale were revised during the course of the program, these changes were minimal for an adolescent population. Differences between admission and discharge ratings are discussed in the findings section.

Table 7
Profile of Offenders' Victims

	Pilot Juvenile Sex Offender Treatment Program:				
	Fresno	San Joaquin	Ventura	Total	%
Total Offenders in Treatment:	101	92	84	277	
TOTAL NUMBER OF VICTIMS:	125	148	129	402	
SEX OF VICTIM NUMBER 1:					
Female	63	70	53	186	67 %
Male	38	22	31	91	33 %
AGE OF VICTIM NUMBER 1:					
Age 00-03	4	12	8	24	9 %
Age 04-07	42	33	27	102	37 %
Age 08-11	37	25	37	99	36 %
Age 12-15	16	17	9	42	15 %
Age 16-17	2	3	0	5	2 %
Age 18 +	0	2	3	5	2 %
VICTIM NUMBER 1: RANGE	(3-16)	(2-25)	(1-34)	(1-34)	
AVERAGE AGE:	8.3	8.3	8.6	8.4	
AGE DIFFERENCE:					
Offender younger than victim					
3 to 18 years younger	0	1	3	4	1 %
2 years younger	1	1	0	2	1 %
Offender same age as victim					
1 year younger thru 1 year older	9	14	3	26	9 %
Offender older than victim					
2 to 3 years older	10	4	10	24	9 %
4 to 6 years older	26	18	19	63	23 %
7 to 9 years older	40	28	31	99	36 %
10 to 14 years older	15	26	18	59	21 %
OFFENDER'S RELATIONSHIP to Victim Number 1					
RELATED OR WITHIN FAMILY:					
Sister (Blood / natural, Half, Step or Foster)	26	26	11	63	23 %
Brother (Blood / natural, Half, Step or Foster)	5	4	5	14	5 %
Extended family (cousin, nephew, niece)	18	16	16	50	18 %
Older relative	0	0	3	3	1 %
Subtotal	49	46	35	130	47 %
NOT RELATED:					
Child caring for when babysitting	1	0	6	7	3 %
Peer, friend, schoolmate	31	24	24	79	29 %
Neighbor	19	20	16	55	20 %
Stranger, no prior relationship	1	2	3	6	2 %
Subtotal	52	46	49	147	54 %
PROXIMITY TO VICTIM:					
N/A	0	3	1	4	1 %
Offenders living with victims	38	29	27	94	34 %
Offenders not living with victims	59	50	47	156	56 %
Offenders' victims both in/out of home	3	7	4	14	5 %
Other environmental situations	1	3	5	9	3 %

The general functioning measures such as DSM-III-R diagnoses and G.A.F. ratings indicated little overt clinical pathology. This is typical of sex offenders, who are usually not psychotic and often not even obviously dysfunctional. Sexual violence is more often associated with personality disorders. Diagnostic

conventions typically preclude adolescents from being diagnosed with personality disorders or sexual compulsions (paraphilias), because of the lack of evidence that these disorders are solidified at that age. While there may be clear tendencies of an emerging personality disorder, diagnosis usually reflects the referring behavior, such as a form of conduct disorder.

The majority of juvenile sex offenders treated in this program were diagnosed as having one of the conduct disorders (150 or 54%) or an adjustment disorder with disturbance of conduct (53 or 19%). Contributing stressors were rated most often as the moderate to severe level. The highest level of functioning was rated in the poor to fair range. G.A.F. ratings were high for an outpatient clinic population, averaging 58 on a 100 point scale. The means for each project ranged from 55 to 62, which suggests offenders were similar in functioning levels across the three projects.

Juvenile Risk Assessment Scale ratings had more value clinically in this program and were focused on the offender's acceptance of responsibility, self-awareness, pattern of offense behavior, level of impulse control, and need for external controls. The program modified the risk assessment rating form which was originally developed for use in the California Youth Authority. The form went through several revisions based on the projects' clinical experiences. The final Juvenile Risk Assessment Scale served as a checklist of the major factors believed to contribute to each of three levels of risk. After rating those factors which applied, the clinician gave a global rating of low, moderate or high risk. Risk ratings were significantly associated with levels of violence used in the offense [ANOVA $F(4,245) = 7.618$, $p < .000$]. The risk ratings were also significantly associated with the offender having a history of being sexually abused [ANOVA $F(1,248) = 3.916$, $p < .05$]. As discussed in the findings section, the Juvenile Risk Assessment Scale shows promise in identifying potential sexual-reoffenders from the non-reoffenders and to monitor treatment changes.

Table 8 shows the global risk at intake for all 350 referrals. The referrals were mostly assessed as low and moderate risk, although the projects did get some high-risk referrals. Of the referrals not accepted, 21% were rated high-risk while only 10% of those who were accepted for treatment were rated high-risk. All three projects accepted some high-risk referrals which indicates that their screening process was not overly constricted. This will help to profile the offenders most likely to benefit from this treatment model. More of the offenders referred to the Fresno County project were identified as high risk than

the other two projects. The Fresno County project also accepted into treatment a greater percent of offenders rated as high-risk.

Table 8
Admission Juvenile Risk Assessment Scale Ratings

	Pilot Juvenile Sex Offender Treatment Program:				
	Fresno	San Joaquin	Ventura	Total	%
Cases not accepted for treatment (47 rated cases):					
Low Risk	6	6	1	13	28 %
Moderate Risk	8	8	8	24	51 %
High Risk	8	2	0	10	21 %
Cases accepted for treatment (250 rated cases):					
Low Risk	27	50	36	113	45 %
Moderate Risk	52	29	32	113	45 %
High Risk	15	6	3	24	10 %

Results of combining services

The evaluation questions identified in SB 890 included one on the effectiveness of treatment services which combined "pedophile" offenders with the "intra-familial" (within-family or incestuous) type of sex offenders. The typology suggested by this legislative question is not as clearly defined in clinical practice. For example, many clinicians believe that all sex offenders against children are pedophiles and differ only in their victim selection preferences. In contrast, the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) is relatively narrow in its definition of a pedophilia disorder. It should be noted that the program also included other types of sex offenders in treatment, such as rapists, who posed other possible treatment compatibility problems.

Several criteria were used in the pilot program to identify the pedophile group referred to in the legislation. In clinical practice, the three pilot projects were more likely to consider offenders to be pedophiles under any of the following conditions, even though their victims may have been family members: the offender had a history of repeatedly victimizing children, a long history of victimizing the same child, and/or a predatory approach to children demonstrated by seeking out vulnerable children.

In light of either the DSM III-R criteria or the clinical criteria, very few of the program's juvenile offenders fit the description of a pedophile. Only 6 (2.2%) were diagnosed as pedophiles. Therapists assessed another 12 offenders as having distinct characteristics of a pedophile, for a total of 6.5%.

As a result of these small numbers, no distinct specialized services were developed for the two groups. Projects reported that staff placed the "pedophile" offender into group sessions based on the characteristics of both the particular

offender and the group. A review of the clinical outcomes, numbers and types of services for these cases did not reveal significant differences from the non-pedophile offenders.

PROGRAM EVALUATION FINDINGS

The evaluation findings for the pilot program are presented in the following section on recidivism and treatment outcomes, and are also summarized in the responses to the legislative questions in the Executive Summary.

Operational definition of recidivism

Treatment success is measured directly by recidivism, which is defined as the rate offenders commit new offenses during a defined period of time. A low rate of recidivism is the best measure of program success. The term "recidivism" needs to be operationally defined because of its importance for evaluating this program and for comparing the results with other studies, which may differ in their definition of recidivism or in the length of time upon which the rates are based.

For the purpose of this study, recidivism is defined as behavior for which there are new charges (a new arrest or petition filed) during the course of treatment. No reoffense reports were provided on offenders after they completed their treatment. New arrests during treatment were reported as either sexual offenses or non-sexual offenses. The reoffenses were examined by type of offense, circumstances of the offense, and characteristics of the offender. It should be noted that recidivism rates based on arrests have the potential to be biased by either under or over reporting.

Recidivism: Under-reporting. Law enforcement and the court may use a probation revocation rather than a new arrest as a way to process a new offense, which would not be included in recidivism rates. A more accurate measure of recidivism might be to count any behavior which meets the criteria of a sex offense as defined in the Penal Code.

As an example, two incidents were described by projects in this study which were most likely reoffenses but were not counted as such because there were no arrests. Two offenders had sexual contact with younger males, one in juvenile hall and the other in a residential facility. Although these were described by investigators as consenting sexual contacts, this might be suspect

because of the offenders' histories and an assumption that these victims were "willing participants".

Recidivism: Over-reporting. Recidivism rates based on arrests may be over-reported if sex-offenders are arrested with charges which are later not sustained or are dropped. Such charges would still count towards the recidivism rate.

The final determination of program effectiveness comes from the reoffense rates for these same offenders several years after discharge from treatment, as compared to those who did not get treatment. While such a longitudinal approach is beyond the scope of this pilot program, this evaluation provides a baseline for such a study.

There were two possible sources for recidivism data: program staff and the criminal justice data system. The criminal justice data system has restrictions on the types of juvenile records kept, as well as on the access to those records and the length of time the records are kept. In this study, program staff are the primary source of information on recidivism. The therapist's awareness of new offenses comes from the offender, the offender's caretakers, and the probation officer. Program staff reported all reoffenses, as well as any other "special incidents", through several reports: monthly service reports, progress reports, reassessment of risk ratings and discharge summaries. Program staff filled out a special incident report for significant risk behavior whether it involved an arrest or not for offenders who were in treatment. There were no reliably consistent means to collect reoffense data for most offenders after they were discharged from these projects, either because they had moved, were off probation, or were no longer juveniles.

A study of the Uniform Data Collection System by the Kempe Center's National Adolescent Sexual Perpetrators Treatment Network also documents difficulty obtaining reliable recidivism data. The Kempe Center's Uniform Data Collection System has served as a national clearinghouse for juvenile sex offender treatment. In 1989, over 1,600 cases had been entered into the system. The Center wanted to study 322 cases which were discharged more than 12 months prior to the 1989 study date. Only 69 (21%) of the 322 cases were able to be followed-up regarding reoffense. The reasons reported in their 1990 newsletter for the lack of follow-up information were that providers "did not have time available to attempt follow-up, others reported that they were unable to obtain the requested information from law enforcement or the court system,

and some reported that they no longer had access within their system to the files which would have allowed them to attempt contact with the parent or offender."

Recidivism rates

The recidivism rate for new arrest for sexual offenses by offenders who were in treatment was 2.5%, as detailed in Table 9. Only seven offenders were rearrested for new sex-related offenses while in treatment. The period of potential opportunity for reoffense in the present study was the period of time offenders participated in treatment. This totaled over 4,000 offender-months, or an average of 15 months of potential risk per offender. Recidivism rates for sexual offenses did not differ among the projects. Five of the seven reoffenses (71%) were misdemeanor sexual offenses and were equal or less serious offenses compared to the original committing offense.

Another 31 offenders were arrested for new non-sexual offenses. Most of these were non-violent, property offenses, such as burglary, theft and substance abuse. The rate for non-sexual offenses involving rearrest by offenders in treatment was 11.2%, for the same average 15-month period of potential opportunity for reoffense. One of the projects had nearly twice the rate for non-sexual reoffenses. Possible reasons for this will be discussed later.

The combination of these two rates equals 13.7%. There are no readily available recidivism studies using a comparable outpatient population. The pilot program's reoffense rate will provide a baseline for possible follow-up studies of these offenders several years after treatment. As a point of reference, the statewide Youth Authority recidivism rate is 34% for a relatively more serious population of combined sexual and non-sexual offenders.

The Kempe Center's National Adolescent Sexual Perpetrators Treatment Network 1990 newsletter reported a national recidivism rate of 9.2% for sexual reoffenses out of 69 cases discharged from treatment for one to two years. The study does not indicate the percent of offenders treated in community versus institutional programs. In their study, therapists' impressions of clinical success and length of treatment did not predict reoffense. However, the ability to identify offense-triggers and the ability to interrupt the offense cycle were significantly associated with preventing reoffenses. The SB 890 pilot study's recidivism rate of 2.5% is based on offenders who were still in treatment and should be expected to have rates comparable to or lower than a post-discharge rate. Again, this is for reference and does not serve as a comparison rate.

The most significant study on recidivism of adult sex offenders, done at Atascadero State Hospital by V. Sturgeon in 1973, indicates that 15% of the

offenders reoffended with sexual crimes within five years of release from the state hospital. Although the offenders considered to be high-risk at discharge committed more than two times the number of offenses during the first three years after discharge as did low risk offenders; these two groups were matched in number of reoffenses in the period between three and fives years post-treatment. This preliminary research has alerted treatment programs to the need for aftercare services and the careful assessment of post-treatment recidivism. It is the period of time after treatment termination that best determines the effectiveness of specific program interventions with various categories of sex offenders.

Table 9
Recidivism Rates

	Pilot Juvenile Sex Offender Treatment Program:				
	Fresno	San Joaquin	Ventura	Total	%
Total Offenders in Treatment:	101	92	84	277	
OFFENDER RECIDIVISM (based on new arrests*)					
Sex Offenses	3 (03.0%)	2 (02.2%)	2 (02.4%)	7	02.5%
Non Sexual Offenses	8 (07.8%)	7 (07.6%)	16 (19.1%)	31	11.2%
Total	11 (10.9%)	9 (09.8%)	18 (21.4%)	38	13.7%
Offenders Who Did Not Reoffend	90 (89.1%)	83 (90.0%)	66 (79.0%)	239	86.3%

* NOTE: Depending on age of the offender, the new charges might have been juvenile petitions filed or an arrest as an adult.

The profiles of the sexual reoffender and the non-sexual reoffender differed considerably in their age and time in treatment, which suggests that there are very different dynamics contributing to these two types of reoffenses. Differences were also noted between the sexual reoffenders and the offenders who had no special incidents.

Table 10
Profile of Offenders by Reoffense Outcome

	Total Number Discharged	Average Admission Age (range)	Average Months of Treatment	Average Admission G.A.F.	Risk
Average for all offenders	277	14.9 (10-19)	13.7	56.4	1.8
Average for non-incident offenders	173	15.0 (11-19)	13.2	56.3	1.4
Average for all sexual reoffenses	7	13.6 (10-17)	6.3	51.7	2.1
Average for all non-sexual reoffenses	31	14.6 (13-18)	10.7	59.4	1.6
Type of non-sexual reoffense:					
Burglary, robbery, auto theft	10	14.4(13-17)	14.4		
Drugs possession or sales, DUI	5	14.2 (13-15)	13.0		
Stealing, shoplifting	11	14.9 (13-18)	8.3		
Assault, fighting	5	15.0 (13-16)	6.0		
Average for other probation violators	32	14.8 (11-18)	13.0	58.3	1.7
Average for any other incident	34	15.2 (12-17)	15.6	54.3	1.4

Age Differences. There was a difference in the mean age at admission for the group which reoffended with sexual as opposed to non-sexual charges, as noted in Table 10. The reoffender with sex charges was younger (13.6 yrs) than the non-sexual reoffender (14.6) and the non-reoffender (15.0). There was also a statistically significant difference in age between those who sexually reoffended and those without any reported incidents during treatment [ANOVA $F(1, 178) = 5.18$, $p<.024$].

Higher Risk Profiles. Despite the small number of sexual reoffenders, there was a statistically significant difference in the admission risk ratings of those who sexually reoffended versus those who had no incidents of any kind. Sex reoffenders were rated more often at admission as being at great risk, with an average higher global risk rating of 2.1 versus 1.4 for those with no incident of any kind [ANOVA $F(4,245) = 3.04$, $p<.018$]. The offenders who sexually reoffended were also rated as more dysfunctional at admission, with lower Global Assessment of Functioning scores than those with no incidents of any kind (51.7 versus 56.3). While not statistically significant, there were also differences for functioning and risk between the sexual-reoffender and the non-sex reoffender.

Reoffense Dispositions. The disposition of the seven sexual reoffenders varied. One reoffending offender was sent directly to the Youth Authority. Two were removed from the program prematurely after their reoffense while going through the court process. Four continued in treatment after spending time in

the local juvenile facility. Of these four, one successfully completed the program, one left treatment after probation ended, one was transferred to another treatment service out of the county, and one was later revoked for non-compliance.

For the non-sexual reoffenses, there was the same range of dispositional variation. Some continued in the program after doing some time in local juvenile facilities and successfully graduated. Others continued in the program but were revoked for continued at-risk behavior. Others were revoked immediately and referred to other programs or to the Youth Authority.

The results of these varied interventions suggest that there is no single recommended response. The range of outcomes suggests that each case should be determined individually. The program demonstrated that sexual and non-sexual reoffenders could successfully complete their program without further reoffenses after a period of incarceration in the local juvenile facility and subsequently return to the treatment program where, typically, the reoffense would be meticulously reexamined through the remaining treatment. Treatment services were often provided to the reoffender while in the local youth facility.

Precipitating Factors. The reoffender with new sex-related charges was more likely initially to have had a younger victim than either the non-sex reoffender or the non-reoffender. The precipitating circumstance for the sexual reoffense was identified most frequently as the presence of young children in the home. Even with "no-contact" probation and court orders, the parents of the offenders had brought other children into the home and requested the offender to provide child care. In another situation, the reoffense occurred soon after the offender first acknowledged in therapy his own victimization. Two other reoffense situations provide useful clinical information. One offender had a compulsion for voyeuristic and exhibitionist behavior and was arrested after a second such incident. Another offender who committed rape, the most serious reoffense, was described by the therapists as "looking too good, too fast". Without significantly modifying treatment, the effectiveness of the pilot treatment model may be more limited for the compulsive "flasher" and for more sociopathic offenders.

Prevention of reoffenses. These findings provide some guidance to juvenile treatment programs by helping to identify the most at-risk offender populations. The following observations are suggested by these findings:

* Younger offenders may be more at risk to reoffend.

* Sexual reoffenses are more apt to occur early in treatment.
* Programs need to work with probation officials and caretakers in monitoring the home situations for the presence of younger children, either by asking the offender directly, by collateral or family therapy sessions with caretakers, or by home visits. One offender, in a good example of a relapse prevention method, had informed treatment staff of being tempted when the parents brought children into the home against the conditions of his probation.
* Other patterns of compulsive sex offending such as exposure and voyeurism need to be specifically and adequately addressed by treatment, or such offenders should be screened out of the program.
* There needs to be more serious assessment of possible sociopathic tendencies in offenders who manifest qualities such as a superficial and glib affect and an effortless accommodation to program activities.

Treatment outcome

Another indicator of program success is the outcome of treatment as measured by the type of discharge and the profile of those who successfully completed treatment. A third of the offenders accepted for treatment completed the course of treatment. Those who did not complete treatment were categorized by four types of discharges as listed in Table 11: still in treatment at the end of the funding (16%), not physically available for treatment (15%), terminated from probation prior to ending treatment (11%), and removed from the program for non-compliance (25%). Only the last type of discharge was based on non-compliance to treatment and constituted either a reoffense or a pro-active intervention. Reoffending offenders were found to have any of these types of discharges. Some even continued in the program after serving time in the local juvenile facility where treatment was often provided.

Table 11
Treatment Outcomes
and percent for each Project

	Pilot Juvenile Sex Offender Treatment Program:				
	Fresno	San Joaquin	Ventura	Total	%
Total Offenders in Treatment:	101	92	84	277	
Still in treatment when grant ended:	15 or 15%	15 or 16%	14 or 17%	44	16 %
Completed program - maximum benefit:	32 or 32%	29 or 32%	32 or 38%	93	34 %
Did not complete program:					
Probation ended	16 or 16%	7 or 08%	6 or 07%	29	11 %
Not available: moved, ill, etc.	13 or 13%	11 or 12%	17 or 20%	41	15 %
Revoked or expelled (This includes proactive interventions)	25 or 25%	30 or 33%	15 or 18%	70	25 %

Offenders who were still in treatment at the end of the program funding were discharged and referred to other therapy services if funding or services were available. The county agency could continue treatment on a less intense basis if the offenders qualified for California public mental health funding. If no treatment was available, the probation officer was notified and was advised to make appropriate arrangements, if only to increase case monitoring.

Another type of discharge occurred when the offender was no longer available for treatment. Usually, the reason was that the offender had moved out of the area. The transient aspect of the juvenile offender's living situation was noted for the referral group as well, and would need to be addressed in any statewide program. Probation officers and program staff approved new living situations that were appropriate and did not put other youths at risk, but often therapy resources were not available in the new location or new county. No follow-up study was done to assess either the new living situation or the continuation of treatment. Other unavailable offenders were discharged for illness or difficulty in getting transportation to therapy. One offender died while in treatment.

One group of offenders was discharged after probation ended and there was no authority to mandate the treatment. None of the offenders continued after probation was terminated. Termination usually occurred because the offender reached the end of the term of probation and/or reached 18 years old. No documentation was collected to determine if requests were made to the court to continue juvenile jurisdiction, or the results of any such requests. Occasionally, the term of probation was shorter than the recommended 18 months of treatment. Projects reported that they felt an obligation to accept some

of those "time-limited" offenders because there were no other treatment options for them in their community.

The last group was discharged either because they were revoked or were expelled from their program. If AWOL, the probation was revoked and the offender was discharged from the program but the final court disposition was not always identified. The offenders in this group included those sent to the Youth Authority or local juvenile facilities, or transferred to residential facilities. They may have been revoked for a reoffense or a proactive intervention such as described below because they were considered at high risk for a reoffense.

Proactive intervention

An important measure of program success is the degree to which a program is able to recognize offender deterioration or escalation of at-risk behavior, prior to another reoffense. Usually, it is the treatment staff which identifies or learns about the offender's high-risk behavior, but the offenders themselves may talk in therapy about their own high-risk behavior. The treatment staff, with the help of law enforcement and the courts, can initiate proactive intervention to interrupt the offense cycle by pressing for a revocation or modification of probation. Such an intervention may result in the court placing more stringent conditions on the offender's probation or remanding the offender to a local juvenile facility or to the Youth Authority if the potential of a reoffense is great enough. Reports of these pre-offense behaviors are indicators of treatment success in case management and should not be equated with the treatment failures. Two-thirds of the offenders were not involved in any special incidents and did not require any intervention.

Proactive intervention was used for 32 offenders (12%) who were identified by the treatment team and/or probation staff as engaging in high risk behavior, which did not constitute reoffense, but may have been pre-reoffense behavior. These offenders were often returned to court on probation violations and considered for increased levels of supervision, or sentencing to local juvenile facilities. The offenders were usually returned to the program to continue with treatment, but occasionally, they were referred to a different type of treatment program (such as substance abuse) or transferred to a residential facility, often in a different county.

In addition to those who were considered for probation violations, another group of offenders was involved in some incident which constituted acting out behavior but which did not require judicial intervention. These behaviors were noted and monitored as having some risk potential. A total of 34

offenders (12%) had some incident noted by treatment staff which did not result in any further intervention.

This potential for at-risk behavior requiring pro-active intervention is consistent with an offender population with histories of victimization, clinical deficiencies, prior offenses and other anti-social activity. In addition to the risk for sexual reoffense, which seemed to be low during treatment in this program, juvenile sex offenders, similar to other types of adolescent offenders, are at risk for a diverse range of other non-sexual offenses such as substance abuse, theft and fights. Treatment was required for those non-sex offense issues as well. Both types of reoffenses were controlled in part by program policies of proactive intervention through frequent treatment and monitoring contacts with the offender and the offender's caretakers. The low rate of recidivism suggests that pro-active intervention serves an important deterrent function in preventing reoffenses.

Treatment compliance

Treatment compliance provides another measure of program success. The overall rate of no-shows for appointments had a statistically significant association with reoffenses [ANOVA $F(3,233) = 4.96, p<.002$]. Not showing for a scheduled appointment was considered by staff as a demonstration of the offender's lack of responsibility. For all offenders, the average rates were low for cancellations, late or missed appointments. Rates were somewhat higher in the San Joaquin County project than the other two projects. This may have been the result of both more scheduled appointments and a more comprehensive reporting system which San Joaquin County established.

Treatment compliance can also be measured by changes in risk levels. Admission and discharge ratings of offenders provide a means of measuring integration of the treatment goals. Program staff rated offenders at admission and at discharge as one of three levels of risk; low, moderate or high. Changes between admission and discharge risk assessment ratings were examined. The Juvenile Risk Assessment Scale ratings, by nature of being only three points, suppresses variability, making it less likely that an offender's rating would change from one level to another. Consistent with that tendency, nearly half the offenders were rated with the same level of risk when they entered the program as when they left, as seen in Table 12. One exception was the offenders who were revoked or expelled. They were more likely to be rated at a higher risk level.

When examining all offenders, only the group which successfully completed their treatment had a decrease in risk ratings. All other groups, none

of which completed treatment, showed no such decrease in risk ratings. The revoked group showed the greatest increase in risk ratings. The Juvenile Risk Assessment Scale promises to be effective in both identifying high-risk offenders and measuring change. The evaluation data can provide a meaningful resource to analyze the risk assessment items and help create a refined scale.

Table 12
Change in Juvenile Risk Assessment Scale Ratings from Admission to Discharge

Percent of Offenders with Change in Ratings:	Decrease in risk level	No change in risk level	Increase in risk level	Difference in risk level
Risk Change Ratings:				
All levels of treatment offenders	24 %	51 %	25 %	+1 %
Distribution by type of discharge:				
Completed treatment	38 %	57 %	6 %	-32 %
Revoked or expelled	10 %	43 %	48 %	+38 %
Probation ended	18 %	50 %	32 %	+14 %
Transferred or moved	20 %	53 %	27 %	+7 %
In treatment at end of funding	23 %	47 %	30 %	+7 %

Program effectiveness

Each measure of program success – recidivism, treatment outcomes, proactive intervention and treatment compliance – can be used to assess program effectiveness. The pilot projects, as described in a previous section, were remarkably similar in their commitment to serving the juvenile sex offender. Treatment philosophies, delivery systems, offender populations and organizational approaches were fairly consistent among the three projects. A few important differences did emerge which bear upon program effectiveness.

Services in all projects were comprehensive and extensive. Table 13 shows the average level of treatment provided by each project for the offenders who completed treatment and for those who were revoked. Successful cases took between 19 and 22 months of treatment, consisting of an average of 161 hours, in over 198 sessions. The revoked and expelled cases received half of those services in half as many months prior to discharge. San Joaquin County had the highest number of the revoked and expelled offenders, but identified them earlier in their course of treatment.

Differences did not emerge regarding sexual reoffenses. Each project had a similar low number of sexual reoffenses, with no particularly unique patterns in the offender profiles or offense consequences. Each project would benefit from a more intensive system of monitoring offender living situations, as previously noted.

Table 13
Treatment Services by Completed and Revoked Treatment Groups

	Pilot Juvenile Sex Offender Treatment Program:				
	Fresno	San Joaquin	Ventura	Total	%
Total Offenders in Treatment:	101	92	84	277	
Completed Program - max benefit:	32	29	32	93	34 %
Average sessions	180	212	203	198	
Average hours	159	203	125	161	
Average months of treatment	22.1	19.7	19.3	20.4	
Revoked or expelled:	25	30	15	70	25 %
Average sessions	113	99	118	108	
Average hours	88	88	68	84	
Average months of treatment	14.3	10.8	11.4	12.2	

Non-sexual reoffenses were not as evenly distributed. Ventura County combined group therapy and skills training in one weekly group session, unlike, for example, San Joaquin. This resulted in fewer weekly contacts with offenders, i.e. less supervision, as well as, perhaps, less intensive focus on techniques for internal control. Another relevant factor might be the lower number of proactive interventions among offenders of this project. The Ventura County offenders were less likely to have probation violated or be given juvenile hall time for non-compliance.

Table 14 shows offender risk profiles by type of discharge. Fresno County rated their offenders as more severely disturbed at admission with lowest psychological functioning as measured by the G.A.F. and higher risk ratings. They were followed by San Joaquin County and Ventura County. The rates for all revoked were found to be associated with both the highest risk ratings and the lowest functioning ratings at admission.

Table 14
Profile of Offender Risk by Project and Type Discharge

AVERAGE:	Number Discharged	Admission Age	Months of Treatment	Admission G.A.F.	Risk
Offenders in Treatment:	277	14.9	13.7	56.4	1.8
Location of Project:					
Fresno	101	14.7	14.9	55.6	1.7
San Joaquin	92	15.0	12.3	52.7	1.4
Ventura	84	15.1	13.8	62.1	1.3
Type of Discharge:					
Completed program	93	15.0	20.4	56.0	1.5
Still in treatment at end of funding	44	14.8	6.9	56.4	1.3
Probation ended	29	15.2	14.1	n/a	1.5
Moved, ill, etc	41	14.7	8.1	63.3	1.3
Revoked expelled	70	14.8	12.2	53.0	1.7

The risk levels of offenders accepted into treatment is described more fully by the findings reported in Table 15. Fresno County accepted the most offenders identified as high-risk, whereas San Joaquin and Ventura Counties accepted more low-risk offenders. The high-risk offenders, as a group, accounted for only ten percent of the treatment cases. The total program population included equal numbers of low- and moderate-risk offenders. Average risk levels were lower at discharge for those who completed treatment; 87% of the completed treatment cases were rated as low-risk.

Table 15
Juvenile Risk Assessment Scale Ratings for Admission and Discharge by Project

	Pilot Juvenile Sex Offender Treatment Program:				
	Fresno	San Joaquin	Ventura	Total	%
Total Offenders in Treatment:	101	92	84	277	
Admission Risk Ratings: (250 cases had ratings)					
Low	27	50	36	113	45 %
Moderate	52	29	32	113	45 %
High	15	6	3	24	10 %
Discharge Risk Ratings -- any type of discharge: (261 cases had ratings)					
Low	42	34	45	121	46 %
Moderate	37	35	25	97	37 %
High	15	22	6	43	16 %
Discharge Risk Ratings -- only completed treatment: (93 cases had ratings)					
Low	26	27	28	81	87 %
Moderate	3	2	4	9	10 %
High	3	0	0	3	03 %

Treatment appraisal

In patient exit summaries, therapists were asked if there was any specific treatment approach which was particularly effective with that offender. A total of 82 case summaries had one or more specific treatment approaches identified for this question. Over half of those responses were for the offenders who successfully completed their program. For all three projects, the responses on what constituted effective treatment for those offenders who successfully completed treatment differed from the responses for those offenders who did not successfully complete treatment.

The San Joaquin County therapists most often identified a cognitive-behavioral therapy approach as most effective for those who completed the program. The Fresno County therapists identified a range of therapies as effective for these who completed treatment; group therapy was listed as the most effective modality, then cognitive-behavioral and psychodynamic individual therapy. The Ventura County therapists identified psychodynamic individual therapy, family therapy and group therapy (conducted with a cognitive-behavioral / relapse-prevention focus) as most effective for those who completed treatment.

A different set of treatment modalities was identified as effective for the offenders who did not complete treatment. These other modalities included family, directive, experiential, art, and play therapies. Visualization, reality and

relaxation techniques were also noted. Except for family therapy, none of these modalities were rated as effective for those who completed treatment.

The pilot projects recommended the following improvements to their treatment model if continued funding were available.

The projects would establish more defined educational components to treatment which use video taped presentations on sex education, assertiveness training, anger control, relapse prevention, etc. They would expand the offenders' groups to include separate skills and process groups, including sessions to specifically address "acquaintance rape" offenses.

With additional resources, the projects would develop out-reach to the more rural areas of the county and greater involvement with the school system, perhaps through prevention efforts. The projects proposed that long term follow-up assessment be part of the court orders and that offenders be tracked for two to five years following treatment. This would be more feasible with the addition of an assigned probation officer to the project.

The projects proposed development of specialized group home for sex offenders. Sex-offender treatment services would be provided at these specialized group homes, as well as at any secure residential facility and regular group home placement in the community. They identified the need for increased specialized training and consultation to group home staff and local psychotherapists to increase the community resources for this offender population.

The question remains, what effect did the program have on the offender rate in the three counties? Can these three counties be compared to three other counties that are similar in size but do not have these projects? While these are important questions, methodologically these questions could not be answered. All adjudicated juvenile offenders in each of the three pilot project counties were required to be referred to the program. Those not accepted were not adjudicated with the same charges or they were seen as higher risk offenders. As a result, no county control population was possible. Comparisons with prior years were not considered to be reliable because of the lack of consistent record keeping and changes in dispositional policies. An attempt was made to identify comparable counties, but the closest matched counties required additional resources, not available in this program, to provide comparable data on a subgroup of offenders not in therapy who fit the same offender profile.

Without comparisons to a controlled sample, an informal assessment of the program's effectiveness can be provided by the response of judges and probation officers to the continuation of the program presented by SB 1895

(Seymour, 1990), which would extend the program for two additional years. Sufficient support was provided for this bill by local officials including legislators, judges, district attorneys, and probation officers, and to result in passing of the bill by both the California Senate and Assembly. No opposition to the activities of the projects was identified in this process. Governor George Deukmejian signed SB 1895 into law (Chapter 1344, Statutes of 1990), however, the $500,000 appropriation was deleted because of the current fiscal deficit.

Additional research

The pilot program generated an extensive set of clinical data which will continue to be useful to explore clinical and program evaluation questions in addition to those addressed by this report. Much of this supplemental clinical information comes from various psychological tests. Juvenile sex offenders treated in this program were tested with several clinical measures at admission and discharge, depending on available staff resources and the nature of offender discharges. The clinical data are being analyzed for subsequent papers and journal articles. The data have also been used, with the support of the three projects, by five doctoral candidates in their dissertation research. The abstracts of the dissertations completed at this time are included in Appendix D. The titles of the five doctoral dissertation studies are as follows:

° Cynthia Bromberg, California School of Professional Psychology – Fresno:
  "Parental absence and prior victimization: Their relationship to treatment outcome in male adolescent sex offenders".
° Thomas Carrillo, US International University – San Diego:
  "Comparison of MMPI profiles of sexually abused and non-sexually abused juvenile sex offenders".
° Melissa Cashman, California School of Professional Psychology – Fresno:
  "Personality profile of juvenile sex offenders – experimental verification of three types".
° Thomas Danner, California School of Professional Psychology – Fresno:
  "Classification of adolescent sexual offenders: correlation of life history with sexual offense based upon aggression and socialization".
° Joseph Randazzo, UC Berkeley School of Social Welfare – Berkeley:
  "Behavioral treatment of adolescent sex offenders".

CONCLUSIONS

The SB 890 Pilot Juvenile Sex Offender Treatment Program enabled the development of three county projects to provide model treatment to those 89% of sentenced juvenile sex offenders who did not go to the Youth Authority and remained in their communities. The three projects (Fresno, San Joaquin and Ventura) developed comprehensive services for the amenable offenders in the community with a dual treatment and monitoring focus. The enabling legislation included provisions for the program to be evaluated at the completion of the four year grant period.

The final program evaluation findings support the concept that certain types of juvenile sex offenders can be safely treated in the community while participating in a comprehensive outpatient program of treatment and case management. Each of the three projects, while similar in their cognitive-behavioral and relapse prevention approaches, developed different mixes of treatment modalities.

The three pilot projects accepted 79% of the 350 referrals. A full treatment course averaged 20 months and involved over two hours of therapy a week, at an average cost of $80 per offender-week. The offender population in the three projects were similar, with some differences noted in average admission risk ratings. A total of 93 offenders successfully completed treatment at the time funding ended.

The level of treatment was consistently high among all three projects, all of which provided common "core" treatment services of individual and group therapy focused on offenders understanding and controlling the dynamics contributing to their offending behavior. Because of the juveniles' developmental needs, they required special interventions, such as appropriate group assignments and residential placements, skills workshops, victim empathy experiences and, if abused, therapy to process their own victimization. Three-fourths of the juvenile offenders were themselves victimized in some way and over one-third were sexually victimized. One-half of the offenders identified their victimization only after some time in treatment.

All three projects were similar in maintaining a low recidivism rate of 2.5%. While a zero tolerance may not be feasible, the rate could be cut in half with increased monitoring by the treatment and probation team. The profile of the sexual reoffenders was distinctly different from those who reoffended with non-sexual offenses. The sexual reoffender was younger, rated as higher risk at admission, reoffended early in treatment and usually victimized a younger child

who was present in the home without the knowledge of the therapist and probation officer.

The non-sexual reoffenders had a different profile. There were 31 offenders (11.2%) who were arrested for non-sexual offenses. These reoffenders committed the non-sexual crimes later in treatment, were older, had less risk identified at admission, and their offenses were mostly property crimes, substance abuse or both. The one treatment project which had the highest rate of these offenses had relatively fewer skills development sessions. Any revision of the treatment model needs to consider that the juvenile offender may have a range of deviant behaviors needing to be addressed by a multi-dimensional treatment program.

These rates indicate that the short-term impact of the program is consistent with the expectations for effective treatment, but needs to be evaluated with the rates of other outpatient programs and needs to be reassessed in a post-treatment follow-up study. There are no similar studies with which to compare the sexual reoffense rate of 2.5%. The program's recidivism rate is, as expected, lower than other studies which report recidivism rates for a period after treatment (Kempe — 9.2% for sex offenses) or for more violent offenders (CYA — 34% for all offenses), but those rates cannot provide a baseline measure of the program's effectiveness. However, the program's recidivism rate does provide a baseline for further study.

Recidivism did not necessarily prohibit continuation in the program. Some of the reoffenders were sent to the local youth facility after their reoffense and were returned to the treatment program. A few completed their treatment program. Another group of offenders who did not reoffend, behaviorally acted out by non-complying with treatment and other high risk, pre-offense activities for which they were usually revoked as a proactive precaution.

All three projects reported that their county's juvenile court judges were more willing to acknowledge the treatment needs for these youthful offenders after the onset of this program. The judges expressed interest in using this type of intervention program as court-ordered diversion for these offenders. The projects had the support of their local agency networks in the efforts to continue the pilot program through SB 1895 (Seymour, 1990).

The following recommendations are proposed as ways to refine this intervention model. Based on the outcomes of this four-year pilot program, California would benefit from the continued development of the pilot program to provide services which help break the cycle of compulsive sexual violence.

RECOMMENDATIONS

The following recommendations are based on the findings of this evaluation report:

1) **Expand the pilot juvenile sex offender treatment model.**
   A. Continue the juvenile sex offender treatment program with financial and legislative support for the continued development and refinement of this treatment model which has shown initial success.
   B. Provide the program with financial and legislative support to develop training materials and workshops on the treatment model for use by other county networks, enabling others to benefit from the program's experiences. The networks should include victim services, probation, the courts and county juvenile corrections.
   C. Develop a plan for coordinating statewide implementation of the successful aspects of the pilot program in all counties, so all communities have access to this important resource.

2) **Develop specialized probation caseloads for juvenile sex offenders.**
   A. Provide financial and legislative support to local probation departments for specialized caseloads, as found by the pilot program to be very effective, using probation officers trained in sex offender treatment to monitor the sex offenders in community placement.
   B. Promote joint effort of juvenile sex offender treatment program staff and probation officers to periodically monitor the offender's living situation for the presence of younger children, particularly in the earlier phases of treatment, as indicated by the recidivism pattern found in this study.

3) **Expand treatment focus to include other anti-social behavior.**
   Expand juvenile sex offender treatment programs to anticipate the non-sexual recidivism pattern noted in this study by assessing the offenders' non-sexual criminal offense potential and by providing the necessary treatment services to address those issues along with the sexual offense treatment.

4) **Develop options for extended and after-care treatment services.**

A. Provide financial and legislative support for the establishment of after-care services to offenders who are discharged from treatment. This allows offenders to return to the program, without jeopardizing their probation and to get help when they feel they are at-risk to reoffend.

B. Provide supplemental resources for out-reach to offenders in rural county areas, including subcontracting, travel and use of other facilities.

C. Provide supplemental resources for services to bilingual offenders.

D. Provide financial and legislative support for probation departments to continue jurisdiction of juvenile sex offenders beyond the age of 18, if indicated by treatment or supervision needs.

E. Provide resources for treatment programs to continue the treatment of offenders over the age of 18, if indicated.

5) **Develop residential placement options.**

Provide financial and legislative support for a continuum of residential placement options for the juvenile sex offender, particularly for removal of the juvenile offender from the same residence as the victim(s).

6) **Support risk assessment efforts and long term recidivism studies.**

A. Develop resources to refine the Juvenile Risk Assessment Scale. This shows promise in identifying at-risk offenders and measuring change through treatment.

B. Provide financial and legislative support to develop mechanisms for probation departments to track, perhaps through sex crime registration, juvenile sex offenders from arrest through discharge for any reoffenses, locally and in other counties, and later as adults, within the limits of the protections for minors.

C. Provide financial and legislative support for a follow-up recidivism study of the offenders treated in this program and conduct comparison studies in other counties.

7) **Provide recognized experts in the program development and evaluation.**

Provide future juvenile sex offender treatment programs with resources for an advisory board to review program treatment activities and program evaluation design. This provides direction and continuity through the course of the program in order to maximize the benefits of these efforts.

APPENDIX A

Enabling Statute

SB 890 - Seymour, 1985

Senate Bill No. 890

CHAPTER 637

An act to add and repeal Chapter 3.7 (commencing with Section 13827) to Title 6 of Part 4 of the Penal Code, relating to sex offenders, and making an appropriation therefor.

[Approved by Governor September 16, 1985. Filed with Secretary of State September 17, 1985.]

LEGISLATIVE COUNSEL'S DIGEST

SB 890, Seymour. Criminal law: juvenile sex offenders.

Under existing law, a person who was a minor at the time of his or her violation of any law prohibiting criminal conduct may be adjudged to be a ward of the juvenile court.

This bill would enact the Juvenile Sex Offender Treatment Act of 1985, which would require the Office of Criminal Justice Planning to select at least 3 counties from among those counties applying therefor in which to establish 4-year pilot programs to provide treatment, as specified, for juveniles adjudged to be wards of the juvenile court on the basis of the commission of certain sexual offenses and who were not committed to the Youth Authority.

The bill would appropriate $500,000 from the General Fund to the Office of Criminal Justice Planning for the purposes of the act, as specified.

The provisions of the act would be repealed January 1, 1991.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Chapter 3.7 (commencing with Section 13827) is added to Title 6 of Part 4 of the Penal Code, to read:

CHAPTER 3.7. JUVENILE SEX OFFENDERS

13827. This chapter shall be known and may be cited as the Juvenile Sex Offender Treatment Act of 1985.

13827.1. From any funds appropriated therefor, the Office of Criminal Justice Planning shall establish a pilot program to provide treatment to juvenile sex offenders declared to be wards of the juvenile court pursuant to Section 602 of the Welfare and Institutions Code, but who are not committed to the Youth Authority. The pilot programs shall be established for a four-year period in up to three counties. The counties shall be selected from among those counties submitting applications to the office requesting to be selected to participate in the program, based on a determination that the counties would be capable of establishing such a program. Capability

may be demonstrated by current county efforts to provide treatment programs to juvenile sex offenders.

The participating counties shall be selected by May 1, 1986. The pilot programs shall be operational by July 1, 1986 and shall terminate on July 1, 1990.

13827.2. A county that applies to participate in the program established by this chapter shall demonstrate the following in its application for participation:

(a) Identification of the need for a juvenile sex offender treatment program.

(b) Evidence that the county agency providing mental health services, the county agency providing public assistance, the district attorney, the juvenile court, the probation department, private entities, and local school districts are participating in and coordinating case referral, case management, and service delivery to the persons whom they serve.

13827.3. Notwithstanding any other provision of law, in a county in which a pilot program is established, on and after the date of the establishment of that program, any person who is adjudged to be a ward of the juvenile court pursuant to Section 602 of the Welfare and Institutions Code on the basis of the violation of Section 261, 264.1, 266, 285, 286, 288, 288a, or 289, and who is not committed to the Youth Authority, shall be ordered to participate in the treatment services provided by the pilot program.

13827.4. The county agency providing mental health services in a county participating in the pilot program shall assign a counselor to any person described in Section 13827.3. Any counselor so assigned shall be qualified to treat juvenile sex offenders, as determined by the county in conjunction with the Office of Criminal Justice Planning.

13827.5. To the extent that funds are appropriated therefor, the state shall reimburse a county for all costs incurred in conducting a pilot program established pursuant to this chapter.

13827,6. On or before January 1, 1991, the Office of Criminal Justice Planning shall submit a written report to the Legislature containing all of the following information:

(a) The number of juveniles that participated in the program.

(b) The costs of the pilot programs.

(c) The nature of the treatment provided to participants in the programs.

(d) The results of the treatment provided to participants in the programs, including data concerning recidivism by participants and any other nonsexually-related criminal offenses committed by participants.

(e) The results of combining intrafamily and pedophile treatment.

13827.7. Counties selected to participate in the pilot program shall utilize any funds available from public and private sources for the purposes of the program and existing treatment services prior to

utilizing state funds allocated for the purposes of the pilot program.

SEC. 2. This act shall remain in effect only until January 1, 1991, and as of that date is repealed, unless a later enacted statute, which is chaptered before January 1, 1991, deletes or extends that date.

SEC. 3. The sum of five hundred thousand dollars ($500,000) is hereby appropriated from the General Fund to the Office of Criminal Justice Planning for expenditure during 1986 for the purposes of this act. No more than 10 percent of that amount may be expended for administrative purposes.

O

APPENDIX B

Project Descriptions:

Fresno County Project
San Joaquin County Project
Ventura County Project

Project Description: FRESNO COUNTY

Project Name:	Comprehensive Sexual Awareness and Treatment Team (CSATT)	
Address:	4753 E. Olive, Suite 103 Fresno, CA 93702	
Phone:	(209) 251-7558	
Project Affiliation:	Associated Center for Therapy (ACT)	
Administration:	Executive Director: Clinical Director:	Francine Oputa Valerie E. Forward, Ph.D.
Clinical Staffing:	Mental Health Workers: Psychologist: Interns: Consultants:	0.50 FTE 1.60 FTE 0.50 FTE 1 clinical consultant
Organization Structure:	Project is a private agency that is designated by the Fresno County probation department to provide treatment to adjudicated juvenile sex offenders. Additional funding sources supports victims services and non SB-890 juvenile sex offender services.	
County Demographics:	Mixed urban and rural, inland valley with multi-cultural population. County Population: 588,300 Based on 1984 data, the county was found to have the highest rates of convicted juvenile sex offenders (11.7 per 100,000 population).	

Project Description: SAN JOAQUIN COUNTY

Project Name:	Valley Community Counseling	
Address:	1221 N. Hunter Stockton, CA 95202	
Phone:	(209) 942-0212	
Project Affiliation:	Private agency affiliated with San Joaquin County Mental Health	
Administration:	Administrative Director: Clinical Director:	David Love Marie Derrick
Clinical Staffing:	Mental Health Workers:	2.50 FTE
Organization Structure:	Private agency delegated by the San Joaquin County Mental Health Department to treat adolescent sex offenders. The agency also provides treatment to victims and their families The San Joaquin County Mental Health Department provides monitoring services and consultation as needed.	
County Demographics:	Rural, inland county County Population: 400,000 (18% Hispanic)	

Project Description: VENTURA COUNTY

Project Name:	Forensic Adolescent Program	
Address:	740 E. Main Street Ventura, CA 93001	
Phone:	(805) 652-7592	
Project Affiliation:	Ventura County Mental Health, Children's Services	
Administration:	Project Director:	Christine Johnson, Ph.D.
Clinical Staffing:	Psychologists:	1.00 FTE
	Social Worker:	0.40 FTE
Organization Structure:	Project is funded 100% by the OCJP pilot program funding. It operates as an outpatient program within the Juvenile Justice Services division of the Department of Mental Health, Ventura County Health Care Agency.	
County Demographics:	Mixed urban/rural,coastal, area of 1884 square miles. Population 585,000; (21.4% Hispanic).	

APPENDIX C

Pilot Program Evaluations Forms

Form A	Administrative Summary
Form B	Intake Screening Form
Form C	Monthly Treatment Summary
Form E	Juvenile Risk Assessment Scale
Form I	Incident Report Form
Kempe	Intake Form
Kempe	Initial Evaluation/Assessment Form
Kempe	Exit Report

ADMINISTRATIVE SUMMARY

Office of Criminal Justice Planning
Pilot Sex Offender Treatment Program
Quarterly Evaluation Report

QUARTERLY ADMINISTRATIVE SUMMARY **FUNDING QUARTER: 1 2 3 4** (Circle Quarter) **FY:**________

PART I. PROJECT ID:

COUNTY OF TREATMENT:

ADULT OFFENDER TREATMENT

- [ ] 1 = San Francisco
- [ ] 2 = San Luis Obispo
- [ ] 3 = Stanislaus

JUVENILE OFFENDER TREATMENT

- [ ] 4 = Fresno
- [ ] 5 = San Joaquin
- [ ] 6 = Ventura

PART II. OCJP GRANT ELIGIBLE CASE LOAD SUMMARY FOR THIS QUARTER:

REFERRALS:

ENTER MONTHS BEING REPORTED

MONTH:	_____	_____	_____	TOTAL
Total number of treatment referrals made by Probation Department or Courts this quarter:				
Number of referrals not appropriate for intake screening: (Intake appointments not scheduled)				
Number of referrals appropriate for an intake screening but who did not show for their intake appointment:				
Number of referrals appropriate for an intake screening who were placed on a waiting list				
Total number of referrals seen for an initial intake screening:				

GRANT ELIGIBLE TREATMENT CASELOAD:

ENTER MONTHS BEING REPORTED

MONTH:	_____	_____	_____	TOTAL
Caseload at beginning of this month:				X
Treatment cases accepted this month:				
Treatment cases terminated this month:				
Total open cases at end of this month:				X

PART III. STAFFING REPORT

CHANGES IN STAFF AND VOLUNTEERS ON OCJP TREATMENT PROJECT

INSTRUCTIONS:

1. Please print names of staff members, their degrees, license number, hours and status under appropriate heading.
2. Do not include previously reported staff unless their status or hours worked per week have changed.
3. Staff members with more than one responsibility may be listed under each of the headings which describe their duties. Include the hours involved for each activity.
4. Complete status entry using the following status codes:

STATUS CODES:
A = Active Paid B= In process of being hired C= No longer on project
V = Volunteers and non-grant paid staff O= Other (Please describe)

ADMINISTRATIVE STAFF:

Name	Degree	License Number	Hrs/Week	Start /End	STATUS
			/wk	/ /	
			/wk	/ /	
			/wk	/ /	
			/wk	/ /	

SUPPORT STAFF (clerical, lab technicians, etc.:

Name	Degree	License Number	Hrs/Week	Start /End	STATUS
			/wk	/ /	
			/wk	/ /	
			/wk	/ /	

CLINICAL STAFF:

Name	Degree	License Number	Hrs/Week	Start /End	STATUS
			/wk	/ /	
			/wk	/ /	
			/wk	/ /	
			/wk	/ /	

CONSULTANTS:

Name	Degree	License Number	Hrs/Week	Start /End	STATUS
			/wk	/ /	
			/wk	/ /	

INTERNS:

Name	Degree	Supervisor	Hrs/Week	Start /End	STATUS
			/wk	/ /	
			/wk	/ /	

INTAKE SCREENING FORM

Office of Criminal Justice Planning
Pilot Sex Offender Treatment Project
Evaluation Report

NOTE: Use this form to report all first time, direct contact intake screenings

PROJECT AND CLIENT ID:

DATE OF INTAKE SCREENING: [ ] [ ] [ ] (mm dd yy)

NAME *(OPTIONAL: FOR PROJECT INTERNAL USE ONLY):* [ ]

PROJECT ID: (Check county of treatment)

- [ ] 1 = San Francisco
- [ ] 2 = San Luis Obispo
- [ ] 3 = Stanislaus
- [ ] 4 = Fresno
- [ ] 5 = San Joaquin
- [ ] 6 = Ventura

CLIENT ID: [ ] [ ] [ ] First MI Last INITIALS; [ ] [ ] [ ] mm dd yy DOB

PART I. CHARACTERISTICS OF THE OFFENDER

Enter coded response here

1. AGE (AT TIME OF LAST BIRTHDAY): [ ] (Age)

2. SEX: M = Male F = Female [ ] (Sex)

3. RACE OR ETHNIC BACKGROUND: 1 = White 2 = Hispanic 3 = Black 4 = Asian/Pacific 5 = Am. Indian 7 = Filipino 8 = Other 9 = Unknown [ ] (Ethnicity)

4. MARITAL STATUS: 1 = Never Married 2 = Now Married 3 = Widowed 4 = Dissolved 5 = Separated 9 = Unknown [ ] (Marital Status)

5. EDUCATION (HIGHEST GRADE COMPLETED): [ ] (Education)

6. OCCUPATION: [ ] ← ***Write in occupation***

7. EMPLOYMENT STATUS 1 = Works 35+ hrs/wk 4 = Shelter 35- hrs/wk 7 = Student 2 = Works 35- hrs/wk 5 = Unemployed 9 = Unknown 3 = Shelter 35+ hrs/wk 6 = Non-student, not in labor force [ ] (Employment)

8. FINANCIAL RESPONSIBILITY 1 = OCJP 2 = Additional Funding: [ ] *Indicate source* [ ] (Financial) ← ***Write in other source***

9. DISABILITY: (sum of impairment codes) 00 = None 01 = Vision 02 = Hearing 04 = Speech 08 = Physical-mobility 16 = Developmental Disability 32 = Other 99 = Unknown [ ] (Disability)

10. LIVING ARRANGEMENT: 01 = Alone 02 = Immed. Family 03 = Extended Family 04 = Non-related 05 = Foster Family 06 = Commty. Care Fac. 09 = Commty. Hosp 11 = Justice Facility 12 = Groups Qts. 13 = Homeless 14 = Other 99 = Unknown [ ] (Living Arrng)

11. PENAL CODE OF RECORD: (Check only one - the most serious conviction possible)

- [ ] PC 243.4 Sexual Battery
- [ ] PC 262 Rape
- [ ] PC 261.5 Statutory rape
- [ ] PC 264.1 Rape in concert
- [ ] PC 266 Enticement (-18 YRS)
- [ ] PC 285 Incest
- [ ] PC 286 Forced sodomy
- [ ] PC 288 Lewd or lacivious (-14 YRS)
- [ ] PC 288A Forced oral copulation
- [ ] PC 289 Penetration w/ foreign object
- [ ] PC 647A Annoying/molesting a child
- [ ] PC 220 Assault w/intent (sex crime
- [ ] PC 664 Attempt to commit (sex) crime
- [ ] OTHER: PC ____ ____________

[ ] [ ] [ ] [ ] PC (Penal Code)

Enter coded response here

PART II. CHARACTERISTICS OF THE OFFENSE AND DISPOSITION

12. OFFENSE TYPE (Proximity to victim at time of offense):
1 = Victim lived in offender's home 2 = Victim lived outside offenders home
3 = Both types 4 = Other: [ ]

[ ] (Victim Proximity)
← Write in other

13. NUMBER OF KNOWN VICTIMS (FOR INSTANT OFFENSE):

[|] (No. Victims)

14. VICTIM PROFILE (at time of offense):
Victim 1: Age [ ] Sex [ ] Relationship [ ]
Victim 2: Age [ ] Sex [ ] Relationship [ ]
Victim 3: Age [ ] Sex [ ] Relationship [ ]
Victim 4: Age [ ] Sex [ ] Relationship [ ]

← Write in reponses to Question 14.

15. CLIENT PROFILE
a. Does client meet profile of pedophile? 1 = YES 2 = NO
b. Does client have story of victimization? 1 = YES 2 = NO
c. Does client have prior criminal offenses? 1 = YES 2 = NO
d. Does client have prior sex offenses? 1 = YES 2 = NO

[ ] (Pedophile)
[ ] (Victimization)
[ ] (Prior criminal)
[ ] (Prior sex)

16. DATE OF (LAST) OFFENSE AS CHARGED:

[| |] mm dd yy (Date charged)

17. DATE OF SENTENCING:

[| |] mm dd yy (Date sentenced)

18. COUNTY OF SENTENCING: [ ]

← Write in county

19. COUNTY OF PROBATION: [ ]

← Write in county

PART III. TREATMENT

20. WILL PROJECT BE DOING A DISPOSITION ASSESSMENT? 1 = YES 2 = NO

[ ] (Disposition Assessment)

21. CLIENT STATUS (at time of this screening/intake):
1 = Pre-sentenced Incarcerated 3 = Pre-sentenced Outpatient
2 = Sentenced Incarcerated 4 = New treatment case

[ ] (Client Status)

22. TREATMENT STATUS (If accepted into treatment)
1 = Transfer from within agency 3 = Transfer from private therapist
2 = Transfer from another agency 4 = New treatment case

[ ] (Tx. Status)

23. DATE PRIOR TREATMENT BEGAN:(If already in therapy)

[| |] mm dd yy (Prior Tx. Began)

24. INTAKE THERAPIST: [ ]
Last name *First initial*

← Write in

25. TREATMENT COMPLIANCE: (At time of OJCP Intake)
a. Did client admit responsibility for offense? 1 = YES 2 = NO 3 = Minimum
b. Did client refuse treatment? 1 = YES 2 = NO

[ ] (Admit responsb.)
[ ] (Refused Tx.)

26. DIAGNOSIS (Use DSM III Diagnostic Codes)
Mental Disorders: PD Focus 1
AXIS I [ ] [| | |]
AXIS II [ ] [| | |]

← Write in

Severity of Psychosocial Stressors: AXIS IV [ ] (Use Codes 1-7, DSM III)
Highest level of adaptive functioning: AXIS V [ ] (Use Codes 1-7, DSM III)

← Write in

27. ADMISSION GLOBAL ASSESSMENT SCALE RATING (GAS):

[|] (GAS)

28. IS CLIENT OCJP ELIGIBLE? 1 = Yes 2 = No 3 = Pending

[ ] (OCJP Eligible)

29. HAS CLIENT BEEN ACCEPTED FOR TREATMENT AT THIS TIME?
1 = Yes 2 = No 3 = Pending

[ ] (Tx. Accepted)

MONTHLY TREATMENT SUMMARY

Office of Criminal Justice Planning
Pilot Sex Offender Treatment Program
Evaluation Report

NOTE: USE THIS FORM TO REPORT ALL CLINICAL SERVICES PROVIDED THIS MONTH

MONTHLY CLIENT TREATMENT SUMMARY MONTH: [ ] YR: 19 ____

NAME *(OPTIONAL: For Project Internal Use Only:* [ ]

PROJECT ID: (CHECK COUNTY OF TREATMENT)

[ ] 1 = San Francisco
[ ] 2 = San Luis Obispo
[ ] 3 = Stanislaus
[ ] 4 = Fresno
[ ] 5 = San Joaquin
[ ] 6 = Ventura

CLIENT ID:

INITIALS: First MI Last
DOB: mm dd yy

PRIMARY THERAPIST: [ ] [ ]
Last name *First initial*

SERVICES PROVIDED: [ ] **OUTPATIENT** [ ] **JAIL** [ ] **BOTH LOCATIONS THIS MONTH**

MODE OF SERVICE:	OUTPATIENT		JAIL		OUTPATIENT SESSIONS:		
	Number Sessions	1/4 Hr Units	Number Sessions	1/4 Hr Units	Client Cancel	Client No show	Client Late
A. Assessment & Testing (screening)							
B. Individual Therapy							
C. Group Therapy							
D. Case Management (reports/calls)							
E. Network Staffing (multi-agency)							
F. Collateral Direct Contact							
G. Family Session & Couples							
H. Home Visit							
I. Medication Visit							
J. Other:							
Other:							
K. Assessment & Testing (treatment)							

SKILLS GROUP:	OUTPATIENT		JAIL		OUTPATIENT SESSIONS:		
	Number Sessions	1/4 Hr Units	Number Sessions	1/4 Hr Units	Client Cancel	Client No show	Client Late
TOPIC CODE: ____							
TOPIC CODE: ____							

TOPIC CODES:

S1 = Relapse Prevention
S2 = Anger/Depression Management
S3 = Victim Empathy
S4 = Self Esteem
S5 = Substance Abuse
S6 = Social Skills
S7 = Human Sexuality
S8 = Assertiveness Group
Other:
S9. ____
____

Form C - OCJP/Eval rev 6/15/87

Supplemental Client Data

INTAKE SCREENING:

a. If an intake screening, has this case been accepted as a treatment case? ☐ YES ☐ NO ☐ PENDING

b. Date accepted as a treament case: [ ][ ][ ] mm dd yy

c. If rejected as a treatment case, please summarize the reason it was not accepted: ______

NEW TREATMENT CASE:

		YES	NO
a. Has the treatment plan been developed	(a)		
b. Has the Pre-MMPI been completed	(b)		
c. Has the Pre-Millon been completed	(c)		
d. Has the sex inventory been completed	(d)		
e. Have the risk assessments been completed	(e)		
f. Has the Kempe-Assessment form been completed	(f)		
g. Has the Kempe-Intake form been completed	(g)		

ON-GOING TREATMENT CASE:

		YES	NO
a. Has the Kempe-Progress Form been done	(a)		
b. Has the treatment plan been revised	(b)		
c. Has there been a significant increase of the the clients risk for reoffense?	(c)		

NOTE: If YES, complete and attach an updated risk assessment rating form.

TREATMENT COMPLIANCE THIS MONTH:

a. Does client admit responsibility for offense? ☐ YES ☐ NO ☐ MINIMAL

b. Did client refuse treatment? ☐ YES, DATE [ ][ ][ ]

c. Was client arrested this month for a non-sexual offense? ☐ YES, Code: ______

d. Was client arrested this month for a sexual offense? ☐ YES, Code: ______

e. Was client involved in any special incidents? ☐ YES, Describe: ______

f. Has client violated parole/probation? ☐ YES, Code: ______

DISCHARGE CASES:

a. Was client discharged? ☐ YES, DATE: [ ][ ][ ] b. Discharge Global Assessment rating: [ ][ ]

c. Reason for discharge: [ ]

		YES	NO
d. Has the discharge summary been completed?	(d)		
e. Has the treatment plan been updated?	(e)		
f. Has the exit MMPI been completed?	(f)		
g. Has the exit-Millon been completed?	(g)		
h. Has the exit risk assessment been completed?	(h)		
i. Has the Kempe-Exit form been completed?	(i)		

COMMENTS: ______

Juvenile Risk Assessment

Office of Criminal Justice Planning
Pilot Sex Offender Treatment Project
Quarterly Evaluation Report

PROJECT AND CLIENT ID MONTH: ____ YEAR ____

NAME *(OPTIONAL: FOR PROJECT INTERNAL USE ONLY):* ____

PROJECT ID: (Check county of treatment)

- ☐ 4 = Fresno
- ☐ 5 = San Joaquin
- ☐ 6 = Ventura

CLIENT ID: ☐ First ☐ MI ☐ Last (INITIALS) ☐ mm ☐ dd ☐ yy (DOB)

CLIENT STATUS: SCREENING: ☐ INTAKE ☐ PROGRESS REVIEW ☐ EXIT ☐

LOW RISK		T	F	N/A	Comment
First documented sexual offense	L1				
No sexual deviance pattern	L2				
Acknowledges involvement in the offense	L3				
Parents acknowledge client's involvement in offense	L4				
Client acknowledges the offense has negative impact on victim(s)	L5				
Feels guilt because of harm to victims(s)	L6				
Understands why the sexual offense was wrong (e.g., exploitive of victim)	L7				
Family appropriately communicates healthy sexual values	L8				
No history of physical aggression prior to the offense	L9				
Functional family	L10				
Family is supportive of treatment	L11				
Adequate pro-social peer support	L12				
No history of school behavior problems	L13				
Natural father is in the home	L14				
Client stopped offense when victim expressed discomfort	L15				
Situational stressors occurring at the time of the offense are no longer present	L16				
No precipitating external stress factors prior to the offense	L17				
Other:	L18				

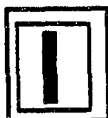
MODERATE RISK		T	F	N/A	Comment
Two or more documented offenses	m1				
Minimal acknowledgement of involvement in offense	m2				
Doesn't understand why offense was wrong (e.g., exploitation of victim)	m3				
Little or no guilt	m4				
Tends to externalize responsibility of offense (e.g., blames victim, parents, drugs, etc.)	m5				
Parents and client are resistant to treatment	m6				
Evidence of affective disorders (e.g., suicide)	m7				
Has been victim of sexual and/or physical abuse	m8				
Either parent has been victim of sexual and/or physical abuse	m9				

MODERATE RISK -- Continued		T	F	N/A	Comment
Either parent has been perpetrator of sexual and/or physical abuse	m10				
Family members unable to identify problems in family	m11				
On-going situational stressors (e.g., loss, move, entry and/or exit of family members)	m12				
Physical aggression (e.g., fighting at school or home)	m13				
Poor social adjustment	m14				
Other:	m15				
Other:	m16				

HIGH RISK		T	F	N/A	Comment
Offense was violent: used force, weapons or threats	h1				
Client continued offense when victim expressed discomfort	h2				
Progression of force (e.g., first grabbed arm, then pulled)	h3				
Denial of offense	h4				
Family denial of offense	h5				
Treatment for previous sexual offenses	h6				
Victim selection was predatory (e.g., victims were sought out)	h7				
Ritualistic pattern of offense	h8				
Offender was molested by mother figure	h9				
Refusal to participate in evaluation process	h10				
Parents denial of any family problems	h11				
Compulsive deviant masturbatory fantasy	h12				
History of fire setting	h13				
Evidence of thought disorder	h14				
Animal cruelty	h15				
Chronic substance abuse	h16				
Victim of chronic physical or sexual abuse	h17				
Family chronically dysfunctional	h18				
Low intellectual functioning and/or serious learning disabilities	h19				
Escalation of violence and/or intrusiveness across offense	h20				
Other:	h21				
Other:	h22				

OVERALL RISK ASSESSMENT RATING: (CHECK the most appropriate rating category)

☐ LOW ☐ MODERATE ☐ HIGH



INCIDENT REPORT FORM

Office of Criminal Justice Planning
Pilot Sex Offender Treatment Project
Program Evaluation

NOTE: Use this form to report any indicent, arrest, revocation or dismissal.

PROJECT AND CLIENT ID: **DATE REPORT COMPLETED:** [ ] [ ] [ ]
mm dd yy

NAME *(OPTIONAL: FOR PROJECT INTERNAL USE ONLY):* [ ]

PROJECT ID: (Check county of treatment)

- [ ] 1 = San Francisco
- [ ] 2 = San Luis Obispo
- [ ] 3 = Stanislaus
- [ ] 4 = Fresno
- [ ] 5 = San Joaquin
- [ ] 6 = Ventura

CLIENT ID:

[ ] [ ] [ ] — First M Last — INITIALS

[ ] [ ] [ ] — mm dd yy — DOB

Use this form to report any special incident, arrest or revocation, and requested follow-up information.
Please complete this form if Follow-Up section is checked. Use last page if more space is needed.
"Special Incident" is defined for this study as any behavior that involves violence or serious risk of violence.

[A] INCIDENT REPORT (Check all that apply):

- [ ] Special Incident (no arrest or revocation)
- [ ] Non-Compliance to treatment
- [ ] Revocation Pending
- [ ] Arrest (non-sexual offense)
- [ ] Physical injury to self or others
- [ ] Awol
- [ ] Violation of no-contact order
- [ ] Revocation ordered by Court
- [ ] Reoffense (reportable sexual offense and/or arrest)
- [ ] Other: (describe)

____

[B] FOLLOW-UP INCIDENT REPORT (Please complete entire form for any incident(s) checked below):

[ ] ARREST: The Department of Justice database reports that the patient was arrested -

on ______________ for ______________________________

[ ] REVOCATION / DISCHARGE: Service records show that the patient was revoked, discharged or involved in an incident -

on ______________ for ______________________________

1. Is this information accurate, according to your sources of information (such as personal communication with patient, local law enforcement, probation reports, etc.)?

   [ ] Yes [ ] No

2. If the above information does not agree with your records, please provide the corrected information:

   ____

   ____

3. Source of this corrected information:

   ____

[C] DESCRIPTION OF INCIDENT

1. Briefly summarize the general type/nature of incident:

____

Approximate date of incident: __________ Type Location: __________

2. How was this incident discovered:

____

____

____

3. Briefly describe this incident in terms of the client's violence and/or risk behavior:

____

____

____

____

____

4. Total number of victim(s) if any: ______ ----- Describe the victim(s) if any:

	Victim #1	Victim #2	Victim #3
Gender (M/F):	______	______	______
Approximate Age:	______	______	______
Race/ethnicity:	______	______	______
Relationship (spouse, family member, stranger, etc):	______	______	______
Type of sexual abuse:	______	______	______
	______	______	______

5. Describe the use of force in the incident (relationship, threat, coercion, violence, weapons, etc):

____

____

6. Describe type and extent of any alcohol and/or drug use by client in relation to this incident:

____

7. What were the apparent motives or precipitators for this incident?

____

____

[D] CONSEQUENCES OF INCIDENT

1. What responsibility does the client take for this incident?

____

2. Was there an arrest associated with this incident?
   ☐ Yes ☐ No
   A. If yes, what were the charges?

   ____

   B. If no arrest, COULD the client potentially have been arrested for this behavior(s)?
   ☐ Yes ☐ No
   C. What offense could the client possibly have been arrested for (state simple categories such as "theft", "child molest", "rape", "assault", etc.)?

   ____

3. Has a revocation petition been initiated?
   ☐ Yes ☐ No
   A. If yes, on what bases is the revocation being initiated?

   ____

   B. If yes, is the petition a proactive intervention to facilitate treatment placement or compliance?
   ☐ Yes ☐ No
   Explain: _______________

4. Has there been a formal revocation of probation sustained?
   ☐ Yes ☐ No
   A. If yes, what has been the outcome of the revocation?

   ____

   B. If no, what is the client's current legal status in regards to the revocation?

   ____

5. If the case has been judicated, what was the final decision in regards to this incident?

____

6. Please provide any additional information on the client's Legal Status and Location related to this incident?

____

____

7. What is the client's current status in the treatment project?

____

____

8. Just prior to the incident, what aspects of the client's behavior and/or participation in treatment would have been predictive of this incident?

9. What, if anything, may have helped reduce the potential for a more serious incident?

[E] ADDITIONAL INFORMATION

Include any other comments to help understand or clarify the incident(s) mentioned above. Attach copies of relevant documents, such as probation reports, if they are available and helpful in providing pertinent details. Please remove names from these documents:

ADOLESCENT PERPETRATOR NETWORK: UNIFORM DATA COLLECTION SYSTEM Revised Edition 1/88

INTAKE FORM

Today's Date: ________ Client ID: _ _ _ _ _ _ _ _ _
(Client's initials; month, day, year of birth)

APN Member # ______

SOCIODEMOGRAPHIC DATA:
City____________ State__ Sex: Male __ Female__

Client's Primary Residence at time of offense/incident?

Parent's Home __ Group Home __ Detention Facility __ Other (specify)_ __
Shelter Care __ Relatives other than Parents __ Hospital __ Foster Care Home __

Adults in client's household:(check all that apply)

Natural Mother __ Stepfather __ Foster Parents __ Adult Relatives __
Natural Father __ Stepmother __ Grandparents __ Non-related adults only __

Does client consider him/herself (check one:)

American Indian __ Hispanic __ White __ Black __ Asian-American __ Other (specify) __

Family's religion or religious preference ________

Is there any indication of substance abuse by client? __ Yes __ No __ Unk
Has client ever been a victim of physical abuse? __ Yes __ No __ Unk
Sexual abuse? __ Yes __ No __ Unk
Neglect? __ Yes __ No __ Unk
Has client ever witnessed family violence? __ Yes __ No __ Unk
Has client ever been in therapy? __ Yes __ No __ Unk

If yes, specify type, duration, referring problem: ________________
____

NON-SEXUAL OFFENSE HISTORY

In the following section please circle whether the client has ever been involved in any of the following offenses. Circle whether the client has ever been arrested for the listed offense.

Offense	Ever Involved?	Ever arrested?	Offense	Ever Involved?	Ever Arrested?
Shoplifting	Yes No Unk	Yes No Unk	Vandalism	Yes No Unk	Yes No Unk
Theft	Yes No Unk	Yes No Unk	Arson/fires	Yes No Unk	Yes No Unk
Burglary	Yes No Unk	Yes No Unk	Animal cruelty	Yes No Unk	Yes No Unk
Car Theft	Yes No Unk	Yes No Unk	Runaway	Yes No Unk	Yes No Unk
Drugs/Alcohol	Yes No Unk	Yes No Unk	Prostitution	Yes No Unk	Yes No Unk
Assault	Yes No Unk	Yes No Unk	Other ________		

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Development Committee: G. Ryan, J. Davis, S. Lane, K. Wilson, D. Bross, T. Miyoshi

For non-sexual offenses, has the client ever been:

	Yes	No	Unk		Yes	No	Unk
Adjudicated a delinquent	___	___	___	Placed in a group setting	___	___	___
Placed in a diversion program	___	___	___	Placed in boys'ranch setting	___	___	___
Placed on probation	___	___	___	Placed in a state institution	___	___	___

SEXUAL OFFENSE HISTORY

In the section below, please circle whether client's referring sexual offense involved in any of the following. CHECK ALL THAT APPLY. If client has prior sexual offenses, indicate the number.

Did the incident include:	Referring Offense		# Prior Offenses	Unk
Exhibiting	Yes	No	________	___
Frottage	Yes	No	________	___
Peeping	Yes	No	________	___
Obscene calls	Yes	No	________	___
Stealing underwear	Yes	No	________	___
Touching victim's breasts	Yes	No	________	___
Touching victim's genitalia	Yes	No	________	___
Masturbation of victim	Yes	No	________	___
Fellatio on victim	Yes	No	________	___
Cunnilungus on victim	Yes	No	________	___
Penile vaginal penetration of victim	Yes	No	________	___
Digital vaginal penetration of victim	Yes	No	________	___
Object penetration of vagina of victim	Yes	No	________	___
Sodomizing of victim	Yes	No	________	___
Digital anal penetration of victim	Yes	No	________	___
Object penetration of anus of victim	Yes	No	________	___
Masturbation by victim	Yes	No	________	___
Fellatio by victim	Yes	No	________	___
Cunnilungus by victim	Yes	No	________	___
Penetration by victim	Yes	No	________	___
Bestiality	Yes	No	________	___
Verbal Coercion/Manipulation	Yes	No	________	___
Verbal Threats of Violence	Yes	No	________	___

Physical Force Yes No ________ __

Weapons Threat Yes No ________ __

Weapons Use Yes No ________ __

Other (specify) ______________________________

Age of Client at time of offense ___ Age at time of earliest prior offense ___

Age of Victim(s) at time of offense ___ Age of victims(s) at time of earliest prior offense ___

Sex of Victim: M F

Location of Offense:

Perpetrator's home ___ Automobile ___ Other building ___ Victim's Home ___ Other Home ___ Outside ___

Relationship of Victim:

Sibling (natural or step) __ __ Adult in household
Child - not related but living in household __ __ Adult outside home
Child neighbor __ __ Peer
Stranger __ __ Was victim in care of perpetrator at time of offense?

LEGAL RESPONSE

Charges filed in adult court ___
in juvenile court ___
in family court (DWA) ___
Dismissed ___

Found not guilty ___
Plea bargain to lesser sexual charge ___
Plea bargain to non-sexual charge ___
Guilty as charged ___

Had previous sexual abuse charges been filed? Yes No

If yes, dismissed? Yes No
plea to lesser sexual offense? Yes No
plea to non-sexual offense? Yes No

DISPOSITION ON REFERRING OFFENSE:

Diversion Yes No Out-of-home placement Yes No
Probation Yes No Hospitalization Yes No Incarceration Yes No

EVALUATION AND TREATMENT

Court-ordered evaluation Yes No Pretrial ___ Presentencing ___

Court-ordered evaluation by sex offender specialist Yes No

Court-ordered evaluation by other (specify) ____________

Total number of prior sexual offenses known ____________

Total number of police contacts known ____________

The above data was obtained from (check all that apply):
Client __ Court records __ Police Records __ Family __ School records __ Other (specify) ______

Is client being referred to another agency/individual for evaluation? Yes No

Is client being referred to another agency/individual for treatment? Yes No
If so, is that agency/individual a participating APN member? Yes No
Or, will you continue to report on this client yourself? Yes No

ADOLESCENT PERPETRATOR NETWORK:
UNIFORM DATA COLECTION SYSTEM

INITIAL EVALUATION/ASSESSMENT FORM

DATE:_______ APN MEMBER #:_ _ _ _ CLIENT ID:___________________
(Client initials, month, day, year of birth)

Note: This form may be completed by an individual whose responsibility is that of performing an assessment of the client. That individual may or may not be the same as the individual who completed the APN Intake form. This form differs from the Intake Form in that this form asks for both factual data and clinical impressions whereas the Intake Form sought only factual data. Be sure the Intake Form has been completed either by yourself or another participating member. If you refer a client after evaluation to another participating member for treatment, notify them that the Intake and Evaluation Forms have been completed.

I. GENERAL INFORMATION

Was the Intake Form for this client completed by yourself or a member of your agency? Yes___ No___
by another APN Network member? Yes___ No___

Who ordered or referred client for your evaluation?
Court___ Self-referral (client)___ Other clinician___ Social Services___ Attorney___
Family___ Diversion?Probation___ School___ Other (specify)_______________

Who is paying for the evaluation? (check all that apply)
Client___ Social Services___ Grant (type)______ Client's family___ Medicaid___
Medical Insurance___ Court___ Champus___ Other (specify)_______________

What records were reviewed by you prior to this evaluation? (check all that apply)
Current Offense Report___ Court Records___ Medical/Psychological Records___
Prior Offense Reports___ Probation Reports___ Witness Accounts___
School Records___ Victim Statements___ None___

In your assessment, did you use any of the following?

MSI	Yes___	No___	Penile Plethysmograph	Yes___	No___	Bender Gestalt	Yes___	No___
MAPI (Milan)	Yes___	No___	Rorschach	Yes___	No___	Draw-A-Person	Yes___	No___
O'Brien Typology	Yes___	No___	WRAT	Yes___	No___	Kinetic Family Drawing	Yes___	No___
Wenet Risk	Yes___	No___	MMPI	Yes___	No___	WISC-R or WAIS-R	Yes___	No___
Card Sort	Yes___	No___	TAT	Yes___	No___	FIRO-B	Yes___	No___
Auchenbach	Yes___	No___	Other (specify)_______________					

II. EDUCATION

Client's current grade in school (circle) 1 2 3 4 5 6 7 8 9 10 11 12 ___not attending

Last grade completed by client (circle) 1 2 3 4 5 6 7 8 9 10 11 12

Circle grade average last year A B C D F

Type of school currently or last attended:
Regular Public___ Private Church Related___ Private___
Special Public (street academy, etc.)___ Trade/Vocational___ Other (specify)____________

Does school report:

	Yes	No	Unk		Yes	No	Unk
Behavior Problems	___	___	___	Special Education: EBD	___	___	___
Truancy History	___	___	___	Special Education: DD	___	___	___

III. IMPRESSIONS OF CLIENT

Disregarding whether or not the client admits any personal involvement in the offense, does the client admit that a sexual offense occurred at all? Yes___ No___

If the client admits took place, does the client:
admit being present at time of the offense Yes___ No___
admit being perpetrator or participant Yes___ No___

	None	Some	Fully	Unk
To what degree does the client accept responsibility for his/her offense?	1	2	3	4
To what degree does the client express empathy for the victim?	1	2	3	4
To what degree does the client express remorse/guilt for the offense?	1	2	3	4

Who/what does client blame for the offense?
Self___ Co-participants___ "Being Sick"___ Drugs/alcohol use___
Victim___ Parents___ Past___ Other (specify)___

IV. SUBSTANCE ABUSE

Has client ever been suspected or reported for alcohol/drug abuse? Yes___ No___ Unk___

Has client ever been treated for alcohol/drug abuse? Yes___ No___ Unk___

Do family members abuse substances?

Mother or primary female figure Yes___ No___ Suspected___ Unkown___
Father of primary male figure Yes___ No___ Suspected___ Unkown___
Siblings Yes___ No___ Suspected___ Unkown___

V. VICTIMIZATION IN CLIENTS HISTORY

Has client ever been a victim of physical abuse? Yes___ No___ Unk___

If YES, was the abuse reported? Yes___ No___ Unk___
was the abuse adjudicated? Yes___ No___ Unk___
how old was the client at the time of abuse(s)? Yes___ No___ Unk___

Abuse inflicted by:

Father___ Stepfather___ Other male___ Mother___ Stepmother___ Other female___

Has there ever been a report of violence between client's parent's Yes___ No___ Unk___

Has there ever been a report of incest in the family? Yes___ No___ Unk___

If YES, specify members involved:________________________________

VI. RELATIONSHIPS

Has client ever been in out-of-home placement? Yes___ No___ At age___

Was client adopted? Yes___ No___ At age___

Does client report loss of a significant relationship in his life?

Parent figure___ Other person___ Pet___

If parent loss, mark all that apply and specify:
___death of_______________
___emotional rejection by_______________
___abandonment by_______________

___divorce: regular visits with non-custodial parent___
sporadic visits with non-custodial parent___
no contact with non-custodial parent___
___perceived loss (specify)_______________

What does client report his parent's reaction was upon hearing of the allegations against him/her?

Anger___ Support___ Denial___ Made Client Feel Guilty___
Blame Selves___ Rejection___ Blame client___ None___

Does client have a group of friends/peers of which he feels a part? Yes___ No___

Is there anyone the client trusts completely? Yes___ No___ Adult___ Peer___

Is there anyone the client feels really trusts him/her? Yes___ No___ Adult___ Peer___

Does client feel persecuted? Yes___ No___ By System___ By Adults___ By Peers___

VII. SEXUALITY

Does client report he is sexually:
Mature___ Different from Others___ Homosexual___ Inadequate___ Normal/Adequate___

Does client report ever having had age appropriate sexual relationships? Yes___ No___

How often does client report masturbation?
More than once a day___ Less___ Once a week___
Several times a week___ Once a day___ None___

Does client ever report masturbating to a fantasy? Yes___ No___
Is fantasy age appropriate and consensual? Yes___ Deviant___
Does fantasy involve a child? Yes___ No___
Does fantasy involve violence? Yes___ No___

Does client think of sex as:

A way of hurting, degrading or punishing___ ___A way of controlling and feeling powerful
A way of dissipating angry___ ___A way of loving
A way of showing you care for someone___ ___Other (specify)_______________

Does client view aggression as:

A way to protect self___ ___A way to hurt others
A way to control others___ ___An expected masculine trait

VII. SEXUALITY (CONT.)

Does client report involvement with pornographic materials or media? Yes___ No___

Does client report a trigger that sets off his deviant sexual behavior?

Anger___ School problems___ Feeling bored___ None___
Feeling helpless___ Problems with Friends___ Stress___
Feeling sad/depressed Feeling Controlled___ Family problems___

Does client report other sexual offenses not previously reported?
None___ Several___
One___ A Lot___

VIII. CLINICAL IMPRESSIONS
(Based on available information from all sources)

Do you feel offender, during evaluation, was: (check all that apply)
Hostile___ Afraid___ Open and honest___ Trying to con you___ Closed___

Does client appear depressed?
More than you expect___ Appropriately___ Not at all___

Do you think client's family is functioning:
Dysfunctionally___ Average___ Reasonably well___

Do you think client's sexual knowledge is:
Distorted___ Accurate___ Inadequate___

Do you think client's sexual behaviors over time have become:
More serious___ More frequent___ Stayed the same___

Do you think this client is a danger to the community at this time?
Definitely___ Probably___ Perhaps___ Not at all___

Do you feel this client is treatable? Yes___ No___ Unk___

Do you feel this client is motivated to change? Yes___ No___ Maybe___ Unk___

What treatment are you recommending?

Secure residential___ Open residential___ Outpatient___ None___

Are you recommending sex offender specific treatment? Yes___ No___

Are you recommending that treatment include:

Group therapy___ Family therapy___ Individual___ Other___

If you had all options available, would your recommendation be the same?___ Different___

Who will pay for treatment?

Court___ Client___ Family___
Medical Insurance___ Social Services___ Private Sector Grant___
Champus___ Medicaid___
Tax supported grant or contract: City___ County___ State___ Federal___

Will you be treating this offender yourself? Yes___ No___

If you are referring to someone else for treatment, are they a participating member? Yes___ No___
If YES, enter treatment provider's APN number from membership list__________ and notify them that Intake and Evaluation Forms have been completed.

ADOLESCENT PERPETRATOR NETWORK UNIFORM DATA COLLECTION SYSTEM Revised Edition 1/88

Exit Report Date: ___________

APN Member # __ __ __ Client ID: __ __ __ __ __ __ __ __
(Client initials, month, day, year of birth)

Months in Treatment: Less than 3 __ 3-6 __ 6-12 __ 12-18 __ 18-24 __ 24-30 __ 30-36 __ More __

Treatment of this client has included: Open residential __ Secure residential __ Outpatient __
Journal __ Didactic Work: Sex education __ Hours/week family therapy __
Homework Assignments __ Values clarification __ Penile Plethysmograph __
Reward/token economy __ Assertiveness training __ Satiation __
Covert sensitization __ Hours/week individual __ Positive Sexuality __
Aversion therapy __ Hours/week sex offender specific group __ Social skills training __
Other ____________

Did you identify a specific approach which was more useful than others with this client?
Yes __ No __ Specify ______________________________

Are you releasing client from treatment because:
Client has completed program __ Client has failed to participate __ Client does not wish to continue __
Court order has expired __ Funds no longer available __ Other (specify) ____________

Do you feel client has succeeded in treatment? Yes __ No __ Unk __
Do you feel client's risk for re-offending is: High __ Moderate __ Low __ None __
Do you feel client is able to monitor self? Yes __ No __ Unk __
Has client accepted responsibility for offense? Yes __ No __
Has client identified trigger or cycle of deviant behavior? Yes __ No __
Has client demonstrated ability to interrupt the offense cycle before offense occurs? Yes __ No __

Has client identified victimization and/or trauma in his/her past? Yes __ No __
IF YES, check all that apply: Sexual abuse __ Parental Rejection __ Abandonment __
Physical abuse __ Sexual trauma __ Other (specify) ____________

If Sexual Abuse: Client was __ years old
Perpetrator was __ years older Male __ Female __ Family Member __ Known __ Stranger __
Victimization was: Hands off sexual trauma __ Coersive, passive sexual __ Fellatio __
Violent, aggressive sexual __ Included vaginal or rectal penetration __

Has client developed victim awareness and/or empathy to a point where potential victims are seen as people rather than objects? Yes __ No __

Has client developed an appropriate, positive sexual identity for self? Yes __ No __

Does client have the skills necessary to function adequately in his situation? Yes __ No __

Will any followup treatment or support be available to this client? Yes __ No __
Does client intend to utilize followup services? Yes __ No __ IF YES: Required by court __ Voluntary __

Does client feel better about himself than he did before treatment? Yes __ No __

How do you feel about this client's future? Optimistic __ Pessimistic __ Unsure __

Will client be living with family __ custodial other __ emancipated __

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RETURN FORM TO: Gail Ryan, APN DATA COLLECTION
Kempe National Center
1205 Oneida Street
Denver, CO 80220 Questions? 303/321-3963

APPENDIX D

Abstracts of dissertation research based on Pilot Program clinical data

ABSTRACT OF THE DISSERTATION

Pre Treatment Status, Intensity of Treatment, and Treatment Outcome in Male Adolescent Sex Offenders

by

Cynthia Kibrick Bromberg

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Data from files of 199 male adolescent sex offenders who were court-ordered to outpatient treatment were analyzed to determine the relationships between their Pre Treatment Status, the Intensity of Treatment they received, and their Treatment Outcome. The Pre Treatment Status variables were: parental absence; prior victimization; and pre existing emotional pathology. The Intensity of Treatment variables were: months in treatment; , number of sessions; , and number of treatment modalities used. The Treatment Outcome variables were: Adolescent Perpetrator Network Total Score and Office of Criminal Justice Planning (Risk Assessment) Change Score. A subset of clients (N = 80) were rated on another Treatment Outcome variable: MMPI Change Score. A structural equation model was created and EQS testing resulted in a significant goodness of fit index (.915, $p < .001$) indicating that both Pre Treatment Status and Intensity of Treatment had effects on Treatment Outcome (the former negative and the latter positive). Pre Treatment Status also had a direct relationship to the Intensity of Treatment received. EQS analysis of the subset (n = 80) produced an insignificant goodness of fit index demonstrating that change on the MMPI had a lack of utility as an indicator of treatment outcome. Discussion concluded that individualization of treatment for adolescent sex offenders based on their past histories was justified.

ABSTRACT OF THE DISSERTATION

Classification of Adolescent Sexual Offenders:
Correlation of Life History With Sexual
Offense Bases Upon Aggression
and Socialization

by
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The present study examined aggression and socialization as central classification variables for the adolescent sexual offender (ASO). Clinician ratings of aggression and socialization in the areas of life history and sexual crime were correlated for adolescent sexual offenders (n=118) from three separate treatment programs in California. Life history was shown to be clearly associated with the perpetrated sexual crime in the area of aggression ($r = .20$, $p < .014$) and socialization ($r = .32$, $p < .001$). These variables were shown to be of importance in differentiating the ASO and merit inclusion in future typologies.

ABSTRACT OF THE DISSERTATION

Personality Profile of Juvenile Sex Offenders–

Experimental Verification of Three Types

by

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Available evidence suggests that child sexual abuse is a major social problem in this country. An examination of the current research indicates there are many unanswered questions regarding identification and treatment of adolescent sex offenders. This exploratory study examined characteristics of three types of adolescent sex offenders as defined by O'Brien's (1989) typology.

There were 122 adolescent sex offenders between the ages of 12 and 18 who were assigned to one of three groups: (a) sibling incest offenders, (b) extrafamilial offenders, and (c) nonchild offenders. The following demographic variables were reviewed: age, offense, ethnicity, living arrangement, educations, and history of prior sexual and criminal offenses. The offenders were also given the Minnesota Multiphasic Personality Inventory (MMPI) either prior to or during the initial phase of treatment.

A discriminate function analysis was performed and successfully discriminated one the three groups: the nonchild offenders. The sibling incest offenders and extrafamilial offenders shared more in common. The nonchild offenders were more successfully classified and appeared to have quite different personality characteristics than the other two groups.

There were differences between the three groups in terms of elevated mean scale scores on the MMPI. The sibling incest offenders tended to be anxious, develop physical symptoms, and act out impulsively. The extrafamilial offenders were self-centered, dependent, and immature. The nonchild offenders, on the other hand, appeared to be the most defensive and potentially the most aggressive offenders. This group was characterized as having classic features of an antisocial personality.

The particular findings are discussed in relation to the three types of offenders. Implications for treatment and suggestions for future research are included.

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PILOT JUVENILE SEX
OFFENDER TREATMENT
PROGRAM