Research and program evaluation in Illinois: Studies on drug abuse and violent crime

An interim report on the Illinois Department of Corrections' juvenile sex offender treatment program

June 1998

Prepared by
Center for Legal Studies
University of Illinois at Springfield

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AN INTERIM REPORT ON THE EVALUATION OF THE ILLINOIS DEPARTMENT OF CORRECTIONS' JUVENILE DIVISION SPECIAL SUPERVISION UNITS PROGRAM; SEX OFFENDER TREATMENT UNIT

Prepared for the
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This interim report covers preliminary findings from the first year of the evaluation project, January 1997 through January 1998. The Sex Offender Treatment Unit has implemented a number of the interim report recommendations and the final evaluation report is expected to aid in further program development and refinement.

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Executive Summary

Introduction

Although identified juvenile sex offenders currently represent a relatively small proportion of the IDOC Youth Division population, they are a highly publicized population due to safety concerns in the community that exist about their release. Until the 1980's, research on sex offenders was concerned almost entirely with adults, even though the weight of clinical evidence now indicates that juvenile and adult sex offenders require different treatment methods. In 1996 the Illinois Criminal Justice Information Authority (ICJIA) funded the Sex Offender Treatment Program at the Illinois Youth Center at Harrisburg (IYC-H) to provide intensive residential treatment and aftercare to juvenile sex offenders. This Program has two components: the Sex Offender Treatment Unit (SOTU), a residential treatment unit located in IYC-H, and the Cook County Juvenile Parole District (CCJDP), which is responsible for the aftercare component.

In September 1996, ICJIA issued a request for proposals to conduct an implementation and impact evaluation of SOTU. In the solicitation, ICJIA identified three broad goals for the implementation evaluation: 1) to determine the extent to which implementation was carried out according to pre-operational expectations; 2) to guide future refinement of the program; and 3) to guide similar undertakings in other jurisdictions. The general goal of the impact evaluation was to determine the extent to which both components of the Sex Offender Treatment Program, working together, are successful in meeting the general program goals of providing effective programs and services that ensure positive treatment outcomes and divert youth from re-offending.

The limited number of studies of programs for juvenile sex offenders suggests that juvenile offenders can be effectively treated when programs combine an intensive, multimodal approach with early intervention. This report reviews treatment alternatives that have been discussed in the existing research literature, including phallometry, pharmaceutical treatment, operant conditioning treatment, outpatient counseling programs, cognitive-behavioral treatment

programs (including the development of social skills, anger management, victim empathy training, and cognitive restructuring), relapse prevention treatment, aftercare programs, and therapeutic community programs. The literature suggests that phallometry and pharmaceutical treatment are generally inappropriate treatment approaches for juvenile sex offenders. Each of the remaining components includes elements that have shown promise, and SOTU included aspects of all of those components.

Program recommendations made by leading groups in the field of juvenile sex offender treatment were also reviewed. These included recommendations made in *Ethical Standards and Principles for the Management of Sexual Abusers*, published in 1997 by the Association for the Treatment of Sexual Abusers (ATSA); the 1993 report of the National Task Force on Juvenile Sexual Offending, which surveyed more than 800 individuals working with juvenile sex offenders; and an approach adapted from a corrections-based model for substance abusers developed in 1991 by the National Task Force on Correctional Substance Abuse Strategies. The presentation and comparison of these three models provides a framework for the analysis of SOTU at IYC-H.

Data Collection Activities

Data for this evaluation were collected through the following: 1) personal and telephone interviews with key policy makers and program staff; 2) field studies at the program site, including 16 consecutive days of observation during the first year; 3) review of reports, archival documents, grant applications and other relevant materials provided by IDOC and the ICJIA; and 4) offender treatment records maintained by SOTU for the first 25 participants admitted to the program. Because recollections and perceptions may differ, multiple data sources were used to increase the validity and reliability of data. A more extensive review of treatment files will occur during the second year, when data will also be available from the computerized Juvenile Tracking System (JTS).

The researchers have not yet gained access to the Juvenile Division Reception Unit at St. Charles, making it impossible to present a complete view of the process by which youth are assigned to IYC-H. The evaluators have submitted a request to conduct research at this facility, and are awaiting a response. Information on the characteristics of sex-offending youth at IYC-H and in IDOC will be obtained during the second year of this study, when the impact analysis will be conducted. Because no youth have yet been released from SOTU to CCJPD, the research team has not yet documented the development or implementation of the CCJPD component of the Sex Offender Treatment.

Goals

Four overall project goals were outlined in the grant application submitted to ICJIA. They are: 1) conduct assessment and classification evaluations to prioritize youth for treatment services; 2) establish a comprehensive, intensive treatment environment that supports life, cognitive and behavioral skills building; 3) establish a system of post-release treatment, case management and support services that will support program graduates as they return to the community; and 4) establish process and outcome evaluations.

The grant proposal also included a list of outcomes that would measure the success of the treatment environment (goal two above). Ideally, the program staff should have been involved in developing both these general goals and the methods of measuring outcomes. These proposed goals and objectives were not well publicized within IYC-H, leading the SOTU treatment specialist to identify the following five objectives within the program. SOTU youth will: 1) acknowledge and accept full responsibility for their sexual offense history; 2) develop knowledge and understanding of human sexuality, including knowledge of their own arousal patterns; 3) identify and correct general and specific thinking errors; 4) learn to identify feeling states and respond with healthy behaviors; and 5) gain understanding of how sexual abuse and assault negatively impacts victims, and develop empathy for their victims.

Structure

Because treatment programs should be developed based on the aggregate needs of the offender population, the first step is to determine the population trends and characteristics of offenders available for treatment. Since the characteristics of the target population are not known at Harrisburg at this time, it is not possible to recommend program changes to meet the needs of the specific population. However, since the IYC-H population will vary based on security concerns and available space, the program should be designed to meet the needs of most of the available offenders in the population.

Function

Sex offenders appear to be increasingly sent to Harrisburg as awareness of the treatment program grows. In February 1997, there were 67 sex offenders at IYC-H, an increase of 98% from October 1996 when SOTU opened. This supports the perception of the interviewees that there is a shift in the population of IDOC in general or a change in classification and assignment decisions. After a youth identified as being eligible for SOTU arrives at IYC-H, he is referred to the Social Worker III who directs the therapeutic program for a clinical assessment. On the basis of this assessment, a formal request to the IYC-H assignment committee is made.

System Resources

The grant agreement provided funding for five full-time and two half-time positions for the Substance Abuse and Sex Offender Treatment Units at IYC-H. These positions included: a Psychology Administrator I to provide overall program management; two Social Worker IIIs to provide direct treatment services to SOTU; one Correctional Counselor III to provide direct service on violence prevention to both units; two half-time Leisure Activity Specialists I to provide leisure time activities to youth in both units; and one Office Associate.

The IYC-H was unable to staff these positions with people who met the full range of qualifications included in the grant. The difficulties in filling the grant positions were related both

to the nature of the positions and the location of the treatment program. The compromises that were made in hiring personnel were reasonable under the circumstances, but resulted in some problems during the first year of the SOTU. The original Program Manager did not take the active role in the development and implementation of SOTU that the grant proposal had envisioned.

The SOTU Correctional Counselor II has an office on L wing and was assigned all the youth placed in that wing. The same Correctional Counselor was assigned the youth on K wing when it opened. This will allow her to have more of a presence on the wing and to become a more active part of the SOTU treatment team. The security staff makes an essential contribution to the SOTU. The regular weekday security staff for both the day and evening shifts are generally recognized as important assets, and are supportive of the treatment program. Because one or more members of the security staff (Correctional Officers) are always with the youth, they are in a unique position to implement and reinforce the treatment program around the clock.

The grant specified that School District 428 would provide six educators for the special units in Building B. In May 1997, the six original teachers transferred to another facility as a group and classes are currently provided by four teachers

Interpersonal Interaction and Communication

SOTU has developed as a fairly self-contained program. While communication appears to be fairly open and direct within the SOTU, particularly between the treatment staff and weekday correctional officers, there was a pattern of poor communication between the SOTU social worker and the first Program Manager. The recent hiring of a new Program Manager provides an opportunity to rebuild this relationship and establish a greater degree of trust and communication.

In addition, there are a number of issues that need to be addressed in the coming year. Many of them have implications for SOTU's ability to provide intensive treatment, which requires

the active support of personnel throughout the facility. They include: improving communication between the casework supervisor and the SOTU Social Workers and Program Manager; establishing a regular exchange of information between the SOTU treatment providers and the Violence Interruption Program (VIP) counselor; improving communication with school educators so that all parties understand the rules and behavioral expectations that apply to SOTU youth; improving communication between security and SOTU staff by developing a method for routinely sharing observations that are not appropriate for an incident report; agreeing on the information about SOTU youth that will be routinely forwarded to all staff associated with SOTU; informing all staff associated with SOTU directly about changes in wing rules and behavioral expectations as they occur; and improving awareness of SOTU activities and scheduled activities by posting a current schedule at least weekly and confirming changes or modifications with those who are affected.

Treatment elements

SOTU follows the IYC-H policy of a reward and punishment system based on points. However, the program needs to integrate this discipline system more fully into its treatment program. This current system of tracking both disciplinary status and SOTU Phase progress creates additional work for the staff.

Youth receive a clinical evaluation at IYC-H before being recommended for SOTU. Basic eligibility depends on documentation of the youth's status as a sexual offender, but the youth also received an individual clinical assessment that focuses on need for sex offender-specific treatment. In developing the SOTU treatment plan, the Social Worker identified a variety of tests and assessment instruments that may be useful in determining need for treatment, but the current evaluation protocol calls for too many screening tests and is both time-consuming and cumbersome. Steps have been initiated to identify and implement a selected number of the best age-appropriate measures.

In addition to the core treatment objectives of SOTU, each individual should have specific objectives or an Individualized Treatment Program (ITP) for his own personal treatment needs.

The overall SOTU treatment program is divided into four phases, each phase is intended to reinforce and support the changes that have occurred in the previous one.

Pre-Treatment focuses on learning the rules for treatment group process, overcoming denial and accepting responsibility for sex offenses committed, and learning terminology and understanding concepts related to sex crimes, thinking errors, and risk factors. Pre-Treatment therapy is carried out through group therapy, family meetings, and individual, self-paced assignments. There are also specific educational modules associated with Pre-Treatment. At the conclusion of this phase each youth must be prepared to make a commitment to treatment goals and to sign a treatment contract.

The primary goal of Phase 1 was for each youth to learn about the concept of a sexual assault cycle and to understand his individual sexual assault cycle. Treatment elements were similar to those included in the Pre-Treatment Phase. During Phase 2 youth were expected to improve their understanding of the consequences of sexual offenses, learn the life factors leading to criminal behavior and develop a plan to alter dysfunctional factors in their own lives, and begin to develop ways to intervene in their own personal offense cycles. In Phase 3, the final phase, youth were expected to develop a specific plan for intervention in their personal offense cycle, exercise group leadership, and complete a relapse prevention plan.

Although the evaluation of the treatment program as implemented will be continued during the second year, the research team is aware that some elements of this program were changed early in program development.

SOTU treatment modules are a work in progress. It was not possible for SOTU to have all the preferred program elements identified and specified in advance, which resulted in the program being implemented before it was fully designed. The elements selected by SOTU

personnel were implemented and tested on the youth. Treatment components continue to be refined as the program progresses. By the end of the two year evaluation period, SOTU staff should have a clearer idea of what elements are central to the program and will be able to focus on them. The SOTU treatment specialist (SWK III) must have adequate time to develop and operationalize the treatment modules envisioned in the original Phase plan, and to modify them as necessary to meet the treatment needs of SOTU youth.

Because of the modifications that have been introduced throughout the first year of the SOTU program, it is difficult to determine which elements have been implemented, and which elements have been identified as necessary but not yet fully designed. The second unit should adopt the program as it has evolved during the first year and implement that evolved program in the new wing. In year two, the progression of development from initial implementation through expansion to the implemented program in the second unit can be documented.

In order to evaluate the program it is important to document the treatment provided to each youth. The elements of the SOTU program and the extent to which they are provided to individual SOTU youth must be documented more fully in year two. Based on data gathered through interviews, document review, and site observation, progress toward SOTU objectives appears to be measured subjectively by the therapist during group therapy sessions and through review of student workbooks and journals. Objectives need to be specified more clearly, and individual progress toward these objectives should be fully documented in the SOTU files.

The grant proposal modeled SOTU as a Therapeutic Community (TC). This treatment component deserves special attention because of its central focus in the IDOC grant application. SOTU does not appear to meet any of the definitions for a complete Therapeutic Community (sometimes called a "TC proper"), although it is drug free. Instead, the evaluation documents that SOTU was implemented as a 'therapeutic environment' with some of the

characteristics of a TC. If policy makers desire to test the TC concept in this treatment program, further actions can be taken to design a TC model that can be implemented.

On-Site Observation

One research assistant observed various aspects of SOTU for 16 consecutive days in August 1997. Two therapy groups met during the shifts observed during this period. One substance abuse group was observed during the 16 day period. These observations confirm information gathered from interviews with staff that SOTU has not always been able to provide a consistent treatment program from week to week.

Four half-days of school were observed during this period. Substance abuse program youths were mixed with sex offender youths in classes and the youth did interact socially on occasion. Outside of school, when the participants engaged in unstructured activities, the observer recorded each youth's behavior once every 10 minutes. The activities were categorized into 17 observable behaviors and summarized in the report.

Negative behaviors included activities such as verbal hostility, negative interaction with an authority figure, and unbecoming social characteristics (such as manipulative behavior). Positive behaviors included voluntary social avoidance of others, competitive social inclusion, and positive interaction with authority figures.

During a total of 37.3 hours of observation of free time, each youth was observed for an average of 20.3 hours. The 18 youth averaged 11.5 (9.4 percent) negative behaviors and 110.9 (90.6 percent) positive behaviors. Proportionately, youth tended to be more negative during zone activities. Most of the negative behavior was verbal hostility during competitive sports.

Other

Youth housed in Building B (both the Sex Offender and the Substance Abuse Treatment Units) attend classes in Building B, apart from the general population. However, the educators are not incorporated into the treatment program, and do not interact regularly with the SOTU treatment providers. Other treatment programs provided to the general population also include

elements that are important for juvenile sex offenders. Treatment activities like these should be integrated into the overall SOTU treatment program, and treatment providers should be aware of the specific goals that SOTU youth have agreed to work toward.

A series of recommendations for program changes and enhancements are made throughout the report. These are compiled in Chapter Six. They place particular emphasis on the importance of improving documentation of the program elements and their provision to SOTU youth, increased involvement of non-therapeutic staff in the overall SOTU treatment program, and improved communication between the various institutional units at IYC-H.

Chapter I: Study Background

Introduction

In September 1996, the Illinois Criminal Justice Information Authority (ICJIA) issued a request for proposals to conduct an implementation and impact evaluation of the Illinois Department of Corrections' (IDOC) Juvenile Division Sex Offender Treatment Unit operated under the Juvenile Special Supervision Units Program. The Sex Offender Treatment Program is comprised of two components; the Sex Offender Treatment Unit (SOTU), located in the Illinois Youth Center-Harrisburg (IYC-H) and the Cook County Juvenile Parole District (CCJDP). The ICJIA identified the goal of Sex Offender Treatment Program as preserving "public safety by improving treatment outcomes for youth who have exhibited sex offending behavior" (ICJIA, 1996b, p.2). The two services work together "to provide effective programs and services that ensure positive treatment outcomes and divert youth from re-offending" (ICJIA, 1996b, p.2).

The goals of this evaluation were to permit officials to assess how well the program was implemented and the impact the program has had on the stated goal of preserving public safety by improving treatment outcomes for sex offending youth. Specifically, this interim report has a two-fold purpose. First, it will document and discuss the preliminary assessment of the implementation process of SOTU, placing the decisions and process in a contextual setting, and provide guidance to administrators and line staff for enhancing the program based on state-of-the-art research results. Second, this report provides a preliminary review of the factors necessary to develop a manual describing the process of implementing a sex offender treatment program by documenting the difficulties and successes of this project from various perspectives.

The two-year evaluation began with a contract effective January 15, 1997. During the first three months, the research team focused on identifying sources of information, developing a working relationship with program staff, and developing interview protocols. During the remainder of the first year of the study, 35 interviews were conducted with 30 individuals who

were connected with the SOTU at IYC-H. Since the final interviews were completed, a new supervisor has been hired. The new supervisor was included in the year end briefing. The SOTU program manual, periodic reports, and various internal IDOC documents were collected during the first year. The reports include information about the program elements (e.g., number of hours of group therapy) and the participants. This material has been compiled and analyzed and comments are included in this report.

On January 8, 1998, the researchers held an administrative update meeting with program administrators from IYC-H. This meeting allowed the researchers and administrators to discuss the following: 1) preliminary findings identified in this report, 2) schedule for the second year as identified in the proposal, and 3) suggestions for program enhancements.

This interim report reviews the preliminary findings of the development and implementation of SOTU. The remainder of this chapter discusses the statement of the problem and the limitations of this report. Chapter Two includes a brief review of the literature, and the research methods are presented in Chapter Three. Chapter Four presents a review of the program implementation and Chapter Five discusses the state-of-the-art treatment components for juvenile sex offenders. This report concludes with a summary of the preliminary findings and recommendations for enhancements in Chapter Six.

Statement of the Problem

The recent trend in juvenile corrections is to commit more youths to juvenile facilities and to impose longer sentences, especially for crimes of violence. This has resulted in growing overcrowding in juvenile correctional facilities. In 1993, almost half of the states reported that their juvenile facilities were over their rated capacity (Maguire and Pastore, 1995). The Illinois Department of Corrections' Juvenile Division (the Division) has reported similar conditions, with future projections indicating a continuation of this trend (IDOC, 1996a). This overcrowding strains the limited resources available to corrections, leading IDOC to increase its efforts to expand community based programs to provide a "continuum of care" (IDOC, 1997, p. 53).

Although identified juvenile sex offenders represent a relatively small proportion of the committed population in the IDOC, approximately 100 of the 1,600 committed juveniles, they are a highly publicized population due to safety concerns in the community that exist about their release. Although the media often exaggerate the risk that exists by focusing on atypical cases, a growing number of studies suggest that adolescent sex offenders often become sex offending adults (e.g., Benoit & Kennedy, 1992).

One solution to citizen concerns would be to reduce the threat posed by juvenile sex offenders at release by providing them with treatment while under the state's authority. Although this solution further taxes already strained resources, effective treatment could prevent further offending and reduce recidivism. Unfortunately, only limited evaluative research has been conducted on juvenile sex offenders. Until the 1980's, research on sex offenders was concerned almost entirely with adults, even though the weight of clinical evidence indicates that juvenile and adult sex offenders require different treatment methods (Marshall & Eccles, 1991). Consequently, there are distinct research needs relating to this population. First, the implementation of juvenile sexual offender treatment programs needs to be documented and assessed. Second, the treatment validity of programs should be assessed in light of what is known about juvenile sex offender treatment. Third, treatment elements with the greatest potential to reduce recidivism need to be identified.

There are three major reasons to conduct such an evaluation. First, juvenile sex offenders represent a resource intensive population in an era of scarce resources. Limited resources need to be used in the most effective manner possible. Second, there is little empirically based knowledge about juvenile sex offenders. Evaluation of a well-designed program will add significantly to the existing body of knowledge. Finally, improvement in sex offender treatment has a desirable impact on both the individuals being treated and the community to which they return. The implementation study detailed in the following pages seeks to evaluate the SOTU at the IYC-H in Illinois, with the aim of providing recommendations for

policy and program enhancement. The results should be helpful to other jurisdictions considering enhancement or development of sex offender treatment programs.

Limitations

This section identifies the following limitations. First, the intake process at St. Charles has not been accessed. The goal is to document the population and institutional assignment process in order to clarify the population actually selected for assignment at IYC-H. An accurate understanding of the classification and assignment process at St. Charles will assist in identifying the sex offender population at Harrisburg and in refining the clinical assessment process carried out there. Several contacts were made to IDOC personnel to arrange access to observe the operations and interview selected personnel at St. Charles intake unit. Each contact resulted in a request for further information about the specific information requested. All requested information has been submitted, including a copy of the proposal. We are awaiting a response.

Second, the impact analysis data have not been requested; this is identified as a second year activity per the proposal. We received the JTS codebook in November 1997 and will submit our data request in the first quarter of 1998. File review has been approved and will be conducted in a timely manner.

Third, the research team has not yet documented the development or implementation of CCJPD (the continuation of the SOTU). The implementation evaluation of CCJPD was originally scheduled to occur during the first year of this evaluation. However, no youth have been released from SOTU to CCJPD. Therefore, no analysis of the transition and related services can be made at this time. This information will be included in the final report in January 1999.

Chapter II: Review Of The Literature[1]

The Problem of Juvenile Sex Offenders

In recent years, increased public awareness and concern about sexual assault have led to more aggressive handling of cases at the juvenile level as well as in adult court, resulting in a growing number of juveniles who are identified as sexual offenders and sentenced accordingly. While accurate estimates of juvenile sexual offenses are difficult to establish, national surveys have found that adolescent males commit more than 20% of all forcible rapes (Davis & Leitenberg, 1987), and retrospective studies of adult sexual offenders report that the majority of them also committed sexual assaults as teens (Benoit & Kennedy, 1992; Groth, Longo & McFadin, 1982).

The label of "sex offender" is applied to individuals who have committed a variety of sexual crimes ranging from forcible sexual assault to sexual conduct with a non-consenting or underage victim to sexual exposure and voyeurism. The definition of a criminal sexual offense may vary from state to state, but most states cover a similar range of actions. Legal minors of any age who commit these acts are classified as juvenile sex offenders, even if they are too young to be adjudicated in juvenile court or old enough to be transferred to adult court for prosecution and sentencing.

Juvenile sexual offenders are part of a larger wave of violent offenders coming into the Illinois Department of Corrections' Juvenile Division. Between 1988 and 1992 the number of juveniles taken into police custody in Illinois for violent index crimes (including criminal sexual assault) increased 16%. Between FY 92 and FY 94 there was a comparable 14% increase in the number of juveniles admitted to the IDOC for violent offenses. The Illinois Department of Corrections' Juvenile Division currently confines over 1,600 youth in seven juvenile institutions,

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[1] A portion of the Review of the Literature is extracted from our proposal for this grant. It is summarized here to provide a foundation for the evaluation and as a convenience to the reader.

a total which approaches 140% of total rated capacity. The IDOC projects these numbers to increase by about 50% by the year 2004 (ICJIA, 1996b).

In 1996 about 100 male youths in the Illinois Department of Corrections' Juvenile Division population were identified as sexual offenders, approximately 5% of the total juvenile population. Additional youth committed on other charges may also have a history of sexual offending that is not always identified in official records. The special needs of this population are of concern to the Division for several reasons. The needs of juvenile sex offenders for treatment and for supervision affect the workload of the Division's staff, who are already overloaded with an average caseload of 35 for counseling staff and as many as 75 youths for mental health professionals. An effective treatment program for these offenders would allow IDOC to make better use of its limited staff to promote positive treatment outcomes for youth and to reduce the likelihood of their re-offending after release.

The development of an effective program that includes post-release programming may allow the earlier release of some juveniles from confinement, freeing needed space for those offenders who must be confined. Juvenile sex offenders are at high risk for re-offending; any program which reduces this risk promotes community safety while also reducing the number of youth who return to custody. There is also considerable pressure on IDOC to protect the public from sexual attacks, a concern that is reinforced by increasing public awareness of the trauma suffered by victims of sexual assault and abuse. An effective treatment program that reduces the risk of juvenile sex offenders re-offending will help to reduce sexual violence and victimization, will contribute to enhanced community safety, and will provide a direct response to public concerns.

Current Alternatives for Juvenile Sex Offenders

Relatively few studies of male juvenile sex offenders exist, although the number has increased in recent years. Descriptive studies of adolescent sex offenders have documented

their existence and described the characteristics of offenders and offenses (Groth, 1977; Lewis, Shanock & Pincus, 1979; Longo, 1982; Vinogradov, Dishotsky, Doty and Tinklenberg, 1988). Studies indicate that most male adolescent sexual offenders come from disturbed family backgrounds (Awad & Saunders, 1989; Becker, Cunningham-Rathner & Kaplan, 1987; Lewis, Shanock & Pincus, 1979; Vinogradov et al., 1988;), and research into the criminal histories of juvenile sex offenders consistently finds prior delinquent offenses, often including earlier sexual offenses (Awad & Saunders, 1991; Fehrenback, Smith, Monastersky & Deisher, 1986; Pierce & Pierce, 1987; Smith, 1988). There is also considerable evidence that many juvenile sex offenders have been victims of sexual abuse (Kendall-Tackett, Williams & Finkelhor, 1993; O'Brien, 1991; Worling, 1995).

When specialized treatment programs began to be developed for sex offenders, the initial emphasis was placed on adult offenders. The National Task Force on Juvenile Sexual Offending (1988) reported that only 20 programs for juvenile sex offenders existed in the United States in 1982, a number that increased to more than 520 by 1988. Knopp, Freeman-Longo and Stevenson (1992) identified a combined total of about 1,500 treatment programs in the United States for adult and juvenile sex offenders by 1992; most of these were out-patient programs operating independently of correctional institutions.

The assessment and treatment of juvenile sex offenders has emerged as a separate field only in the last 15 years (Ertl & McNamara, 1997; Sermabeikian & Martinez, 1994). According to Marshall (1996), "the most substantial shift in treatment in recent years has been the marked increase in focus on treating juvenile sex offenders" (p. 189). But treatment programs continue to be influenced heavily by theories and methodologies derived from research on adult sex offenders (Hunter & Becker, 1994; Sermabeikian & Martinez, 1994). Hunter and Becker (1994) urge clinicians "to use evaluative and treatment methodologies derived from work with adult sex offenders in a judicious manner with juveniles and to be

cognizant of the likelihood that juvenile offenders are a heterogeneous population" (p. 146). The limited number of studies of programs for juvenile sex offenders suggest that juvenile offenders can be effectively treated so as to reduce subsequent re-offending (Becker & Hunter, 1992; Marshall, Jones, Ward, Johnston & Barbaree, 1991) when programs combine an intensive, multimodal approach with early intervention (Chaffin, 1994; Marshall & Eccles, 1991). Treatment alternatives that have been discussed in the existing research literature are reviewed below.

Alternative Treatment Approaches for Sex Offenders

Phallometry

Kurt Freund (1963) pioneered phallometric assessment, which involves the direct measurement of penile tumescence during the presentation of appropriate sexual stimuli in order to assess the individual's degree of deviance. The Association for the Treatment of Sexual Abusers (ATSA, 1997) suggests phallometry and/or polygraph measurement may be used to assess the accuracy of self-reports for adults. In 1992, Knopp, Freeman-Longo & Stevenson reported that although 168 juvenile sex offender treatment programs in the United States used phallometric assessment, there had been little research on the use of this technique. A number of studies, summarized in Malcolm, Andrews & Quinsey (1993), have found phallometric assessment useful in discriminating among adult offenders, but Hunter and his colleagues found weaker associations between measured arousal and offense histories for juveniles (Hunter & Becker, 1994; Hunter, Goodwin & Becker, 1994), and Marshall and Eccles (1991) found that erectile responses often did not satisfactorily differentiate sex offenders from other adult or adolescent males. There is no standardized approach to phallometric assessment, and Marshall (1996) concludes that there is "very limited empirical support" for its use with juveniles (p. 166).

Marshall (1996) also argues that the use of phallometry with juvenile offenders raises serious ethical questions: "Presenting very young males with clear depictions of deviant sex seems as likely to enhance offending tendencies as it is to play a role in diminishing such proclivities" (p. 166). Given these concerns, and the fact that the theoretical basis for the "sexual preference" hypothesis that underlies phallometric assessment and conditioning has been judged less convincing by contemporary researchers (Marshall, 1996; Marshall & Eccles, 1991), the use of this technique is increasingly difficult to justify.

Pharmaceutical Treatment

Psychopharmacological and hormonal therapies have been used with varying success to influence deviant sexual interest and sexually abusive behavior in adult offenders (Becker & Hunter, 1992; Bradford, 1990). Marshall, Barbaree & Eccles (1991) favorably evaluated the effectiveness of antiandrogens to reduce serum testosterone, when combined with psychological treatment, although the only published outcome studies depend entirely on self-reports of changes in arousal and behavior. Other researchers, reviewed in Bradford (1990), have documented undesirable side effects with this treatment, and Cooper (1987) found that the physiological effects of treatment (reductions in serum testosterone) did not always lead to desired reductions in deviant sexual behavior. Prentky (1994) reported some potential for serotonin reuptake inhibitors for highly compulsive adult offenders, but acknowledged a possible offsetting increase in other deviant behaviors. Overall, evaluations of drug treatments for adult offenders have identified two serious problems: undesirable side effects and possible increases in nonsexual offenses as deviant sexual behaviors decrease.

There are no published studies documenting the effectiveness of drug treatments with juvenile sex offenders. The National Task Force on Juvenile Sexual Offending (1988) discouraged pharmaceutical treatment generally because of the possible side effects of hormones and other drugs on patterns of juvenile growth and development. In their 1991

review of the literature, Marshall and Eccles also found little reason to recommend drug treatment for juveniles, due to the possibility of both physiological and behavioral side effects.

Operant Conditioning Treatment

Many early treatment programs for adult sex offenders emphasized aversive conditioning to discourage deviant sexual responses and to encourage the substitution of appropriate choices in their place (Marshall & Eccles, 1991; McGuire, Carlisle & Young, 1965). Evaluations of specific treatment programs for adults have reported inconsistent or extremely limited effects for such treatment. Marshall & Barbaree (1988) described a Canadian program for convicted child molesters that combined aversive therapy and masturbatory reconditioning with some social skills training. Based on preliminary evaluations, the program was revised to place a greater emphasis on skills development and group therapy processes, which were found to be more effective than conditioning. Rice, Quinsey & Harris (1991) found no positive effects from a program using electrical aversive therapy and biofeedback to reduce deviant arousal, and Quinsey, Chaplin & Carrigan (1980) also concluded that biofeedback procedures did not effectively reduce deviant arousal. In one of the few studies to focus on juvenile sex offenders, Hunter & Santos (1990) examined the use of satiation and covert sensitization therapies as part of a comprehensive residential treatment program and found an identifiable decrease in deviant arousal. However, there was no follow-up data to determine whether this change in arousal patterns during the residential period was associated with a change in offense patterns after release. Recent surveys have concluded that the use of conditioning therapies to alter deviant sexual preferences have limited empirical support (Laws & Marshall, 1991; Marshall, Barbaree & Eccles, 1991). Aversion therapy has not been found to produce long-term effects unless combined with other strategies to promote the positive development of appropriate sexual arousal (Marshall & Eccles, 1991).

Outpatient Counseling Programs

A common treatment approach for adult offenders, particularly in incest cases, has been to mandate outpatient treatment as a condition of probation rather than to impose a prison sentence (Berliner, Schram, Miller & Milloy, 1995; Knopp, Freeman-Longo & Stevenson, 1992). A study sponsored by the American Bar Association involving almost 1,000 cases of child sexual assault in ten jurisdictions found that almost two-thirds of those convicted were sentenced to probation, with counseling required as a condition of probation in 60% of those cases (Smith, Elstein, Trost & Bulkley, 1993). The Washington State Special Sex Offender Sentencing Alternative (SSOSA), initiated in 1984, is a good example of such a program, authorizing a combination of probation and treatment in lieu of imprisonment. Since there was no state-approved treatment approach, offenders selected their own treatment providers. This made it impossible to accurately describe or measure the treatment provided or to examine treatment outcomes. A study of those sentenced between January 1985 and July 1986 found similarly low rates of sexual re-offending for both SSOSA probationers and those receiving prison sentences, although non-SSOSA offenders were more likely to be rearrested and reconvicted for non-sexual recidivism (Berliner, Schram, Miller & Milloy, 1995).

While outpatient therapy groups and individual therapists provide a substantial array of services to sex offenders, much of what is done in these settings is not documented in the literature or evaluated in a way that allows it to be compared to other treatment programs. Many treatment specialists working in the field now agree that group treatment is generally preferable to individual therapy because it is more effective in addressing relevant issues of denial and minimization (Marshall, 1996). It is also less costly to provide. Most also agree that no one approach is likely to be equally effective for all sex offenders. Marshall & Pithers (1994) conclude a review of therapeutic approaches with a call for multiple approaches:

> Implementation of a single therapeutic intervention, even by the most highly skilled practitioners, cannot be considered sufficient treatment for most sex offenders, and we doubt that anyone today would deem such an approach to be satisfactory (p. 13).

Cognitive-Behavioral Treatment Programs

Cognitive-behavioral treatment programs assume that offending behavior has been learned in a social context, and can be unlearned and changed through a multimodal program that includes both cognitive elements and behavioral skill development (Sermabeikian & Martinez, 1994). Cognitive-behavioral programs for sex offenders have developed over the last 20 years, gradually expanding the range of treatment elements that are considered appropriate. In a recent review of the treatment field, Marshall & Pithers (1994) argue that even the early cognitive-behavioral programs, which included relatively few elements, were demonstrably more effective than the traditional milieu/psychotherapy approaches then in use.

Almost all treatment programs for sex offenders during the past twenty years have included components aimed at enhancing the social competence of sex offenders to improve their ability to relate successfully to peers in appropriate ways (Marshall & Eccles, 1991). Early programs tended to focus primarily on conversational and assertiveness skills, but subsequent research has identified a wide range of other skill deficits including interpersonal interaction skills (Marshall & Eccles, 1991), self-esteem and self-confidence (Marshall, 1996), social perception and information processing (McFall, 1990), intimacy and the maintenance of interpersonal relationships (Marshall, 1993), and anger management (Marshall & Eccles, 1991). Prentky (1994) notes that one of the major recent developments in cognitive-behavioral treatment is the development and refinement of techniques specifically for use with sex offenders, including victim empathy training (Knopp, Freeman-Longo & Stevenson, 1992; Pithers, 1994; Salter, 1988), and cognitive restructuring to address offender denial and minimization (Abel & Rouleau, 1990; Marshall, 1994; Marshall, Laws & Barbaree, 1990). Many

cognitive-behavioral programs also now include life skills such as literacy and employment readiness and treatment for substance abuse (Marshall & Eccles, 1991).

Although cognitive-behavioral programs are not necessarily effective with every offender, there is evidence that cognitive-behavioral programs are having an effect on recidivism rates and that programs without these elements are relatively less effective (Marshall & Eccles, 1991; Rice, Quinsey & Harris, 1991). A number of recent studies on current programs with adult sex offenders have reported that sex offenders who participate in specialized cognitive-behavioral treatment re-offend at lower rates than do nonparticipants (Maletzky, 1991; Marshall & Pithers, 1994). In their overview of sex offender treatment programs, Marshall & Eccles (1991) identified adult institutional programs for sex offenders in Canada, California and Vermont where a comprehensive cognitive-behavioral approach seems to have reduced recidivism by adult sex offenders. Some out-patient programs have also reported good results. Within adult prisons, the meta-analysis of correctional programs in general conducted by Andrews, et al. (1990) also identified the multimodal, cognitive-behavioral approach as an effective treatment strategy.

Studies of juvenile sex offenders have consistently found that they generally lack adequate social skills to develop close and meaningful peer relationships, and are therefore appropriate subjects for cognitive-behavioral treatment (Awad & Saunders, 1991; Blaske, Borduin, Henggeler & Mann, 1989; Fehrenback, Smith, Monastersky & Deisher, 1986; Figia, Lang, Plutchik & Holden, 1987; Ford & Linney, 1995;). However, the programs for juvenile offenders are more likely to be described than evaluated in these studies. Pithers' 1994 article provides information on an innovative program to increase empathy in juvenile sex offenders, but no evaluation was carried out to determine whether changes in victim empathy and distorted views of sexual assault are associated with long-term reductions in sexual re-offending. Becker, Kaplan & Kavoussi (1988) examined a cognitive-behavioral outpatient

treatment program made up of seven components that included weekly therapy sessions, social skills training, anger control, sex education, and relapse prevention. While the program had a measurable impact on patient attitudes, its impact on sex offense recidivism was not evaluated.

The Juvenile Sexual Behavior Program (JSBP), an outpatient program at Barnert Hospital Mental Health Clinic in Paterson, New Jersey, is another good example of a comprehensive cognitive-behavioral program (Sermabeikian & Martinez, 1994). The program uses a group treatment modality to focus on taking responsibility for one's sexual behavior, developing victim empathy, and developing skills to prevent future offending. Sermabeikian and Martinez (1994) effectively show how this program illustrates the underlying therapeutic principles of the cognitive-behavioral approach, but provide no evaluation of the program's effectiveness.

Relapse Prevention Treatment

In recent years cognitive-behavioral treatment programs have adapted the relapse prevention model, derived from work with substance abuse and other addictions and focusing on the transition from treatment to post-discharge status, to sex offender treatment (Prentky, 1994). The model's application to sex offender treatment was first described by Pithers, Marques, Gibat & Marlatt (1983), with subsequent revisions and expansions of the model by Laws (1989), Pithers (1990), and Marques and her colleagues (Marques, Day, Nelson & Miner, 1989; Nelson, Miner, Marques, Russell & Achterkirchen, 1988). Use of this model has subsequently generated useful research into the offense chain of sexual offenders. The relapse prevention approach requires careful attention to the background factors and problems that make an offender vulnerable to re-offending and to the steps, including passive or active planning, that lead to an offense (Ward, Louden, Hudson & Marshall, 1995).

Judith Becker and her colleagues were among the first to develop treatment programs for juvenile sex offenders which incorporate relapse prevention elements (Becker, 1988; Becker

& Kaplan, 1993). According to Marshall (1996), Becker refined and adapted a program that she and Abel initially developed for adult offenders. The early data on treatment outcomes, reported in Becker and Kaplan (1993), appear encouraging. Gray and Pithers (1993) have also employed relapse prevention strategies in their work with juvenile sex offenders. A number of other programs that use relapse prevention principles to shape treatment programs for juvenile offenders have also been described in the literature (Elliot, 1987; Isaac & Lane, 1990; Johnson & Berry, 1989; Kahn & Lafond, 1988).

However, no carefully controlled evaluations or outcome studies of these juvenile programs have been reported in the research literature. Marshall and others acknowledge that empirical support for the relapse prevention model has not been presented, but believe the model provides useful guidance in developing more effective overall treatment packages (Marshall & Eccles, 1991; Marshall & Pithers, 1994). Rice, Quinsey & Harris (1991) specifically point to the lack of a relapse prevention component in discussing the relative ineffectiveness of some treatment programs.

Relapse prevention treatment programs for adult offenders have been more carefully evaluated. Grubin and Thornton (1994) report on a national program for the treatment of adult sex offenders in the English prison system which uses the relapse prevention model and concentrates on high-risk cases. The program includes a Core Program of structured group work for all participants, an Extended Program which provides a menu of treatment options, and a Booster Program given close to release from prison. However, the treatment program is weakened by its lack of an organized post-release treatment component or other consistent supervision and support.

One of the most significant treatment programs to add a relapse prevention element to the cognitive-behavioral approach is the Sex Offender Treatment and Evaluation Project (SOTEP) at Atascadero State Hospital in California. SOTEP provides a comprehensive

cognitive-behavioral program within a relapse prevention framework which includes both group and individual treatment and specialty units that include relaxation training, sex education, social skills training, and stress and anger management. Participants with significant substance abuse histories are required to complete a substance abuse group. After completing the hospital program, subjects participate in the Sex Offender Aftercare Program for one year under the supervision of clinicians in their community. Eligible sex offenders who volunteer for the program are randomly assigned to treatment or nontreatment groups due to the limited availability of resources (Chaffin, 1994; Marques, Day, Nelson & West, 1994). Preliminary findings from SOTEP indicate that treated adult sex offenders, especially child molesters, show gains in terms of fewer cognitive distortions, improved sense of internal control, less deviant arousal, and improved ability to cope with potential relapse situations compared to prisoners who did not volunteer for treatment. However, no significant differences in re-offending were found between treated offenders and offenders who volunteered for treatment but were assigned to a no-treatment group. The ongoing evaluation of the SOTEP program must address this finding.

Aftercare Programs

Aftercare programs that provide treatment opportunities and reinforce rehabilitative changes in offenders after they leave the correctional institution have long been assumed to be an essential part of effective treatment. Although the belief in this possibility remains strong and is reflected in calls for more comprehensive treatment programs for both juvenile and adult sex offenders (Marshall & Pithers, 1994), aftercare is rarely evaluated as part of such a program. As the authors of one study note, "Sentencing alternatives for sex offenders are common, although the evidence for their effectiveness is sparse" (Berliner, Schram, Miller & Milloy, 1995, p. 490).

In an early essay that described aftercare as "the neglected phase of adolescent treatment," Daum (1981) criticized juvenile corrections for failing to provide effective intervention and support to juveniles after they are released from detention. The absence of such aftercare means that youthful offenders lack basic support as they return to their home communities, and consequently are more vulnerable to pressures to revert to previous delinquent patterns.

Too often probation and parole, the most common forms of aftercare, are primarily matters of surveillance and formalistic record-keeping, ways to relieve institutional crowding rather than positive treatment alternatives (Lurigio & Petersilia, 1992). A study of probation sentences given to adults convicted of child sexual offenses concluded that in most cases probation provided neither effective surveillance nor active support (Smith, Hillenbrand & Goretsky, 1990). The authors recommended more specialized supervision by probation officers and closer coordination between probation officers and treatment providers, as well as a greater variety of sentencing options.

Aftercare programs are sometimes difficult to organize because of institutional discontinuities between those responsible for treatment during confinement and those responsible for providing outpatient services. In a recent study of aftercare provided to graduates of "boot camp"-style "shock incarceration" programs, for example, administrators and service providers sometimes disagreed on whether an aftercare program even existed (Cowles & Castellano, 1995). This study confirmed that both support and surveillance are essential to reintegration of released offenders, and recommended that continuing treatment and accountability during transition to the community and a long period of supervision and support in the community be made integral parts of any treatment program.

Therapeutic Community Programs

The Therapeutic Community (TC) model, initially developed for use in substance abuse treatment, is one of the most intensive residential treatment alternatives available. In recent years attention has turned to the possibility of using this approach to provide treatment to sexual offenders. The therapeutic community consists of an integrated series of components which resemble the operations of a healthy family, and are intended to provide a cohesive and supportive environment where TC participants can work toward common goals (De Leon, 1985). Most therapeutic community programs also acknowledge the essential role played by aftercare programs that reinforce and help to sustain the changes initiated during residence. The work of Wexler and his associates identifies "continuity of care that extends into the community" as one of seven important conditions for successful correctional rehabilitation (Wexler & Graham, 1992, p. 3). Most corrections-based TC programs encourage their graduates to continue residential treatment in community-based facilities for at least a transitional period. Those who do not are encouraged to maintain their ties to the therapeutic community by attending meetings and other functions, and to participate in community-based addiction treatment programs such as AA.

Numerous research projects have demonstrated that correctional-based therapeutic community treatment for substance abusers is effective in reducing and delaying recidivist drug use (Hubbard, Marsden & Rachal, 1989; Tims & Ludford, 1984). For example, a five year study of the "Stay'n Out" prison therapeutic community in New York found that the percent of TC participants rearrested was significantly lower than for the no-treatment control and comparison treatment groups (Wexler & Graham, 1992). Similar results were reported in Wexler & Graham's (1992) initial report on a California prison-based therapeutic community for substance abusers called Amity Righturn. Amity Righturn modified the therapeutic community model, which assumes an isolated or self-contained treatment unit for the TC "family," in order

to fit into a correctional institution. For example, as in the proposed Sex Offender Treatment Unit discussed in this report, Amity Righturn participants were housed in a separate residential unit, but ate in a common dining room and participated in prison activities with other prisoners.

Therapeutic community units are not a new treatment milieu for IDOC. Six units identified as Therapeutic Communities existed before 1997 at four Illinois Youth Center locations, including a Juvenile Sex Offender Program at IYC-Valley View (ICJIA, 1996b). The new Sex Offender Treatment Unit at IYC-H was designed to combine elements of cognitive-behavior therapy and relapse prevention treatment, currently accepted as effective elements in the treatment of juvenile sex offenders (Becker & Hunter, 1992; Marshall, Jones, Ward, Johnston & Barbaree, 1991) with the supportive atmosphere of a therapeutic community.

Summary of Alternative Treatment Approaches

Table 2.1 summarizes the preceding review of the literature. As indicated in this table, very few treatment components for juvenile sex offenders have been well documented in the published literature. Treatment programs for adults have been researched more thoroughly, yet even here considerable information is unknown. The literature suggests that it is prudent to avoid phallometry and pharmaceutical treatment when developing juvenile programs because of the ethical issues involved. Operant conditioning has some limited positive outcomes, but involves similar ethical concerns. For example, Breer (1996) notes that it is likely to be difficult to convince policy makers that teaching youth to masturbate to appropriate stimuli is a desirable use of public funds. SOTU has not selected any of these three components as core elements in the program, and this choice is supported by the available literature.

The effectiveness of the remaining five treatment components is not documented sufficiently in the research literature, but each component has elements that have shown promise. SOTU has included aspects of each of these treatment approaches in its program design. A complete discussion of these elements follows.

Table 2.1 Summary of the treatment components identified in the literature.

Treatment Component	Effective with Juvenile Sex Offenders?	Effective with Adult Sex Offenders?
Phallometry	NO	Mixed results
Pharmaceutical Treatment	NO	Limited
Operant Conditioning	Limited	Limited
Outpatient Counseling	Not sufficiently documented	Limited; treatment elements not sufficiently documented
Cognitive-Behavioral Treatment Programs	Not sufficiently documented	YES
Relapse Prevention	Promising	Promising
Aftercare	Not sufficiently documented	Not sufficiently documented
Therapeutic Community	Not sufficiently documented with Sex Offenders	Not sufficiently documented with Sex Offenders

Treatment Elements

Until the early 1980's, the treatment of sex offenders focused primarily on adult perpetrators. The treatment of juvenile sexual offenders as a unique population is a relatively new field. As a result, only limited substantive research has been carried out in this sub-field. The demand for treatment specifically designed to meet the needs of juvenile sexual offenders has risen as the proportional number of juvenile sexual crime convictions has increased and as research has documented that many adult sex offenders also exhibited sexual deviance in their youth (Longo & Groth, 1983).

In 1997 the Association for the Treatment of Sexual Abusers (ATSA) issued a publication titled *Ethical Standards and Principles for the Management of Sexual Abusers.* Although the manual is primarily focused on adult perpetrators (as is true of the research

literature generally), it presents the current thinking in the field of sex offender treatment and is likely to play a role in the future development or replication of programs geared specifically to the juvenile sex offender population. Because the field of juvenile sexual offender treatment is in its infancy, standards like those established by ATSA for the treatment of adult sex offenders have yet to be established for the corresponding youth population (ATSA, 1997). Simply transferring adult sex offender treatment standards to juvenile sex offenders may not be satisfactory because of developmental and ethical considerations.

Progress has been made toward establishing treatment standards for juvenile sex offenders. In 1993, the National Task Force on Juvenile Sexual Offending (the Task Force) prepared a report based on a survey of more than 800 individuals who worked in a clinical capacity with juvenile sex offenders (National Task Force, 1993). The survey identified the present state of the art in treatment programs, and presented a number of recommendations regarding the treatment of juvenile sex offenders based on this data. Although this report did not define standards for the field of treatment of juvenile sex offenders, the "consensus building" effort that it promoted might well lay the groundwork for the establishment of future standards (National Task Force, 1993). In addition, the treatment model developed by the Task Force is the most representative model that exists of the best practices available to benefit the juvenile sexual offender. Other clinicians refer to this effort as "the standard" for juvenile sex offender treatment (see Breer, 1996).

Many sexual offenders enter the correctional systems. A third attempt at setting a standard for sex offender treatment is based on effective treatment programs for substance abusers in the correctional setting (Smith, 1995). Smith (1995) argues that the similarities between sexual offenders and substance abusers allow administrators to use a similar program planning process. As a result, Smith (1995) modifies and outlines the National Task Force on Correctional Substance Abuse Strategies (1991) in his article (see Table 2.5 for further details).

According to Breer (1996), many sex offender treatment providers utilize relatively narrow views of treatment options. In other words, a provider subscribes to a single theory and provides treatment based on that particular theory, even though multiple theories exist which have overlapping treatment implications. However, each of the three state-of-the-art treatment directives discussed in this paper agrees that treatment should include a well-rounded array of methods.

The following section examines and compares three different sets of recommended treatment standards: the standards set by the Task Force , the recommended treatment standards developed by the Association for the Treatment of Sexual Abusers (ATSA), and the modified substance abuse model. The treatment elements included in each model or set of recommended standards are outlined in Table 2.2. These models are compared to the implemented SOTU program at IYC-H in Chapter Five. It is important to keep in mind that there is very little confirmed information as to what works with juvenile sex offenders. While clinicians and others involved in the treatment of juveniles have agreed on some standards (National Task Force, 1993), the extent to which these elements actually contribute to a reduction in sex offenses and other desired outcomes is as yet unknown. There is limited conclusive information in the literature of the field. These issues will be revisited during the second year of the evaluation, and an updated review of the literature will be included in the Final Report.

Table 2.2 presents three models, represented by the vertical columns, and the corresponding treatment components categorized by theoretical models that each recommends as the standard for treatment. Leaders in the field of juvenile sex offender treatment have identified these explanatory theoretical models and their treatment components as state-of-the-art. Careful consideration of each theory is necessary to fully understand its treatment implications. As Gail Ryan notes, "Many aspects of these various theories are interwoven, and

Table 2.2 Theoretical Models and Components

Theoretical Models and Treatment Components	Task Force 1993	ATSA 1997	National Task Force on Correctional Substance Abuse Strategies 1991
Cognitive-Behavioral Theory			
Cognitive therapy for cognitive distortions	X	X	X
Arousal Control, (e.g., verbal & masturbatory satiation)	X	X	
Cognitive therapy for chain of events analysis (offense cycle)	X	X	X
Develop healthy relationships	X	X	X
Social competence (psycho-educational program)	X	X	X
Communication	X	X	X
Anger management	X	X	X
Stress management		X	X
Life skills development			X
Assertiveness		X	X
Violence intervention			
Relapse prevention (see Addictions Theory)	X	X	X
Social Learning Theory			
Staffing – Professionals		X	X
Staffing – Correctional			X
Attachment Theory			
Victim awareness & empathy	X	X	X
Biological Theory			
Chemotherapy intervention		X	
Addictions Theory			
Self-help programs, peer groups		X	X
Relapse prevention (self-control program)	X	X	X
Prerelease planning			X
Reunification w/children		X	
Family System Theory			
Family therapy	X	X	
Other Components			
Drug /Gang treatment	X		X
Physical and mental health	X		X
Restitution/reparation to victims	X		
Special needs	X	X	X
Aftercare upon release	X	X	X

similar issues surface in the application of different theories to sexual offending" (Ryan, 1997, p. 19).

It is particularly important to understand these underlying theoretical models when developing a program for a diverse population. Common treatment elements for all sex offenders can be identified, and the core treatment should be focused on those elements. However, each youth in the program should also have a treatment plan for specific needs that may not be shared by others in the program. Program staff can begin to identify treatment methods appropriate for a variety of needs by examining the underpinning theoretical construct. Unfortunately, theoretical models for sex offenders remain significantly underdeveloped (Sermabeikian and Martinez, 1994), creating problems in the identification of appropriate methods of treatment. The Task Force standard was specifically developed for juvenile sex offenders, and recommends treatment methods based on identified issues for juvenile offenders (see Table 2.3). The ATSA model focuses on adult offenders, and relies heavily on cognitive-behavioral theory. Roger Smith (1995) reports on an addiction-based model program adapted from drug treatment models. This model draws on recommendations designed for adults, but it is included in this discussion because it is specifically designed for implementation in the correctional setting.

The Task Force advocates at least one treatment component from each of the identified theories, with the exception of Biological Theory. The Task Force also recommended that an Individual Treatment Plan (ITP) be developed for each juvenile sex offender. This plan should map out the pertinent issues and goals to be addressed in treatment and the strategies to be used to meet these issues and goals (National Task Force, 1993). Specialized treatment should flow from the ITP to include treatment specific to the offending behavior coupled with a broad, holistic approach that will also allow the youth to progress developmentally and socially (National Task Force, 1993). In assessing juvenile sex offenders it is also important to identify

areas in which the youths may need additional specialized attention (see, for example, the discussion of identity development issues in National Task Force, 1993).

Table 2.3

Issues Vital to the Treatment of Juvenile Sex Offenders
Treatment Model of the National Task Force on Juvenile Sexual Offending (1993)

1. Acceptance of responsibility for behavior without minimization or externalization of blame;
2. Identification of pattern or cycle of abusive behavior;
3. Interruption of cycle before abusive behavior occurs and control of behavior;
4. Resolution of victimization in the history of the abusive youth;
5. Development of victim awareness/empathy to a point where potential victims are seen as people rather than objects;
6. Development of internal sense of mastery and control;
7. Understanding the role of sexual arousal in sexually abusive behavior, reduction of deviant sexual arousal; definition of non-abusive sexual fantasy;
8. Development of a positive sexual identity;
9. Understanding the consequences of offending behavior for self, the victim, and their families in addition to developing victim empathy;
10. Identification (and remediation to the extent possible) of family issues or dysfunctions which support or trigger offending; attachment disorders and boundary problems in family;
11. Identification of cognitive distortions, irrational thinking or "thinking errors" which support or trigger offending;
12. Identification and expressions of feelings;
13. Development of pro-social relationship skills with peers;
14. Development of realistic levels of trust in relating to adults;
15. Management of addictive/compulsive qualities contributing to reinforcement of deviancy;
16. Remediation of developmental delays/development of competent psychological health skills;

17. Indication of substance abuse or gang involvement;

18. Reconciliation of cross-cultural issues;

19. Management of concurrent psychiatric disorders;

20. Remediation of skill deficits which interfere with successful functioning;

21. Development of relapse prevention strategies;

22. Restitution/reparation to victims and community (National Task Force, 1993 pp. 43-44).

Although the Task Force has generated the closest thing to treatment standards in the field, other treatment models have also been developed for sexually abusive youth. Almost a decade before the Task Force issued its recommendations Fay Honey Knopp (1985) identified six major goals in the treatment of juvenile sex offenders (see Table 2.4). Knopp recommended the use of individual assessment and an individualized treatment plan, a recommendation adopted by the Task Force, mandated the need for offenders to accept personal responsibility, and recognized the importance of understanding "offense antecedents" and control mechanisms for relapse prevention. The goals also included resocialization, graduated release, and post-therapeutic support provisions (Knopp, 1985).

Table 2.4

Knopp's Six Goals of Juvenile Sex Offender Treatment (1985)

1. Individual assessment and treatment plan for each offender;
2. Recognition of personal responsibility for all sexual offenses to reduce denial and rationalization of actions; identification of the events that lead up to sexual offending, or "links in the offense chain of events".
3. Take action to stop the offense pattern at first recognition of onset with control techniques;
4. Resocialization:
   - minimize antisocial thoughts and behaviors;
   - reflect a positive self-image to include new attitudes and expectation of self;
   - build healthy and non-threatening relationships with others with the application of new sexual and social skills

5. Gradual release of offenders back into the community to allow offender recognition of relapse and an opportunity to test preventative strategies learned in treatment without posing risk to society;

6. Opportunity for post-treatment support or assistance (e.g., a hotline) (Knopp, 1985, p. 21).

The Association for the Treatment of Sexual Abusers (ATSA) proposes that current sexual offender treatment interventions should be based on the premises of personal responsibility, deviant sexual thought identification and management, and attitudinal and behavioral changes. The contemporary goal of sex offender treatment is to teach an offender to avoid sexually abusive behavior by employing "simple, practical techniques" (ATSA, 1997).

ATSA suggests the most effective treatment method in sex offending is Cognitive-Behavioral therapy. Cognitive therapy focuses on the series of core beliefs that an individual develops over a period of years, influenced by family and major life events. These core beliefs, or cognitions, steer an individual's actions and emotions and guides both self-perception and the perception of others. Sex offenders often commit their crimes by minimizing or rationalizing their actions. Such inappropriate thought processes, known as "cognitive distortions," "allow the abuser to overcome inhibitions and ultimately progress from fantasy to behavior" (ATSA, 1997).

The goals of cognitive therapy, sometimes called "cognitive restructuring," are to identify the cognitive distortions that allow an individual to commit sexual offenses and to modify these distortions. Modification of cognitive distortions seeks to change inappropriate beliefs into "accurate, appropriate messages" through the use of repetition. Once the cognitions that allowed the individual to offend are identified and addressed, it is believed the offender will be more able to empathize with potential victims and can interrupt or change his behavior (ATSA, 1997).

Relapse Prevention, a second treatment intervention supported by ATSA, has its roots in addictions therapy. Relapse prevention teaches offenders to anticipate a "problem situation" and assists them in developing a feasible plan to offset the offense pattern (ATSA, 1997). The goal of Relapse Prevention is not to "cure" a sex offender, but rather to focus the offender on taking responsibility for offense behaviors and acquiring skills to prevent recidivism. The active participation of the offender in treatment and cognitive-behavioral therapy is critical to the success of the Relapse Prevention model.

Offenders in relapse prevention treatment must learn to identify and analyze the psychological, behavioral, and situational factors that led to their sexually abusive behavior. Upon recognition of these factors, offenders must actively work to create and practice a coping mechanism in order to break the offense chain upon first recognition of a problem situation (ATSA, 1997). Therapy is often coupled with educational and vocational training. ATSA also recommends the formation of a support group of family, friends, or clergy to ease an offender's transition from treatment to community and to reduce the risk of recidivism (ATSA, 1997).

A related treatment intervention is Victim Empathy, which has its foundation in attachment theory. Based on the view that an offender's lack of empathy for a victim allows him to rationalize or minimize his abusive behavior, treatment providers believe that instilling some victim empathy, or at least victim awareness, may reduce recidivism (ATSA, 1997).

Another method used in treating male sex offenders is Arousal Control, the goal of which is to reduce undesirable sexual arousal. It is believed that "deviant fantasy and masturbation to deviant themes are precursors to deviant sexual behavior" (ATSA, 1997, p. 21). Male sexual arousal is measured using a penile plesthysmograph, an instrument that measures the dilation of the penis in response to various stimuli (Breer, 1996). "Successful application of arousal control methods will result in deviant arousal being maintained at levels below 20% of full erection" (ATSA, 1997, p. 21).

The three most common methods of Arousal Control are termed Odor Aversion, Verbal Satiation and Masturbatory Satiation. Odor Aversion attempts to interrupt deviant fantasy by having the offender inhale "foul smelling substances." Verbal Satiation seeks to "destroy the existing repertoire of deviant fantasy with a consequent decline in deviant arousal" by having the offender talk about his deviant sexual fantasy for twenty minutes or more without stopping (ATSA, 1997, p. 21). Finally, Masturbatory Satiation employs the same procedure as the Verbal Satiation method, but the offender also "masturbates to ejaculation and continues masturbation while he is refractory" (ATSA, 1997, p 22). "The effect is to uncouple the deviant fantasy and resulting sexual arousal produced by masturbation" (ATSA, 1997, p 22).

Use of the plethysmograph is a source of controversy, especially when it is used with juveniles. Concerns over the use of the device range from questions about the validity and significance of its measurements to developmental and ethical issues. The stimuli presented to determine whether arousal is present contain nudity and sexual behavior, and may introduce a young subject to new sexually deviant material (Breer, 1996).

A final strategy employed in the treatment of sex offenders and advocated by ATSA is the development of social competence and healthy relationships. Sexual offenders often exhibit deficiencies in social skills, which impede the development of healthy relationships. Due to the variation of individual social competency, specialized treatment groups are often formed and offenders are assigned to them based on individual assessments (ATSA, 1997).

Addictions theory, sometimes referred to as addictive theory (Ryan, 1997), has been used to explain the strength and intensity of offending behavior patterns in both substance abusers and sex offenders. Within this theoretical model, sexually abusive behavior is viewed as providing a source of powerful reinforcement that the offender comes to need more and more over time. Treatment programs have been developed for substance abusers that

explicitly recognize the addictive quality of substance abuse and intervene to interrupt that addiction.

Because of the parallels drawn between substance abusers and sex offenders, one approach to sex offender treatment is to model programming after substance abuse treatment. The National Task Force on Correctional Substance Abuse Strategies developed a 1991 corrections-based model for the treatment of substance abuse. Using this substance abuse model as a prototype, a new model for the successful implementation of a corrections-based sex offender treatment program has been developed. This model is presented in Table 2.2, where it can be compared to the other models previously discussed.

The sex offender treatment model adapted by Roger Smith (1995) is unusual in that it concentrates on the goals and commitment of the corrections staff and institution to provide quality sex offender treatment instead of focusing primarily on specific treatment goals for the offender. For example, one goal of the program is a commitment to the hiring and retention of a quality staff for the treatment program. Although the qualified candidate pool for sex offender clinicians is likely to be limited if the institution is located in a remote area, valuable and committed staff members may be retained with support from the administration. Administrative support filters down to all levels in the command chain, and a program viewed as a positive asset by the administration will maintain facility-wide support (Smith, 1995).

The model calls for all sex offenders to receive an individual assessment as part of the institutional intake process. This assessment should include both criminal and social histories. If possible, it should also consider the sexual, victimization, and treatment history of the offender and should provide "an assessment of dangerousness and amenability to treatment" (Smith, 1995, p.7-6). Clinical assessment must be viewed as an on-going process. Offenders who qualify for treatment should be tested further to identify their programming needs. An array

of pencil and paper tests should be administered, and offender interviews should also be conducted. The model also advocates the use of plethysmography (Smith, 1995).

This model emphasizes the importance of a safe physical and psychological environment to an effective treatment program for sex offenders. The treatment program should be physically separated from the general population in the rest of the institution, in order to provide a non-threatening environment in which offenders can participate freely and fully in programming without fear of embarrassment or social stigma (Smith, 1995). Effective staff education and communication are also necessary for a corrections-based sex offender treatment program to thrive. All staff members who have even occasional contact with program participants must fully understand the nature and goals of the program, as well as the methods being used to achieve those goals (Smith, 1995). The corrections-based sex offender treatment model requires the correctional facility to combine effective internal and external communication with a high level of internal and external cooperation. Smith (1995) recommends frequent staff meetings and coordinated training and planning to help promote these conditions.

Another goal of this programming model is to offer a sound array of programming tailored to the individual needs of program participants. The corrections facility should take an integrative staffing approach to treatment, integrating clinicians and institutional staff into program development. Treatment programming should consist of either relapse prevention, behavioral, or confrontational group psychotherapy for sex offenders in addition to life skills and educational training (Smith, 1995). The model also stresses the importance of providing sex offenders in treatment with some of the same services offered to the general prison population, including religious, vocational, and educational opportunities within the institution (Smith, 1995).

Evaluation of offender progress in treatment should be documented in "specific, measurable goals instead of vague, subjective therapeutic impressions" (Smith, 1995, p.7-9). It

is important for clinicians to provide concrete evidence of a sexual offender's progress rather than merely making a parole recommendation, since one goal of this programming model is to provide input for parole boards (Smith, 1995).

Maintaining positive working relationships with external service providers is vital to providing a comprehensive post-treatment program by securing community-based care for paroled offenders (Smith, 1995). Before leaving the residential program, the offender should have contact with the community-based service provider who is responsible for follow-up care. The sex offender program is responsible for providing a smooth transition from intensive treatment to aftercare programming by contacting the local community provider, arranging services, and sharing all pertinent clinical data and assessments on the offender (Smith, 1995).

Finally, standardized data collection must be implemented to track each offender in programming, to track the need for sex offender programming in general, to assist in program evaluation, and to measure program effectiveness using both traditional and non-traditional recidivism measures (Smith, 1995, p.7-11).

Table 2.5

Goals of the Sex Offender Treatment Programming Model Adapted from the National Task Force on Correctional Substance Abuse Strategies, (1991)

Goal 1:	Assess all sex offenders entering the corrections system to determine their need for specialized intervention.
Goal 2:	Conduct intensive clinical assessment on all offenders who require and can profit from specialized programming.
Goal 3:	Provide a range of high quality programs for incarcerated sexual offenders responsive to a level of service need and individual differences.
Goal 4:	Provide parole boards with relevant information on community treatment and supervision needs, progress attained, potential risk, and specific stipulations enhancing successful community adjustment.
Goal 5:	Prepare sex offender to return to the community; establish links to appropriate community-based resources for treatment and supervision.

Goal 6: Create a workplace environment that attracts and retains qualified clinical staff.

Goal 7: Create environments within correctional facilities which promote effective delivery of educational and treatment services.

Goal 8: Establish and maintain data systems facilitating tracking of offenders, program processes and outcome evaluation, and program planning (Smith, 1995, pp. 7-6 – 7-12).

The theories used to explain sexually abusive behavior are not fully identified or explored in the literature. The purpose of this report is not to explore abstract theoretical questions, but to determine the best practices available for treating sex offenders and to provide a framework for building that ideal program. As a result, this report will summarize only the highlights of the relevant theories and provide selected sources for future reference for the interested reader. The three perspectives presented in this paper suggest that at least the following six theories are applicable to some sex offenders and have corresponding treatment implications (see Table 2.6 for a summary).

The first theory is Cognitive-Behavioral Theory. The development of this theory over time suggests that the cause of sex offending is a combination of cognitive error, reinforced by behavior. An abusive or deviant sexual experience at a young age is generalized through conditioning, such as repeated similar experience or masturbation. This is certainly the most widely accepted treatment foundation in sex offender therapy today. (For further discussion of cognitive-behavior theoretical approaches, see Marshall & Eccles, 1993; McGuire, Carlisle, & Young, 1965; Pithers & Cumming, 1995.) Treatment under this theory might include repetitive reconditioning exercises (e.g., aversive stimuli or reconditioning from one stimulus to another) or cognitive restructuring activities. This theory adequately describes the pedophile who was sexually abused at a young age, experienced some pleasure as part of the experience, and then reinforced the abusive pattern by masturbating to recurring thoughts of the experience. Such an offender may generalize his response subsequently to abuse numerous victims.

Table 2.6 Theory and Treatment Implications

Theory	Cause	Explanation	Treatment Implications	Sex Offender Group
Cognitive-Behavioral Theory	Deviant sexual arousal [Behavioral model (McGuire, Carlisle, & Young, 1965)] with thought and reasoning patterns [Cognition (Marshall and Eccles, 1993)]	Abusive experience (at young age) generalized through conditioning (repeated experience or masturbation)	Operant Conditioning: reconditioning exercises (e.g., aversive stimuli) . Cognitive Restructuring: correcting thinking errors Relapse Prevention (see also Addictions Theory) Psycho-educational programming	Pedophiles, molesters
(Social) Learning Theory	Significant adults teach, overtly or by action, or reinforce sexually abusive behavior (Bandura & Walters, 1963; Sermabeikian & Martinez, 1994)	Children are molded by significant adults	Have significant adults reshape the youth. Provide alternative role models.	
Attachment Theory	Developmental problems (e.g., bonding/ attachment) (Marshall, 1989, as cited in Breer, 1996)	Failure during infancy to bond with parents which is the way humans learn affection and empathy for others.	Victim awareness and empathy training.	
Biological Theory	1. Basic male aggressiveness (Marshall & Barbaree, 1990, as cited in Breer, 1996)	Males are genetically predisposed to aggression. Additional testosterone at puberty result in more difficult control of aggression.	Develop inhibitory controls (e.g., through impulse control, strong ego, pharmaceutical)	Male offenders only
	2. Origins of sexual orientation and behavior (LeVay, 1991)	Sexual orientation (homosexuality) is hereditary. Other orientations may also have a genetic basis.		Pedophiles with specific types of victims
	3. Critical periods or windows of opportunity for learning (Bateson, 1978)	Behavior is ingrained in the brain and is very difficult to change after the window of opportunity is closed.	Treatment must happen during window of opportunity.	Offenders who began offending as adolescents
Addictions Theory	Dysfunctional family patterns (Carnes, 1983)	"The addictive cycle begins with distorted beliefs, progresses to impaired thinking, and progresses to an acting-out pattern similar to substance abuse" (Smith, 1995 p. 2-17).	Self-help groups, Relapse prevention, Pre-release planning	
Family System Theory	Either the dynamics of the family or the maladaptive coping behavior of the individual	The dysfunction of the family or the family member leads to addictive behaviors.	See addiction theory.	

However, this approach is less successful in explaining the behavior of the rapist or the incestuous molester.

Social Learning Theory is merely a step away from Cognitive-Behavioral Theory. Social Learning Theory suggests that significant adults who overtly teach, model, or reinforce sexually abusive behavior may shape the behavior of sex offenders. Children are molded by the significant adults in their lives. (For further discussion of this approach, see Bandura & Walters, 1963; Sermabeikian & Martinez, 1994). This theory suggests that treatment should involve significant adults in helping to reshape the youth's learned behavior. Ideally, the significant adult would be the initial role model, but the use of surrogate role models is more frequently found in the literature.

Attachment Theory is also closely related to the theories discussed above. Here, the cause of sex offending is explained as a result of developmental problems, frequently connected with bonding or attachment at infancy. The infant fails to bond with the parent, a process believed to be the foundation of affection and empathy for others. The treatment implication under this theory is victim awareness and empathy training.

Biological theories, with their emphasis on genetic characteristics and biological causes of behavior, depart considerably from the theories reviewed above. (For example, see, Bateson, 1978; LeVay, 1991; and Marshall & Barbaree, 1990). Three different causes of sex offending are considered within this theoretical framework. One explanation is that the male is predisposed to aggression. At puberty, testosterone levels are high and some males are unprepared to suppress the strong impulses that arise as a result. The treatment implications for this problem include developing inhibitory controls through impulse control, developing a strong ego, or using pharmaceutical therapy. This theory only accounts for male offending. A second explanation is based on the assumption that sexual orientation, including homosexuality, is hereditary. This implies that other orientations, including a sexual preference

for certain sexual activities or specific kinds of victims, may also be genetic. This theory provides little guidance for treatment implications and is only applicable to pedophiles.

The third biological explanation of sex offending in this theory is based on the concept of critical periods or "windows of opportunity" for learning. Behavior is viewed as being neurologically imprinted in the brain and therefore very difficult to change after the window of opportunity has closed. This theory suggests that the initial imprint is stronger than any "re-write." This would explain why therapy must be lengthy. One treatment implication is that the rewriting process must occur during the window of opportunity, which supports early intervention. This theory does not explain sex offenders who began their abusive behavior after the pubescent period.

Addictions Theory is borrowed from substance abuse treatment, although experts disagree about whether it is appropriate to use the idea of "addiction," which implies physiological dependence, outside the substance abuse field. This theory explains sexual offending as caused by dysfunctional family patterns. "The addictive cycle begins with distorted beliefs, progresses to impaired thinking, and progresses to an acting-out pattern similar to substance abuse" (Smith, 1995 p. 2-17). The application of this theory to sexual behavior has led many practitioners to draw on treatment programs and concepts originally designed for substance abusers. The primary treatment suggested is self-help groups and relapse prevention therapy. Addictions theory does not explain the single event offender.

Family System Theory takes a "whole system" approach, suggesting that either the dynamics of the family or the maladaptive coping response of the individual to the dysfunctional family is the cause of sexually abusive behavior. The emphasis is on relationships within the family rather than the characteristics of any one family member. (See, for example, Satir, 1983). The treatment implications of this theory are similar to those of the addictions model.

Summary of Treatment Approaches

Three general treatment perspectives have been presented as examples of state-of-the-art thinking. The manual prepared by ATSA focuses primarily on the adult sex offender, but also provides a view of the perspective shaping the current thinking in juvenile sex offender treatment. ATSA suggests that treatment elements supported by all six of the theories reviewed in this report should be considered options for juvenile sex offender treatment. The consensus of the participants in the Task Force, a subgroup of the National Adolescent Perpetrator Network, is that the treatment model for juvenile sex offenders should include treatment elements from four of the six theories presented here. The Task Force did not recommend the use of role models, an element that comes out of Social Learning Theory, or any treatments associated with the biological theories. The adapted substance abuse model excludes elements drawn specifically from Biological and Family System Theory, but suggests that treatment based on the other four theories should be fully implemented.

The presentation and comparison of these three models provides a framework for the analysis of the Sex Offender Treatment Unit at Harrisburg that will be presented later in this report. Practitioners designing treatment programs for juvenile sex offenders are strongly encouraged to consider the theoretical assumptions and framework from which specific treatment elements have been drawn as an integral part of the program development process.

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Chapter III: Methodology

Scope of Implementation Evaluation

As reflected in the *Request for Proposals,* the Illinois Criminal Justice Information Authority (ICJIA) identified three principal objectives for the implementation portion of the evaluation project: 1) to assess the extent to which program implementation is conducted in accordance with pre-operational expectations; 2) to guide the refinement of the program in the future; and 3) to guide similar undertakings by other agencies in the future (ICJIA, 1996b, p.4).

Data Sources

The implementation evaluation followed a case study approach. Data sources included: 1) personal and telephone interviews with key policy makers and program staff; 2) field studies at the program site, including 16 consecutive days of observation during the first year; 3) reports, archival documents, grant applications and other relevant materials provided by IDOC and the ICJIA; and 4) offender treatment records maintained by SOTU for the first 25 participants admitted to the program.

- **Interviews:** Thirty key officials including component administrators, SOTU intake assessment personnel, unit staff, educators, mental health professionals, substance abuse specialists, counselors, clerical support, leisure time specialists, select volunteers, and caseworkers identified as having affected program development and operation were interviewed to collect information regarding the implementation of SOTU. (See Appendices A and B for the interview protocol.)
- **Field Studies at SOTU:** The research team made four site visits to IYC-H. Three of the visits lasted two or three days. The team interviewed various individuals, collected documents, and surveyed the physical setting. The fourth visit was specifically to observe and document the treatment program in operation. One researcher observed SOTU for 16 consecutive days. His hours of observation varied every two or three days to ensure that

activities during each shift of each day would be observed, because programs and staff were scheduled at varying times. The data collection instruments included a sociogram form designed to collect information on both verbal and nonverbal interaction during group therapy sessions (see Appendix C). Significant issues discussed during the sessions were noted. The second instrument was a checklist of behaviors exhibited by the participants during other periods, including scheduled leisure activities and physical activities at various locations in the institution (see Appendix D). During leisure time the youth are generally involved in various activities or games with one another. This form was designed to document the activities and record the behavior of each SOTU youth every ten minutes. The third instrument was a sociogram form designed to collect information similar to the group therapy form for use during other structured activities, such as school (see Appendix E).

- **IDOC Component Records:** Internal procedural manuals and assessment process documentation were a source of information on treatment module development, staffing needs, programming, and interaction between various key actors in the program. For example, implementation dates and data on key stages of the program were extracted from these reports. Aggregate component records were used to document a variety of program, staff, and participant performance factors including interaction among unit staff, decision-making techniques, component development, component implementation, staff training, staffing requirements, and administrative involvement.
- **ICJIA Records:** Grant proposal documents submitted by the treatment components, program reports and documentation, and other pertinent information were collected from ICJIA to determine pre-operational expectations and to place program implementation in context.

- **SOTU Treatment Records:** SOTU gathered considerable information from the IDOC master file, the youth, and collateral sources during the intake assessment process. These records (including social history, academic achievement, sex offending assessment, and mental health screening) were used to profile the first 25 participants. The purpose of this brief profile is to provide a preliminary assessment of the needs of the treatment group.

  A more extensive file review will occur during the second year, when data will also be available from the computerized Juvenile Tracking System (JTS) as planned. The participants of the two SOTU wings will be compared to two separate control groups. The first control group will be the sex offenders who were eligible for treatment, but could not be included because the units were full. The second comparison group will be made up of youth who are not identified as sex offenders, but who are matched on other characteristics.

Implementation Process Evaluation Data Collection Strategy

Several data collection strategies were used to obtain the information needed to explore the objectives posed in the implementation evaluation. In some instances the research team relied on program documents and the recollections of interviewed individuals for events taking place before the initiation of the evaluation. Because recollections and perceptions may differ, multiple data sources were used to increase the validity and reliability of data. By using a variety of program documentation, interview information, and on-site program observation by the research team, the accuracy of information was cross-checked. Those strategies are described below and tasks associated with each data collection strategy are specified.

Personal Interviews

Information concerning the pre-program environment and the operation of the program after its inception was obtained from semi-structured personal interviews with key actors in SOTU. Interview subjects were identified based on the formal positions they held and through a "snowball" process in which initial interview subjects were asked to identify other appropriate

subjects who should be interviewed. Each person identified as an appropriate subject was interviewed during 1997 and will be reinterviewed during the second year of the evaluation. The interviews focused on obtaining information regarding the initiation context of the program, initial program features and procedures, and the operation of the program during its early months.

Site-observations

During the site visits, research team members observed and documented program operations. These observations supplied additional descriptive information about the program's functioning not contained in program documents, and provided a cross-reference to information collected from other sources. As mentioned previously, the research assistant observed activities of the youth in L Wing of SOTU for 16 consecutive days, documenting program operations and participant activities.

Accessing Program Documents

Documents gathered or prepared by SOTU and the IYC-H management during the inception of the program, including grant applications, working papers, and reports, have been an important source of information. The data provided by these records were essential to the description of the program's developmental context, its initial design, and its operational procedures. Documents were collected periodically and analyzed for this report.

SOTU Treatment Records

Information collected by SOTU therapists is maintained on site in a treatment file, separate from the institutional master file. Information was extracted from the files of 17 of the first 25[2] participants to provide a preliminary profile of the program population and to assess treatment needs. An important early step in developing a program is to determine the nature of

[2] Files for youths removed from the program were not available. Also, youth who had recently arrived did not have sufficient information in their file to be included.

the population to be served. Data were not available at this time to determine the total population of identified sex offenders in IDOC or IYC-H. The next best data are the participant files. As indicated previously, the researchers will have access to an automated data base which can be used to obtain information about the IDOC population during the second year of this evaluation.

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Chapter IV: Review of the Program Implementation

Description of the Pre-program Environment

The implementation evaluation of SOTU begins with a description of the pre-program environment in order to identify gaps in programming. The bulk of this chapter analyzes the implementation process, beginning with an identification of the goals, structure, function, and system resources of SOTU. Flow diagrams showing the paths of offender processing and key decision points are included to provide insight into linkages within the system and the corresponding communication points. The discussion of structure includes information on the number of offenders committed to IDOC and pre-existing program options for sex offenders. The section on system resources includes information on caseload sizes, staffing, and the availability of SOTU staff to carry out desired functions.

Goals

In response to the special needs of juvenile sex offenders within the increasingly crowded IDOC Juvenile Division, IYC-H established the SOTU in order to provide residential treatment services for selected sex offenders. This project fit within the general goals of IDOC, identified in the SOTU grant proposal as being "to provide effective programs and services that ensure positive treatment outcomes and divert the youth from re-offending" (ICJIA, 1996a, p. 4).

Structure

The IYC-H is one of seven juvenile correctional facilities operated by the Illinois Department of Corrections. It is the "youngest" of the regular institutional facilities. The juvenile boot camp at Murphysboro, which opened in 1997, is the only juvenile facility to open since Harrisburg was converted from a mental health facility to a juvenile correctional institution in 1983. Only the Illinois Youth Center at St. Charles, with a rated capacity of 318, is larger than Harrisburg, but the St. Charles facility also operates the Reception Center for all juvenile males committed to the Department of Corrections and has a significant transient population. Harrisburg opened with a rated capacity of 125 and the expectation that it might eventually

house 300 youths. Additional renovation projects over the years gradually increased its rated capacity, which reached 200 in 1986 and expanded to 276 in FY 91. Its average daily population in FY 96 was 430, with a year-end high of 454 youths. This was an average of 156% of rated capacity, greater than that experienced by any other large facility and exceeded only by the Illinois Youth Center at Pere Marquette, which averaged 160% of its rated capacity of 40 in FY 96. Throughout 1996 and 1997 the population at Harrisburg has continued to increase.

The IYC-H is unusual in that it originally housed a mental health facility, and the Department of Corrections subsequently employed many of those employees. This helped to maintain a local institutional culture that supports treatment programs. At the same time, a number of correctional counselors and other program-based employees initially entered IDOC as correctional officers, and understand the security concerns of correctional staff. This situation results in a generally supportive atmosphere for new treatment programs as they are initiated at the center. Most employees at the IYC-H are drawn from the Harrisburg/ Marion/ Carbondale area and plan to stay in the area. This represents a strength for the maintenance of Harrisburg's unique institutional culture, but it also creates a potential problem in developing and staffing new programs. The limited pool of applicants for employment means that there may be a shortage of trained personnel in specific operational and program areas.

The origins of IYC-H as a mental health facility also have shaped its physical plant. The facility is made up of a number of separate buildings, which allows for a variety of segregated programs and recreational activities. Although many of the living units originally provided a dormitory setting for residents, all have been converted to individual rooms, which are increasingly double-bunked. However, some space which was usable for program activities before the conversion is no longer appropriate for interaction with youth on a regular basis due to security concerns related to access and isolation from security staff.

IDOC reports show that IYC-H had 430 youths in residence at the end of November 1995, rising to 454 by the end of June 1996. This represents the continuation of a steady trend.

The end-of-year population count for Harrisburg increased from 352 in FY 93 to 381 in FY 94, 405 in FY 95 and 454 in FY 96 (IDOC, 1996a). In November 1995, 64% of the youths at Harrisburg (274) were double-celled, and 36% (156) were single-celled. Harrisburg ranked third in the proportion of residents who were single-celled, behind Valley View (69%) and Joliet (54%); in the Juvenile Division as a whole, 40% of residents were single-celled at this time. In November 1995, 68% of youths at IYC-H had committed a Class 2 offense or higher, comparable to 69% for the Juvenile Division as a whole (IDOC, 1996b). During the last 10 years the Juvenile Division has experienced a gradual shift in the county of origin of its inmates. In FY 87 57% of the youths were committed from Cook County, with the remaining 43% coming from Downstate. By FY 96 the proportions were reversed: only 41% of the youth were committed from Cook County, while 59% came from Downstate (IDOC, 1996a). Harrisburg, the most southerly of the Centers, experienced a similar pattern over these years.

The DOC Annual Report for FY 96 (IDOC, 1997) noted that population increases at IYC-H were posing the greatest challenges for that institution, increasing the number of double bunked rooms, limiting recreation opportunities, and affecting school schedules. For example, Harrisburg reported that students 16 years and over attended only a half day school program in FY 96. The staff-to-resident ratio at Harrisburg in November 1995 was among the lowest in the Juvenile Division. Harrisburg employed 0.352 security staff per resident, second only to Valley View, compared to a Juvenile Division average of 0.383 security staff per resident. Harrisburg reported the lowest ratio of total employees to residents: 0.532, compared to a Juvenile Division average of 0.612. (IDOC, 1996b)

Prior to the establishment of SOTU at IYC-H in 1996, recognized treatment programs for sex offenders existed at three DOC institutions. The Big Muddy River Correctional Center provided a treatment program for adults, emphasizing group treatment using a "cognitive-behavioral/emotional" treatment modality (IDOC, 1997). This program can accommodate up to 200 inmates, and serves two groups: inmates who have been convicted of criminal offenses,

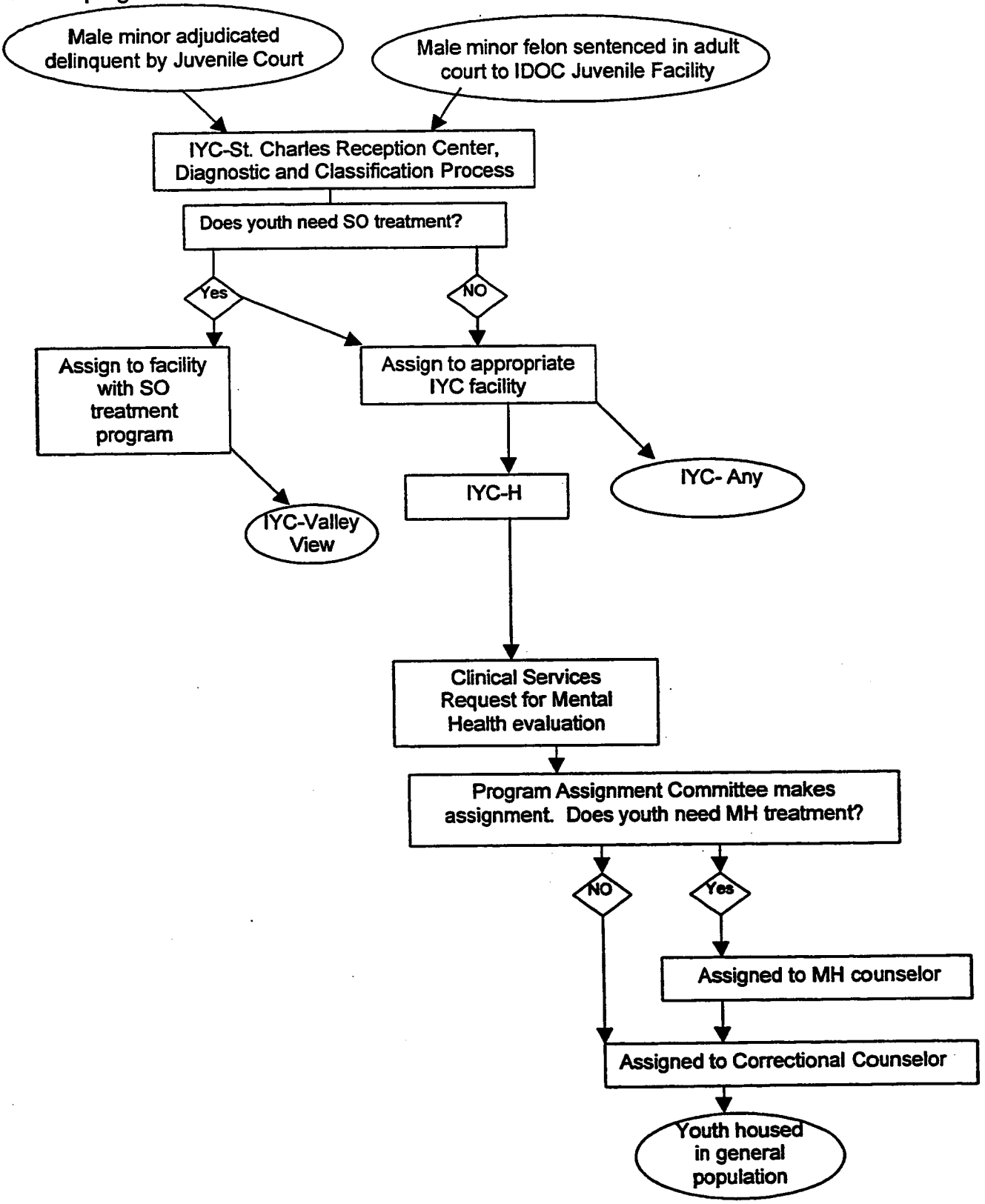
and men who have been civilly committed as sexually dangerous persons. A residential treatment community at the Graham Correctional Center provided treatment to 50 adult sex offenders in a single housing unit. This program included education, group therapy and behavior treatment components. The IYC at Valley View offered an intensive sex offender treatment program for juveniles which employed both group and individual counseling.

In addition to these organized group programs, a number of facilities reported providing some form of specialized mental health services for sex offenders. In the annual report for FY 96, the Youth Centers at Joliet and St. Charles reported providing sex offender treatment through individual and/or group counseling. IYC-H also provided individual counseling for sex offenders based on the treatment recommendations of the Reception Center at St. Charles and the Placement Advisory Committee at Harrisburg.

Function

Figure 4.1 outlines the pre-program process of youth assignment at IYC-H. Prior to the establishment of SOTU, all male youth committed to IDOC were first sent to the St. Charles Reception Center where they went through "extensive personal interviews, including a psychological screening evaluation, medical screening and orientation services" (IDOC, 1996b). As part of this process, youth could be identified as sex offenders either by their committing offense or because there was a prior record of a sexual offense in their file. Youth seldom voluntarily identified themselves as sex offenders because of denial or because of fear of the treatment they might receive from other youth in IDOC. Specific screening tests to identify and classify sex offenders were not generally available at St. Charles, as they were for those with substance abuse problems. Youth were then assigned to an IDOC facility based on their security risk level, their treatment needs, and available institutional capacity.[1] Youth recommended for a sex offender treatment program were frequently transferred to IYC-Valley View, but other facilities also may have received sex offenders.

Fig 4.1 Pre-program Process



[1] Further study of this process will occur in year two of the evaluation.

Prior to the establishment of SOTU at IYC-H, the youth were screened and their files reviewed by staff for both committing offense and offense history by members of the mental health unit. The Strategies for Juvenile Supervision (SJS) form was used to interview and evaluate all residents at intake. In addition, there was a separate form used at IYC-H to interview identified sex offenders. However, information identifying a youth as a sex offender was available only to the mental health staff and to the assigned correctional counselor. Security staff and other youth in the facility would know if a youth had been single bunked, but sex offenders were not the only ones who were single bunked. The Program Assignment Committee (PAC) made an assignment to a mental health counselor based on need. The youth was also assigned a Correctional Counselor and usually housed in the general population.

System Resources

Prior to the creation of SOTU, IYC-H had the lowest staff-to-resident ratio of all the IDOC juvenile facilities. Because IYC-H was often at more than 150% of rated capacity, there were a limited number of specialized treatment programs. A special intervention unit for physically aggressive and disruptive youth opened in FY 95, providing a treatment program that focused on anger management and non-violent responses to problems and frustrations in a structured, secure environment. A key part of this resocialization unit was the Violence Interruption Program (VIP). The unit was intended to provide short-term, intensive treatment to youths who then were returned to the general population. During FY 95 IYC-H significantly increased the drug abuse education and treatment programs it offered, with three staff providing group counseling while working towards certification as substance abuse counselors. The educational programming offered by School District 428 included some parenting and life skills classes, and a variety of vocational programs were also offered.

Given its staff-to-resident ratio, it is not surprising that IYC-H experienced high case loads throughout the facility. In 1996 each Correctional Counselor II had a caseload of between 35 and 40 youths. Mental health services, provided primarily through a contract with

Corrections Medical Services, experienced similarly high case loads, and a large proportion of their time was spent providing short-term crisis intervention services. Although a number of youths at IYC-H had been committed on a sexual offense or had a sexual offense noted in their record, they were not systematically assigned to a single mental health counselor or Correctional Counselor. Still, some staff were assigned such youth more frequently than others and began to build up a certain amount of informal expertise based on their experience with these youth.

Implementation Process

This analysis of the implementation process provides a description of the events in chronological order, including a timeline for SOTU implementation. The original conceptualization, as recorded in the grant application submitted by IDOC, is compared to the initial stages of program implementation. The development of the SOTU program is presented through the goals, structure, function, and system resources. Chapter Four concludes with a discussion of interpersonal communication and cooperation associated with SOTU.

Chronological Description of Events

Initiation of the SOTU began with the hiring of a Program Director, who was responsible for overall direction of both SOTU and the Substance Abuse Treatment Program. While this hire was completed on schedule, IYC-H was unable to hire a Program Director with the qualifications that were originally specified in the grant proposal. The director who was hired had substantial experience in substance abuse treatment but lacked comparable experience in sex offender treatment, and had an MSW rather than the preferred doctoral degree.

The next step was to hire the two sex offender treatment professionals who would design and implement the SOTU program and would have responsibility for the immediate direction of these programs. This was not completed within the anticipated time frame. IYC-H was unable to attract applicants with the desired level of experience in the treatment of sex offenders. One of the Social Worker III positions was filled in July 1996, when a social worker

with limited experience in individual counseling with sex offenders was hired. The first SOTU wing (L wing) opened in October 1996, approximately two months behind the anticipated start date. The second Social Worker III was not hired until September 1997. The second SOTU wing (K wing) was opened in October 1997, approximately one year later than anticipated.

The treatment program described in the grant application (and discussed in detail in Chapter Five) was based on the belief that it would require from 20 to 24 months to complete, but some youth may move through the program in less time. Participants were selected in part based on their likely release dates from the IYC-H. Residents in L Wing, the first SOTU opened, are currently completing Phase 2, and will be entering the final phase of the program later this year. This rate of progress toward completion of the treatment program is in general agreement with the schedule described in the initial program design. Youths admitted to the K wing unit, which opened in October 1997, are a year behind the initial schedule but are progressing at an appropriate pace relative to their start date.

SOTU is part of an integrated treatment program that includes an intensified period of post-release aftercare for those youths released to the Cook County Juvenile Parole Division. No youths enrolled in the SOTU program at IYC-H have yet been released to direct parole supervision in Cook County, although some have been placed in residential treatment programs. The development and implementation of the aftercare component of the program, and the implementation of a coordinated case management approach between IYC-H and the CCJPD will be described and evaluated in the second year.

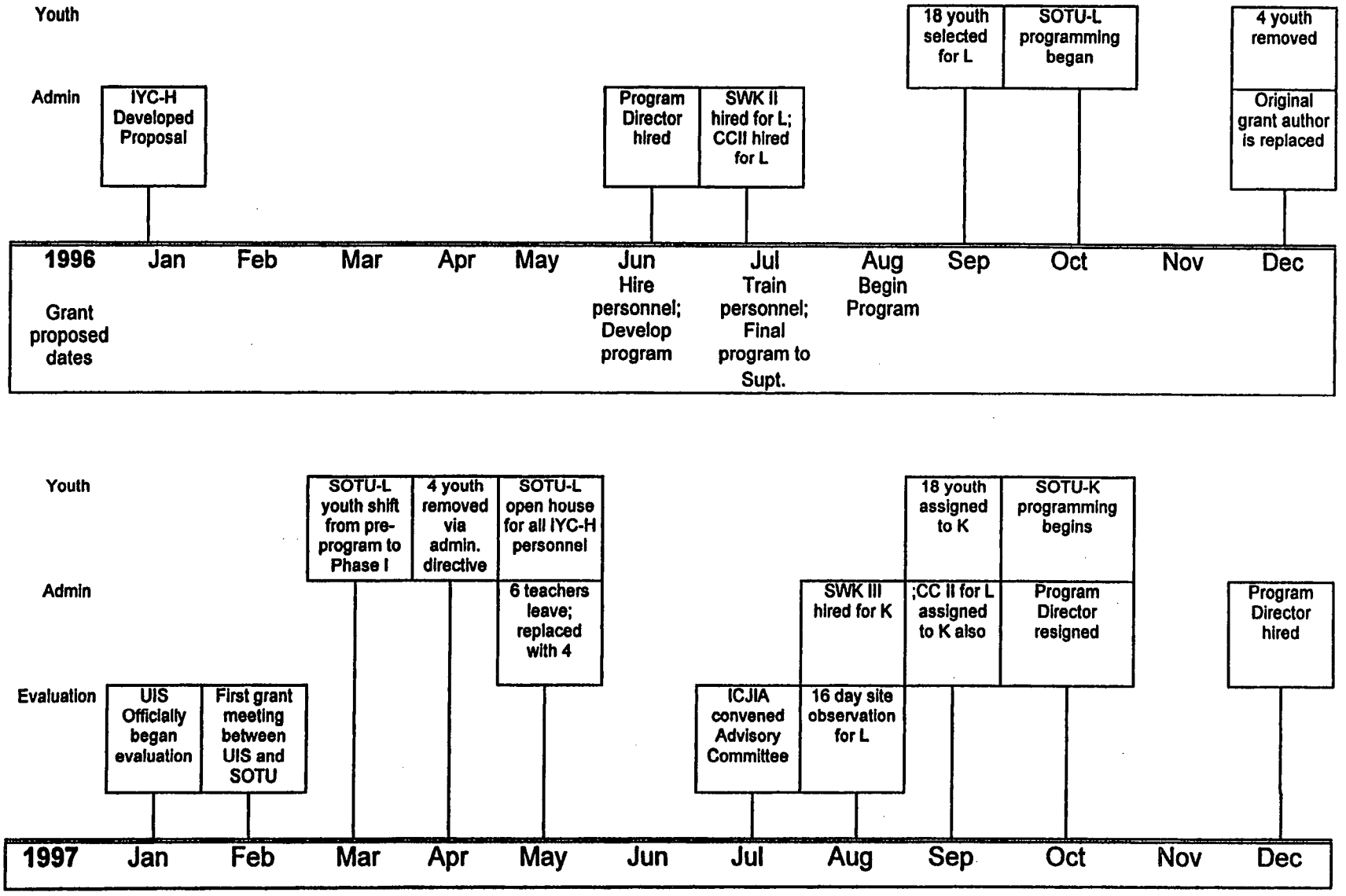
Timeline

The implementation of SOTU during the first year of operation includes the following events (see Figure 4.2):

- Early 1996 (process began in 1995): Grant proposal covering both SOTU and the Substance Abuse Treatment Unit (SATU) was developed by IDOC personnel and funded by ICJIA

- June 1996: Program Director (Public Service Administrator position) was hired to supervise both SOTU and SATU
- June 1996: Grant proposal indicated the personnel should be hired and the treatment program should be developed
- July 1996: Grant proposal indicated the personnel hired should be trained and the final treatment program plan should be submitted to the Superintendent.
- July/August 1996: First SOTU Social Worker III (Treatment Unit Therapist) was hired and a Correctional Counselor II (CC II) was hired for L wing. Other specialized grant-funded staff hired.
- August 1996: Grant proposal indicated the program should begin
- September 1996: First 18 youths selected for SOTU and assigned to L wing in B Building
- October 1996: SOTU programming began
- December 1996: 4 youths removed from SOTU program (3 for sexual activities)
- December 1996: Original grant author leaves IYC-H and is replaced. The grant author was the supervisor of the Program Director.
- March/April 1997: SOTU youths begin to shift from pre-program phase to Phase I of treatment program
- April 1997: 4 youths removed from SOTU program according to an administrative directive (not open to treatment)
- May 1997: Temporarily assigned teachers working in B Building leave for permanent assignment at another facility; replaced with fewer teachers
- May 1997: SOTU open house held for all IYC-H personnel
- August 1997: On-site three week observation period for L wing by research team member
- August 1997: Second Social Worker III (SWK III) hired to head K wing portion of SOTU
- September 1997: 18 youths assigned to K wing; Correctional Counselor II for L wing is assigned to K wing also
- October 1997: Program Director resigns; SOTU programming begins on K wing
- December 1997: New Program Director is hired

Figure 4.2 Timeline for SOTU Implementation.



From Original Conceptualization to the Operationalized Program

This section of the report delineates the process of implementation of goals, structure, function, and resources from original conceptualization to an operationalized program. Each section is organized to present the original proposal, as presented in the grant application, first. A description and analysis of the implementation process follows. Once the operationalized program has been examined, it is assessed in one of three ways. Enhancement comments provide suggestions which would enhance the program, but may not be possible in the present correctional setting. Recommendations provide direction to assist the program to develop in a positive direction. A recommendation indicates that the program has not included something the literature suggests would be beneficial, or identifies a component that may need additional development. A compliment is intended to recognize personnel for significant accomplishments in implementing the program.

Goals. "Goals are generally abstract, idealized statements of desired outcomes" (Rossi & Freeman, 1993, p.112). Programs usually strive for a limited number of goals. While reviewing the program documents, the research team examined several lists of items identified as goals. It was determined that many of the lists were actually objectives. Objectives are the operationalized outcome measures for the goals (Rossi & Freeman, 1993). For clarity in this report, the four global goals identified in the grant proposal will be identified as goals. The operationalized outcome measures in the grant will be identified as Grant objectives and the outcome measures in the program manual and other documentation in the program will be identified as the SOTU objectives. Other lists comprised detailed strategies or elements utilized in the program. The elements are the methods employed by the program which guide the youth to the objectives, which results in goal attainment.

For example:

Goal: "Conduct assessment and classification evaluations so youth can be effectively prioritized for treatment services" (IDOC, 1996a, p. 4).

Objective: Administer and analyze results of the MMPI, Abel and Becker Cognition Scale, and Carich-Adkerson Victim Empathy & Remorse Inventory to each identified sex offender youth entering IYC-H within 30 days of entry.

Element: Clinical assessment (see Screening / Assessment for a full description of this element)

The IDOC submitted an application for grant funding for two treatment units, a substance abuse treatment program and a sex offender treatment program, which were to be linked administratively but to operate as separate programs. The overall project goals and objectives for treatment outlined in the grant application are the same for both units. This evaluation considers only the sex offender portion of the grant. This section begins by enumerating and discussing the goals proposed in the grant and the Grant objectives used to measure a participant's success in achieving program goals. The SOTU objectives will then be itemized and compared to the Grant objectives.

The goals identified for SOTU in the grant application are as follows:

1. "Conduct assessment and classification evaluations so youth can be effectively prioritized for treatment services.
2. Establish a comprehensive, intensive treatment environment that supports life, cognitive and behavioral skills building.
3. Establish a system of post-release treatment, case management and support services that will support program graduates during their return into the community.
4. Establish process and outcome evaluations" (IDOC, 1996a, p. 4).

The first goal has been implemented. An assessment process has been developed and put into operation at IYC-H, and is fully discussed later in this report. Implementation of the second goal has been only partially documented, making a full assessment of its status difficult. The extent to which SOTU has been able to establish an intensive and comprehensive treatment environment has not been fully documented. The treatment needs of juvenile sex

offenders have been well researched by the treatment staff, and an extensive treatment program that develops and intensifies over time has been partially designed. Line staff appear eager to learn and eager to assist in treatment. According to interviews, some staff paid to attend training sessions on an independent basis. Grant goals three and four will be considered in the final report.

The Grant also included a list of outcomes that would measure the success of the treatment environment (goal two). They were as follows:

1. Youth will accept responsibility for offending behavior.
2. Youth will acknowledge impact of offending behavior on victim, family and community.
3. Youth will exhibit non-violent methods of communication, behavior and conflict resolution.
4. Youth will increase reading scores.
5. Youth will improve feelings of self-esteem.
6. Youth will decrease re-offending/relapse behavior(s) (ICJIA, 1996a, p. 4).

Ideally, the program staff should have been involved in developing these goals and methods of measuring the outcomes. However, the goals and objectives were established before the program staff were hired, a situation common to many programs during the initial start-up period. Moreover, these proposed goals and objectives were not well publicized within IYC-H. According to interviews, the program staff were generally unaware of the goals and objectives that had been specified in the grant. The staff therefore developed specific SOTU objectives as part of the unit's program development process. The SOTU manual (Cotter, 1997) identified the following five objectives:

1. Acknowledge and accept full responsibility for complete sexual assault/abuse history.
2. Develop knowledge and understanding of human sexuality including your own arousal patterns.
3. Identify and correct general and specific thinking errors.

4. Learn to identify feeling states and respond with healthy behaviors.
5. Gain understanding of how sexual abuse/assault negatively impacts victims and develop empathy for own victims.

In program development it is important to have clearly stated goals with measurable objectives that are known and understood by the treatment community. Developing a cohesive treatment team and enhancing ownership in the program includes developing (or at least agreeing to) the goals and mission statement as a team (Gibson, Ivancevich & Donnelly, 1994; Rossi & Freeman, 1993).

RECOMMENDATION 1: SOTU staff need to revisit the grant program and reach agreement on common goals and objectives, involving all personnel who are affected by SOTU. The unit has an unusual opportunity to do this now because of the recent changes in key personnel, including the hiring of a new Program Director and the addition of a second unit program supervisor.

A comparison of the Grant and SOTU objectives reveals that two of the objectives are almost identical, and three of the remaining four Grant objectives are reflected in somewhat more specific SOTU objectives. The Grant objectives also specifically include academic achievement, while the SOTU objectives do not. Because every SOTU youth who does not have a high school diploma or a G.E.D. certificate attends school, this does not represent a discrepancy in programming. However, it does indicate that some programming which is provided to all IYC-H has not been identified as a part of the SOTU treatment environment. SOTU needs to consider how all treatment goals for youth will be met, while at the same time distinguishing between general correctional objectives and sex offender-specific treatment. Ideally, the SOTU would modify and then incorporate all objectives into treatment specific components to create an intensive treatment environment.

The SOTU objectives have not been well disseminated within IYC-H. According to interviews, most staff knew the general IDOC goals, but did not know the specific goals that

were specified in the grant proposal or any of the objectives specified in the SOTU manual. Most of the interviewees described the basic goal of SOTU as "to provide treatment" or "to reduce sex offenses," but were unable to elaborate on these general concepts.

COMPLIMENT 1: Goals and objectives presented in the grant and adopted by SOTU are similar to those recognized in the research literature and adopted in other treatment programs. (For example, see Epps, 1994; Hagan, King, & Patros, 1994).

Structure. The program should be developed based on the aggregate needs of the offender population. As discussed in Chapter II, Breer (1996) and Marshall and Eccles (1991) support selecting elements from at least five of the recognized theoretical models, based on the population targeted by the program. As a result, the first step in developing treatment is to determine the population trends and characteristics of offenders available for treatment. No adequate typology of offender characteristics has been developed. However, research is currently being conducted through the Office of Juvenile Justice Delinquency Prevention (Hayler & Smith, 1997). Unfortunately, we do not as yet know the characteristics of the target population at Harrisburg. Therefore, recommending program changes to meet the needs of this specific population would be impossible at this time.

However, as discussed previously, the IYC-H population will vary based on security concerns and available space. Therefore, IYC-H population will always be changing. Although the program should not try to meet the needs of every sex offender, it should be designed to meet the needs of most of the available offenders in the population. Theoretical constructs suggest that different types of sex offenders require different treatment strategies. Therefore, the program should be designed to meet the needs of this specific, although still heterogeneous, group.

The following table (4.1) is a summary profile of 17 of the first 25 youth. Comparisons to internal reports indicate that the average age of offenders is gradually getting younger,

decreasing from 16.8 years old to 15.3 years old. The urban-to-rural ratio has shown little change. More of the participants in the program have been

Table 4.1 Profile of youth in SOTU as of April 1997.

Characteristic	Summary of 17 youth
Average Age	15.3
DSMIV Diagnosis	➢ 11 had more than one diagnosis ➢ 4 were diagnosed with Alcohol abuse
Crime	➢ 2 Aggravated Criminal Sexual Abuse ➢ 6 Aggravated Criminal Sexual Assault ➢ 9 Criminal Sexual Assault
Region	Less than 40% were from Cook or the collar counties
Sex of victim	➢ 11 had only female victims ➢ 3 had male and female victims
Relationship of the victim	➢ 8 had only unrelated victims ➢ 3 had related and unrelated victims
Victim of Sexual Abuse	More than 50% were victims
Previous Treatment	8 had previous treatment documented

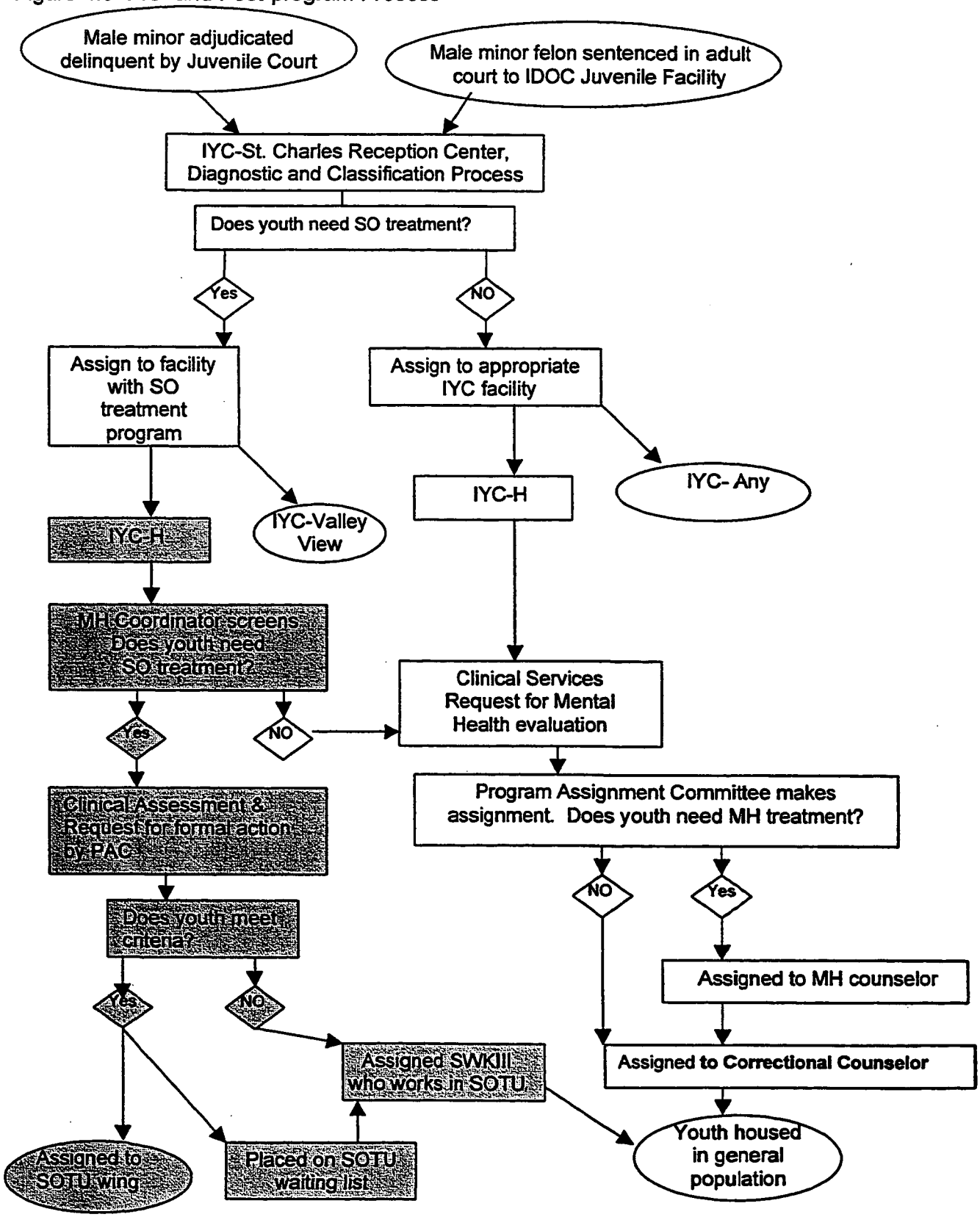
committed on Criminal Sexual Assault charges than was previously the case. The percent of youth who are identified as victims of sexual abuse has remained relatively constant at more than 50 percent.

Interviewees at IYC-H believe that sex offenders are increasingly being sent to Harrisburg as awareness of the treatment program grows. In February 1997, there were 67 sex offenders at IYC-H, an increase of 98% from October 1996 when SOTU opened. This supports the perception of the interviewees that there is a shift in the population of IDOC in general or a change in classification and assignment decisions. During the second year of evaluation, the researchers will try to ascertain the basis for the shift. Juvenile court judges may also be more

likely to commit offending youths when treatment programs exist, even though they cannot mandate assignment to a specific treatment program.

Function. After SOTU began operation, the number of sex offenders arriving at IYC-H appeared to increase. The processing path for sex offenders after they entered IYC-H changed once SOTU was in place (see the shaded process on Figure 4.3). If a youth is identified as being eligible for SOTU, he is referred to the Social Worker III who directs the therapeutic program for a clinical assessment. On the basis of this assessment, a formal request to the PAC is made. If the youth meets the criteria for sex offender treatment, the PAC is asked to assign him to the SOTU wing or to place him on the SOTU waiting list. Youths on the waiting list who are determined to be in immediate need of mental health treatment are assigned to a SWK III who works in SOTU. The youth then resides in the general population while waiting for a SOTU opening.

Figure 4.3 Pre- and Post-program Process



Highlighted symbols indicate the added process from SOTU.

System Resources. The Grant agreement provided funding for five full-time and two half-time positions for the Substance Abuse and Sex Offender Treatment Units at IYC-H to assist in staffing and supporting the units. These positions included: a Psychology Administrator I to provide overall program management for both units; two Social Workers III to provide direct treatment services to the SOTU; one Correctional Counselor III to provide direct service on violence prevention to both units; two half-time Leisure Activity Specialists I to provide recreational and leisure time activities to youth in both units; and one Office Associate to provide clerical and support services to staff on both units.

The IYC-H was unable to staff these positions with people who met the full range of qualifications included in the grant. The Psychology Administrator I position was initially described as requiring a doctoral level degree in social work and/or clinical psychology, and experience or expertise in the treatment of both sex offenders and substance abusers. The position was initially filled by an individual with a masters level degree in social work and experience primarily in the treatment of substance abusers. Later, this individual was replaced by a veteran administrator, but without the prerequisite experience or education. The qualifications for the Social Worker III position included a masters level degree in social work and/or accreditation as a licensed clinical social worker, and experience or expertise in the treatment of sex offenders. The first Social Worker III who was hired had the specified educational qualifications but had limited experience providing individual mental health services to sex offenders. The second Social Worker III position was not filled until September 1997; the person who was hired had the specified educational qualifications but again had limited experience in the treatment of sex offenders.

The Correctional Counselor III position included special qualifications of a bachelor's degree and extensive experience in violence prevention and group process. This position was filled through internal promotion late in 1996; the person hired had a bachelor's degree but limited experience in the specified areas.

Difficulties in filling the grant positions were related both to the nature of the positions and the location of the treatment program. Since the grant included both Substance Abuse and Sex Offender treatment units, applicants with qualifications in both of these fields were sought for two professional staff positions. However, since most treatment programs focus on a specific target population, relatively few people have comparable training and/or experience in both of these fields. In addition, the location of the program in a rural area contributed to the difficulty of attracting professional staff with the preferred special qualifications. Roger Smith (1995) recognizes this problem, and recommends that sex offender programs be offered at facilities that are not geographically isolated to minimize this problem. Finally, the nature of the proposed treatment schedule also discouraged some candidates. The juvenile offenders who receive treatment were also expected to go to school and, in some cases, work at job assignments during the weekdays. The Social Workers III who would directly provide and supervise treatment were expected to work a schedule that included some evening and weekend hours.

The compromises that were made in hiring personnel were reasonable under the circumstances, but resulted in some problems during the first year of the SOTU. The original Program Manager lacked expertise in the treatment of sex offenders, and did not take the active role in the development and implementation of the SOTU that the grant proposal had envisioned. She was not able to develop program modules or to provide direct services to youth in the SOTU. While this limited expertise in the treatment of sex offenders should not necessarily reduce the Program Manager's effectiveness as a supervisor, it became increasingly difficult for her to provide the support and direction required as the treatment units developed. The fact that the Substance Abuse Treatment Unit (SATU), in the field where the Program Manager had more direct experience and expertise, was initiated several months before the SOTU may have helped to create a context in which the SOTU was perceived as receiving less attention and support.

COMPLIMENT 2: The research team recognizes that the Social Worker III hired to develop the SOTU goals and objectives and to provide individual and group therapy has done a remarkable job of designing and implementing a treatment program that incorporates a wide range of broadly accepted elements and approaches for the treatment of sex offenders. She researched a broad range of treatment elements, modified them for implementation in the IYC-H setting, and brought them together into a series of coherent modules. Interviews consistently indicated that she had gathered extensive materials and generated a great deal of enthusiasm on the part of both professional staff and line personnel in the facility.

ENHANCEMENT 1: Build morale within the SOTU by recognizing the accomplishments of staff and giving appropriate credit. The Social Worker III developed the treatment program that is currently being offered with little assistance or feedback from her supervisor. Based on information received to date, the current Program Manager will acknowledge the primary role of the SOTU Social Worker in creating the program while serving as an active advocate for the program, which should have a very positive effect.

RECOMMENDATION 2: Where it is difficult to attract applicants with specific preferred experience and/or expertise, plan to provide training in treatment areas to build the necessary skills and develop expertise. Encourage the growth and development of a treatment team approach that involves the Program Manager in the design of program materials and the delivery of treatment in both treatment units.

The Correctional Counselor II hired for the SOTU has an office on L wing, and was assigned all the youth placed in that wing (the first portion of the unit to open). This is a change from established Harrisburg procedure, which calls for youths to remain with the counselor to

whom they were initially assigned regardless of their physical location within the facility. Although the transfer of youths from one counselor to another created some disruption, overall it appears to have been beneficial both to the youths and to the operation of the SOTU. The Correctional Counselor is more readily able to meet with the youths on her caseload because about half of them are located on the wing where she maintains an office, and less time is devoted to efforts to contact youths in various locations. She is also developing growing expertise in the treatment of sex offenders. This fall the same Correctional Counselor was assigned the youth on K wing, the second wing in the SOTU. This will allow her to specialize even more, to have more of a presence on the wing, and to become a more active part of the SOTU treatment team.

ENHANCEMENT 2: The involvement of the Correctional Counselor II in the therapeutic and treatment activities of the SOTU should be encouraged and supported where possible. Close cooperation between the Social Worker responsible for the treatment on the SOTU and the Correctional Counselor is an essential aspect of the proposed continuum of care that connects the IYC-H and the CCJPD.

The Violence Interruption Process (VIP) is the only specialized treatment element for which a separate person (Correctional Counselor III) has been hired. The person hired to fill this position has received only limited training in the VIP group process (40 hours). Additional training is recommended, which could include trips to other IDOC facilities where the VIP process is used in order to observe and to participate in the provision of the treatment program. The initial grant anticipated that this person also would provide some individual treatment for youths in the SOTU and/or the SATU. This does not appear to be happening on a regular basis. An improved understanding of this person's counseling responsibilities might strengthen one or more of the existing treatment components.

ENHANCEMENT 3: Provide additional VIP training to increase the employee's ability to develop treatment modules and train others in their delivery.

RECOMMENDATION 3: Clarify this position's responsibility for individual counseling and integrate any such responsibilities with the existing treatment programs on the SOTU.

The security staff makes an essential contribution to the SOTU. The regular weekday security staff for both the day and evening shifts are generally recognized as important assets. They are supportive of the treatment program and have taken steps to inform themselves more fully about the treatment elements and principles involved. Both of these officers volunteered for assignment to the SOTU L unit since it opened in 1996. Those who provide security at other times, or who fill in for the regular staff when they are absent, do not appear to have the same involvement with the SOTU. Many of these staff rotate frequently and do not have the opportunity to become as familiar with either the youths on the wing or the special procedures that have been established. Even though the weekday staff have been assigned to the SOTU since its inception, interviews indicated that IYC-H policies require the renewal of the assignment every three months. This weakens the sense of commitment to the wing, and reduces their incentive to complete additional educational or training activities.

ENHANCEMENT 4: Explore the possibility of longer-term assignments of support staff to special treatment units.

RECOMMENDATION 4: Continue the policy of selecting personnel for regular security staff assignments on both SOTU wings from volunteers, and extend it to include replacement staff as much as possible.

Because one or more members of the security staff (Correctional Officers) are always with the youth, they are in a unique position to implement and reinforce the treatment program around the clock. An analysis of the implemented program indicates that program treatment specialists are unlikely to see any one youth for more than a few hours each week. Security

staff currently sit in on group therapy sessions and provide advice and assistance to youth in various informal ways. Acknowledging their role in the treatment process and assisting them to become a consistent presence will strengthen the therapeutic environment (see Wexler & Graham, 1992).

ENHANCEMENT 5: To more fully develop an intensive treatment environment it would be helpful to provide training for the security staff and to increase their involvement as treatment providers, perhaps in the role of surrogate parents or alternative positive role models.

The grant specified that School District 428 General Revenue and contractual dollars would fund six secondary and special education educators to provide educational services to the SOTU and SATU youth. Services were provided until May 1997 by six teachers who had been recruited for the IYC-Murphysboro, and who transferred there as a group to staff that school. Although educational services continue to be provided in building B for SOTU youth and one wing of the SATU, the number of teachers has been reduced to four. (An additional teacher is currently on maternity leave, and cannot be replaced.) Throughout the period of SOTU's existence educational services have been provided in a limited manner, generally on a half-time basis.

ENHANCEMENT 6: More fully include the education staff in the program (e.g., monthly staffing for each youth). The educational staff could prove to be an important source of assistance in attaining treatment goals, particularly through life skills education.

Caseload Issues. The establishment of the SOTU does not appear to have substantially reduced the size of the client caseloads carried by its correctional counselor. The caseload for a Correctional Counselor II has ranged from the mid-30's to the mid-40's. The recent decision to assign the youth on both SOTU wings to one counselor brings her SOTU caseload to 36 youths. This caseload will be sufficient after the youths remaining from her previous caseload are reassigned.

The caseload for the Social Worker III has decreased from approximately 40 (18 SOTU youths and 20-25 non-SOTU youths) during most of the first year of the SOTU to 24 (18 SOTU youths and 6 non-SOTU youths). The second Social Worker III was assigned a caseload of 24 sex offenders also. Since these Social Worker III's are expected to provide regular individual counseling sessions with the non-SOTU portion of their case load in addition to their SOTU responsibilities, 24 appears to be an appropriate case load size.

In addition to these specific responsibilities, the Social Workers for the SOTU unit are now being assigned the following additional responsibilities: assessment and evaluation of identified sex offenders at intake at IYC-H; rotating on-call status for the response to mental health crises; and response to all Clinical Services Requests (CSRs) stemming from sexual acts.

RECOMMENDATION 5: Identify and, if necessary, provide training for another mental health professional to provide crisis response and treatment to sex offenders who are not assigned to the SOTU.

Volunteers. The Social Worker III for L Wing has been very successful in recruiting interns from Southern Illinois University, initially from the Bachelor's of Social Work (BSW) and more recently from the Master's of Social Work (MSW) degree programs. It is generally agreed that the ability to provide a full array of treatment elements currently depends on the presence of interns. However, these interns must receive appropriate supervision of their work, gradually developing more independent responsibility after first working closely with the Social Worker III. It is important that any treatment element or support service provided by a volunteer intern be carefully described and documented. This will insure that the intern's responsibilities are clearly defined, and will also allow someone else to continue a project if an intern is unable to do so.

Training. The grant specified that new staff would receive 40 hours of training at the Corrections Training Academy, as well as orientation to IYC-H. Training in the goals and strategies of the SOTU was to be provided by the Program Manager and IYC-H administrative

staff to all staff who work in the unit. Staff were also to be encouraged to obtain additional training through workshops and conferences. While an orientation to the two units was provided in 1996, there was broad consensus that more training was needed to increase institutional awareness and understanding of the SOTU and to enhance the ability of support staff to contribute to treatment.

The Social Worker III and Correctional Counselor II for SOTU received training and observed treatment programs for sex offenders at the Graham Correctional Center and Big Muddy River Correctional Center (both adult facilities) and the IYC-Valley View, for a total of approximately 8 days in 1996 and early 1997. In addition, the Social Worker III attended the 1996 annual meeting of The Association for the Treatment of Sexual Abusers (ATSA), which provided additional training opportunities. The Correctional Counselor III with responsibility for violence prevention education received 40 hours of training on the Violence Interruption Program in 1996. In addition to this training, which was funded by IDOC, the Social Worker III in SOTU and the Correctional Counselor II attended several day-long training sessions at their own expense. A number of other Correctional Counselors and a casework supervisor also paid to attend these sessions.

There is a general perception among staff that the IYC-H could have done more to support training, and that treatment providers in the SATU received more state-supported training than did those in the SOTU. This perception may grow in part out of two misunderstandings. First, the grant provided no contractual or travel funds. Thus, all training expenses had to be covered out of the facility's existing budget. Second, the SATU was funded differently than the SOTU, as a contractual agreement with an outside service provider rather than through a state budget. Thus, most of the treatment-specific training that SATU employees received was not funded directly by the state. Finally, IYC-H was already supporting efforts by some employees to become state-certified substance abuse counselors, apart from the grant.

ENHANCEMENT 7: Provide more budget information through the Program Manager to SOTU staff, so that they have a realistic sense of what can be supported and can plan to seek training accordingly.

The Social Worker III provided some limited training on SOTU for the professional staff at the facility, but interviews indicated that most of them did not have a detailed understanding of the SOTU treatment program and goals. Other staff who interact with SOTU have not had the opportunity to receive information about the program. Facility staff were encouraged to attend the SOTU Open House that was held in May in order to learn more about the program, and those who did received credit for one hour of training, but there has been no opportunity to provide structured training.

RECOMMENDATION 6: Add a module to the annual cycle training of staff about the SOTU and its treatment modality, required for all employees at IYC-H. Expand the training on SOTU available to staff, in order to increase institutional awareness of the program.

ENHANCEMENT 8: Increase support for additional training for SOTU staff that focuses specifically on treatment needs and programs for juvenile sex offenders.

Interpersonal Interaction and Communication

The SOTU has developed as a fairly self-contained program. While this has often been a strength, allowing it to focus its efforts and make the most of limited resources, it has also been a weakness in that others at IYC-H do not know about the program or its basic principles and procedures. While communication appears to be fairly open and direct within the SOTU, particularly between the treatment staff and weekday correctional officers, there has been a pattern of poor communication between the SOTU social worker and the Program Manager. The recent hiring of a new Program Manager provides an opportunity to rebuild this relationship and establish a greater degree of trust and communication.

In addition, there are a number of issues that need to be addressed in the coming year. Many of them have implications for SOTU's ability to provide intensive treatment, which requires the active support of personnel throughout the facility. They include:

- Improve communication between the casework supervisor, who supervises the SOTU Correctional Counselor II, and the SOTU Social Worker and Program Manager.
- Establish a regular exchange of information between the SOTU treatment providers and the Correctional Counselor III who provides VIP sessions.
- Improve communication with school educators, including the Assistant Principal, so that all parties understand the rules and behavioral expectations that apply to SOTU youth.
- Improve communication between security and SOTU staff by developing a method for routinely sharing observations that are not appropriate for an incident report.
- Reach agreement on the descriptive information about SOTU youth that will be routinely forwarded, on a regular basis, to all staff associated with SOTU. This information should include such things as school status, job assignment or schedule, medical treatment (including continuing medications), and the youth's "Level" status.
- Directly inform all staff associated with SOTU about changes in wing rules and behavioral expectations, rather than relying solely on a general memo or posted notice.
- Improve awareness of SOTU activities and scheduled activities by posting a current schedule at least weekly and confirming changes or modifications with those who are affected.

Chapter V: Treatment Components

Introduction

It may have been beneficial for the evaluation team and the program developers at IDOC to have designed the treatment program together, prior to implementing treatment. This was not an option under the current system of grant requests for proposals. The research literature in Chapter Two identified a compilation of treatment components that represent the most current recommendations of recognized groups of therapists and/ or researchers in the field of juvenile sex offender treatment. While there is currently no clear consensus on what constitutes an effective juvenile sex offender treatment program, the table developed from this literature has been included in this section, with additional columns to compare the treatment components of the grant and SOTU to the treatment literature (see Table 5.1). While a number of general theories based on single schools of thought exist, no integrated theories have been developed that bring these separate approaches together. The treatment literature suggests humans are complicated composites of various behaviors, only some of which may be explained by any specific theory.

The treatment elements identified in the grant include "comprehensive assessment, group and individual counseling [concerning multiple issues], educational and life skills building, and case management services," and follow-up treatment and aftercare (ICJIA, 1996a, p. 5). In order to operationalize these elements, the SOTU drew on multiple theories presented in the research literature. As the treatment staff implemented the grant design, the elements of the treatment program included not only most of the elements identified in the grant proposal, but others recognized in the treatment literature. The treatment philosophy of SOTU has two stated theoretical bases: addictions theory and cognitive-behavioral theory (Cotter, 1997). However, a review of the elements reveals that SOTU has drawn some treatment elements from each of the theories, with the exception of Biological Theory.

Table 5.1 compares the relevant treatment components of each theory, based on a review of the literature, to the treatment components envisioned in the grant and operationalized by the treatment program. Note that while some general elements of the proposal may not be specifically implemented as separate treatment modules in the SOTU program manual, many of these general goals are related to specific treatment elements. Both the grant proposal and the SOTU implementation include elements from each of the theoretical foundations except biological theory.

Treatment Preparation

Programs typically have some components that set the stage for treatment. The standards identified in the literature include various combinations of six elements. Frequently programs entice the participants to come to treatment prepared to make changes by offering some reward that encourages participation. Programs must selectively choose their participants and fully identify the needs of the clients through formal and informal screening and assessment. Next, the results of the assessment process are used to determine which offenders should be included in the treatment program based on matching their needs to the program's treatment focus. Additional needs that are not met by the general program should be addressed through an Individualized Treatment Plan. Frequently, therapeutic programs are housed in separate treatment facilities to protect the residents from outside influence during treatment. Also, a specified length of treatment is identified. The following sections briefly present relevant issues identified in these six aspects of treatment preparation.

Table 5.1 Treatment Components in SOTU

Theoretical Model and Components	National Task Force 1993	ATSA 1997	National Task Force on Correctional Substance Abuse Strategies 1991	IYC-H 1997 Grant	IYC-H 1997 SOTU
Treatment Preparation					
Encouragement to treatment		X	X		
Screening/Assessment	X	X	X	X	X
Matching inmate needs w/ treatment type		X	X		
Individualized Treatment Plan (ITP)	X		X	X	X
Separate treatment setting			X	X	X
Length of treatment	X	X		X	X
Cognitive-Behavioral Theory					
Cognitive therapy for cognitive distortions	X	X	X	X	X
Arousal Control	X	X			
Cognitive therapy for chain of events analysis	X	X	X	X	X
Develop healthy relationships	X	X	X	X	X
Social competence	X	X	X	X	X
Communication	X	X	X		X
Anger management	X	X	X	X	X
Stress management		X	X		
Life skills development			X	X	
Assertiveness		X	X		X
Violence intervention					
Relapse Prevention (see Addictions Theory)				X	X
Social Learning Theory					
Staffing – Professional Mental Health		X	X	X	X
Staffing – Correctional Officers			X		
Therapeutic Community			X	X	
Attachment Theory					
Victim awareness & empathy	X	X	X	X	X
Biological Theory					
Chemotherapy intervention		X			
Addictions Theory					
Self-help programs, peer groups		X	X	X	
Relapse prevention	X	X	X	X	X
Prerelease planning			X	X	X
Reunification w/ children		X			
Family System Theory					
Family therapy	X	X		X	
Other Components					
Drug /Gang treatment	X		X	X	X
Physical and mental health	X		X	X	X
Restitution/reparation to victims	X				
Special needs	X	X	X	X	
Aftercare upon release	X	X	X	X	X

Encouragement to Treatment

Youths who are identified at IYC-H as needing treatment undergo an assessment to determine if they will benefit from participation in a sex offender-specific treatment program. The assessment process also considers whether or not the youth is open to receiving treatment. According to interviews, participating in treatment for sexual offending in a correctional setting may open the offender to ridicule or violence by other offenders in the general population. Some aspect of the treatment program should outweigh this negative aspect of being in treatment (e.g., candy, extra recreation time).

Behavior Modification System in IYC-H. SOTU follows the IYC-H policy of a reward and punishment system based on points. Youth can lose their opportunity to have leisure time activity if their points drop below a specified number (moving them from one "level" to another). This system operates throughout the institution, and is separate from the Phases of the SOTU treatment program. This dual system creates double tracking and additional work for the staff and clouds the treatment focus of the residents.

ENHANCEMENT 9: Connect the point system to the overall treatment program. Using the point system to encourage youth to attend to treatment may increase treatment cooperation.

RECOMMENDATION 7: Create a method within SOTU of holding the youth accountable for inappropriate treatment behavior. For example, a youth may behave in a way that is not beneficial to treatment, but the behavior may not violate the standards of the institution or may not be sufficiently inappropriate to warrant the loss of points. One suggestion is to have a treatment violation box where residents and staff can drop a violation slip explaining the incident and recording the date and time recorded. Treatment violation meetings where the behavior can be addressed and an appropriate learning experience assigned can be held daily (or as needed). For example, a youth winks at another youth.

The youth who is winked at records the incident and drops it in the box. That evening at the meeting, staff or youth can confront the offender and get some kind of commitment that the behavior will not recur. An appropriate assignment for this behavior might be to write an essay on why the behavior was inappropriate.

Screening / Assessment

An essential component of any therapeutic program is the identification of appropriate individuals for inclusion in the treatment group. In the SOTU program, basic eligibility depends on documentation of the youth's status as a sexual offender, as demonstrated through: (1) a committing charge which is a sexual offense, (2) a documented history of sexual offending, or (3) a self-report of sexual offending supported by objective documentation. In addition, the youth must satisfy three additional criteria to be recommended for inclusion: (1) recommendation for treatment based on psychological evaluation, (2) assessment which establishes the need for sex offender-specific treatment, and (3) an appropriate length of stay for completion of a 20-24 month treatment program.

The first two standards can be established based on a careful review of the youth's Juvenile Court record. Self-reports of sexual offending are rarely made during the intake stage, which usually takes no more than 3-5 weeks. Reporting is more likely to occur to a counselor later, in the context of crisis intervention or other mental health treatment. Given the relatively straight-forward nature of records review, the more critical determination is whether a sex offender meets the remaining clinical criteria for admission to the SOTU program.

Youths at the IYC-St. Charles Reception Center go through a series of interviews and tests to assess their risk levels for such things as suicide, escape attempts, gang involvement, substance abuse, and violent behavior, as well as health screenings and educational testing. While recommendations for mental health services are sometimes made based on the assessments completed at St. Charles, the Reception Center does not have the ability to

conduct extensive psychiatric evaluations. As a result, it appears likely that most determinations of the need for sex offender-specific treatment are based primarily, if not exclusively, on a review of the youth's juvenile record. On-site interviews to be conducted during the second year will enable the evaluators to gather additional information on the screening processes carried out at St. Charles.

During the intake process at IYC-H, the eligibility of a youth to be considered for the SOTU based on his committing charge and/or documented juvenile history is reconfirmed. Any youth that appears to be eligible for consideration is referred to the SOTU Social Worker who conducts a clinical evaluation to determine the youth's need for sex offender-specific mental health treatment.

In developing the SOTU treatment plan, the SOTU Social Worker identified at least ten different tests and assessment instruments that may be useful in determining need for treatment. Based on the results of the standardized instruments administered, as well as an individual interview, she completes an individual clinical assessment. On the basis of that assessment, and taking into consideration the time remaining until release, the SOTU Social Worker makes a recommendation for or against SOTU treatment. If the recommendation is for treatment, the youth's name is placed on the list of those eligible to be assigned to SOTU as space becomes available.

In reviewing this process, it became clear that use of all the identified instruments resulted in a cumbersome and sometimes impractical screening procedure. Faced with a full wing of individuals who needed immediate treatment, the detailed clinical assessment of youths who might receive treatment in the future was, by necessity, given a lower priority. Because these tests are time consuming to administer and to score, interns ultimately managed many of them. A preliminary file review indicated the ways in which these tests and inventories were handled reduced their reliability as assessment measures. The tests were not always

administered in accordance with designated procedures, as some of them were not properly interpreted, and others could not be scored in a timely manner.

RECOMMENDATION 8: Training should be provided to selected interns and on-site employees to ensure that assessment tests and screening instruments selected for use are administered in a consistent and reliable manner.

Although there is no indication the evaluations conducted by the SOTU Social Worker were carried out improperly, it is important that the most appropriate tests and inventories be used in the future, and that the tests be properly scored to provide the information they were intended to gather. The SOTU Social Worker has already initiated a series of steps to identify the best age-appropriate measures of assessment, and a consultant to this evaluation will be assisting in this review. From the assessment results, the SOTU Social Worker can identify the treatment needs of the youth.

Matching Inmate Needs With Treatment Type

The results of the assessment process should be used to determine whether an offender needs the treatment that is offered by the program and is willing to make a commitment to participate in the program. For SOTU this judgement is part of the assessment carried out by the SOTU Social Worker, who makes a recommendation to the IYC-H Program Assignment Committee (PAC) for or against SOTU placement. SOTU has the opportunity to be selective because there are more juvenile sex offenders in the general population at IYC-H than there are available treatment beds. It is also important to insure that the types of offenders brought together in an intense, residential treatment program can be treated in a single group. Combining vulnerable offenders, many of whom may also have been abused, with predatory offenders who are not committed to making changes through treatment can undermine the therapeutic environment and create serious threats to the safety of some youths or to their success in treatment.

Individualized Treatment Plan / Phase System

The Individualized Treatment Plan (ITP) is commonly found in many treatment programs and is recommended in the standards for juvenile sex offender treatment (Knopp, 1985; National Task Force, 1993). As discussed in Chapter Two, common treatment objectives should be identified and incorporated into the Phase system of SOTU. In addition to these core treatment objectives, each individual should have specific objectives or an ITP for his own personal treatment needs (National Task Force, 1993). The following discussion of the Phase program creates the shell within which treatment objectives can be offered.

The overall SOTU treatment program is divided into four phases: Pre-Treatment, Phase 1, Phase 2 and Phase 3. Each Phase is intended to reinforce and support the changes that have occurred in the previous one, creating a cumulative therapeutic program that allows more intense activities to build upon understanding and trust developed in earlier Phases.

The initial phase, Pre-Treatment, focuses on learning the rules for the treatment group process, overcoming denial and accepting responsibility for sex offenses committed, and learning terminology and understanding concepts related to sex crimes, thinking errors, and risk factors. Pre-Treatment therapy is carried out through group therapy, family meetings, and individual, self-paced assignments. There are also specific educational modules associated with Pre-Treatment. At the conclusion of this phase each youth must be prepared to make a commitment to treatment goals and to sign a treatment contract. Pre-Treatment is expected to take approximately four months. The SOTU Social Worker on K wing has been experimenting with dividing the Pre-Treatment into a pre-group learning experience and a group therapy experience. In the pre-group learning experience, the youths work individually and make an initial commitment to treatment before admittance to the group therapy experience. As

originally planned, Pre-Treatment was intended to include a total of 9.5 hours of structured activities, as shown below:

- Group therapy in small groups (3 groups of 6 youths) for one hour each week
- Education modules in Communication Skills and Sex Education, for one hour each week
- Violence Interruption Process (VIP) groups for one hour each week
- Leisure Time Activity (LTA) for five hours each week
- Family groups (4 groups of 4-5 youths each) for one hour each week
- Individual counseling (1/2 hour per week for each youth)

Although the evaluation of the treatment program as implemented will be continued during the second year, the research team is aware that some elements of this program were changed early in the development process. Family groups, for example, gradually came to play a less significant role in the treatment program. In addition, it was not possible for the SOTU Social Worker to provide individual counseling on a weekly basis to every youth on her caseload.

According to the original SOTU Program Manual (Cotter, 1997), the primary goal of Phase 1 was for each youth to learn about the concept of a sexual assault cycle and to understand his individual sexual assault cycle. Treatment elements were similar to those included in Pre-Treatment. The education module in Phase 1 was supposed to be a victim empathy group. In addition, the weekly VIP group was scheduled to be phased out and replaced with a weekly Victimization Group in which youths could gain understanding of how their own sexual victimization might relate to their pattern of offending. Total structured treatment time would increase to11.5 hours a week for each youth through the addition of two hours per week of structured fitness training. Fitness training was seen as a positive physical activity that would increase youth well-being and self-esteem, reduce vulnerability, and contribute to a routine, stabilized schedule of activities.

A victim empathy group and a victimization group were established and delivered in 1997 by interns to selected program participants for a limited period of time, but neither treatment element could be continued after the departure of the intern responsible for the group. Regular "family" meetings were gradually eliminated as group therapy periods were lengthened during this period. SOTU youths continued to be involved with VIP groups to some extent during Phase 1.

During Phase 2 youth were expected to improve their understanding of the consequences of sexual offenses, learn the life factors leading to criminal behavior and develop a plan to alter dysfunctional factors in their own lives, and begin to develop ways to intervene in their own personal offense cycles. In place of the education modules and VIP groups specified in Pre-Treatment and Phase 1, treatment groups focusing on relapse prevention, sexual modification, covert desensitization, and deviant fantasy were to be developed. Total structured treatment time remained at 11.5 hours/week for each youth.

In Phase 3, the final phase, youth were expected to develop a specific plan for intervention in their personal offense cycle, exercise group leadership, and complete a relapse prevention plan. Youths in Phase 3 would also continue to participate in three specialized treatment groups in addition to the original group therapy program.

ENHANCEMENT 10: Identify the overall objectives that all participants will achieve and incorporate them into the appropriate phase. Then develop individual treatment plans (ITPs) for the other needs of the offenders. The new Program Director has begun to guide the development of this process. For example, there are several treatment needs that appear to be common to most of the juvenile sex offenders in SOTU, as evidenced by the treatment objectives listed on each resident's Treatment Objectives form. The ITP should address individualized treatment needs that differentiate from the treatment objectives common to all program participants. For a summary of the common Treatment

Objectives as listed in the files of the 17 offenders reviewed for this report, see Appendix F.

The treatment elements chosen for the shared portion of the treatment program are not explicitly supported in the literature. This is not to say they are not accurate, but rather that the research is insufficient at this time to determine if each is an effective treatment objective for each juvenile sex offender in this heterogeneous group. It would considerably enhance the research literature to begin documenting successful completion of each of these objectives. One way to do this is demonstrated in the sample form in Appendix G.

The SOTU Social Worker must have adequate time to develop and operationalize the treatment modules envisioned in the original Phase plan and to modify them as necessary to meet the treatment needs of SOTU youth. In order to complete these activities, the therapist's caseload will need to be limited, probably to about 20 youths in treatment. If it is not possible to make available the amount of time needed to develop a complete program, then SOTU should concentrate on developing programming for a specific type of offender.

Separate Treatment Setting

To provide a combined treatment and residential area separated from the remainder of the facility for the Sex Offender and Substance Abuse Treatment Units, portions of Building B at Harrisburg were dedicated to these programs. Four residential wings were established in the building: I and J wings for the Substance Abuse Treatment Units and K and L wings for the Sex Offender Treatment Units. K wing was used as the intake wing until September 1997, when the second SOTU wing was established. There are 18 individual rooms for residents on each wing, nine on each side of the dayroom, and one office for the Correctional Counselor. Shower facilities are located at one end of the wing, where the youth may be observed by security and other staff. There is a recreation room with game equipment and limited gymnasium facilities between the substance abuse wing and the sex offender wing.

Four additional classrooms were constructed on the first floor of Building B in which classes for the youths in these wings could be held, and four rooms on the upper floor were also modified to provide additional program space (IDOC, 1997). However, security concerns limit the use of these rooms for program activities. The medical and mental health staff offices are also located also on the ground floor of Building B. The cafeteria, storeroom, and commissary are located well away from Building B. SOTU youth must walk past other unit housing buildings to get to the cafeteria.

Recreation and fitness activities occur in several settings. A gymnasium with a full basketball court and weight training area is located across the exterior courtyard from Building B. General free time is available in the dayroom of the unit. Usually no more than nine of the youth are out of their rooms at a time for free time. Designated outdoor recreational areas are used for team sports such as basketball and volleyball. Structured Leisure Time Activity (LTA) occurs in a variety of settings under the supervision of an LTA Specialist. Common leisure time activities for SOTU youth include teen center activities, game tournaments, bingo, and popcorn treats.

The SOTU program is located in a building separate from the general population and SOTU youth have limited contact with other IYC-H youth. This separation helps to create a psychologically secure treatment environment where sexually explicit details can be more easily divulged and addressed in therapy. Smith (1995) emphasizes the importance of a non-threatening environment in which participants can freely share in treatment. It is necessary to examine the dynamics between residents periodically to ensure that exploitative or abusive interactions have not developed. SOTU youth are frequently reassigned to different recreation groups to break up any such patterns of interaction that may be developing, and room assignments are also changed on a less frequent basis.

Length in Treatment

There is no consensus as to how long residential treatment should continue, only that it should be for an extended period of time. The theoretical research literature supports a lengthy treatment process. According to our preliminary review to date, the few residents of SOTU that have been released have continued their treatment in other residential programs. Length of stay depends in part on the youth's probable release date. This issue will be further examined during the second year of the evaluation.

Treatment Elements

SOTU treatment modules are a work in progress. First, there was not enough time to fully develop all of the modules and phases prior to implementation. Second, juvenile sex offender treatment program development is in preliminary stages according to the literature. As previously stated, various elements must be tested to determine if they are effective with this population. As a result, juvenile sex offender programs will continue to cycle through program development, implementing new ideas, testing for effectiveness, and then refining according to the results. Many treatment providers in the fields of both sexual assault and domestic violence argue that it is desirable to continue testing a variety of treatment elements under various conditions to avoid prematurely limiting the treatment options (for example, see Chalk, 1997).

Various elements were drawn from a variety of existing programs observed by SOTU personnel, including the IDOC programs at Big Muddy, Graham, and Valley View. The elements selected by SOTU personnel were implemented and tested on the youth. Treatment components continue to be refined as the program progresses. By the end of the two year period, SOTU staff should have a clearer idea of what elements are central to the program and will be able to focus on them.

The documentation process of the treatment elements has evolved over the first year of operation. It is difficult to determine which elements have been implemented, and which elements have been identified as necessary, but not yet fully designed (see Table 5.1 for the

various treatment components). Ideally the second unit, which has recently begun operation, will adopt the program as it has evolved during the first year and implement that evolved program in the new wing. In the second year, the progression of development from initial implementation through expansion to the implemented program in the second unit can be documented.

Interviews with IYC-H personnel, both in and out of the unit, revealed that most staff do not know the nature of the treatment that is provided in SOTU. The treatment elements that were identified by at least one interviewee include the following: therapeutic community, group therapy, violence interruption, education, leisure time activities, and journaling.

RECOMMENDATION 9: Priority should be given to fully documenting the elements currently used in SOTU in the program procedures manual. The new Program Director recently requested this information from the SOTU Social Worker treatment providers. Changes in these elements should be documented as they develop (for example, evolving modifications in specific treatment elements should be identified, numbered in succession, and saved to document the process of change and revision). Established procedures, including biweekly interviews conducted by the research staff and monthly reports prepared by SOTU, document some aspects of the program but need to be supplemented with more detailed information. SOTU staff need to create a work schedule that provides adequate time for both treatment and paperwork, and then adhere to it.

Table 5.2 identifies the treatment elements and their intended frequency of occurrence as specified in the SOTU treatment manual (Cotter, 1997). The table also indicates the number of times each element was observed during the sixteen day on-site observation period. These observations confirm information gathered from interviews with staff that SOTU has not always been able to provide a consistent treatment program from week to week.

Table 5.2 SOTU treatment elements and frequency.

Element	Frequency	Observed in 16 days[1]
Sex Offender Group Therapy	2 hour / week/ group 6 youth per group	Two of the three groups observed once
Victim Empathy Group	10-11 AM on Wed.	Not observed
Family Group	Deleted element	
Sex Education	10-11 AM on Mon. or Fri. 8-9 youth per group	Not observed
Drug Intervention Group	During Phase I	One time
Violence Interruption Process (VIP)	1 hour/ week/ group 6 youth per group	Not observed
Leisure Time Activity	At least 5 hours/ week Level 1 youth	Observed sixteen times
Individual Counseling	On-going ½ hour/ week	Not directly observed
Sexual Modification Group	Phase 2 & 3 activity	Youths not in Phase 2
Relapse Prevention	Phase 2 & 3 activity	Youths not in Phase 2
Covert Desensitization	Phase 3 activity	Youths not in Phase 3
Deviant Fantasy Group	Phase 2 activity	Youths not in Phase 2

RECOMMENDATION 10: Establish a program schedule that provides the recommended treatment elements and adhere to it on a regular and consistent basis. Interviews with treatment providers indicate treatment activities are generally more effective when they occur on a regular schedule. Changes in the schedule, or the inability to conform to an established schedule, disrupt the

[1] The observer worked alternating shifts. It is possible that these events occurred on the alternate shift and the observer would not have known.

treatment program and disturb the youth and sometimes result in behavior problems during recreation or free time.

For program evaluation, it is important to document the treatment provided to each youth. For example, the SOTU manual states each youth will receive one hour of group therapy each week. As the effectiveness of treatment is evaluated during the second year of this project, the researchers will consider the way in which each treatment element is provided to the youth in the program, including the number of treatment sessions. When combined with the youth's history, this information will begin to identify which treatment works best with what types of sexual offenders. Currently, however, there is no way of knowing if the treatment envisioned in the program design actually occurs as scheduled.

RECOMMENDATION 11: Fully document the treatment provided to each youth in the program. Document each contact with each youth using a simple check list format to simplify record keeping. (See Appendix G for a sample check list form.) In addition to knowing what treatment elements are generally provided, it is important to be able to identify specifically which youths have received what treatment, how frequently, and over what period of time.

Based on data gathered through interviews, document review, and site observation, youth progress toward SOTU objectives appears to be measured subjectively by the therapist during group therapy sessions and through review of student workbooks and journals. Objectives need to be specified more clearly, and individual progress toward these objectives should be fully documented in the SOTU files. File review will occur in the second year of the evaluation.

ENHANCEMENT 11: Document the specific treatment elements and the duration of each element more completely and consistently in each youth's file. To implement this recommendation, the therapist must have a reasonable work schedule and a caseload that allows time to prepare the required paperwork.

Implementing this program enhancement involves a significant time investment, but will greatly improve the facility's ability to document and reproduce the treatment program with turnover in staff.

The specific treatment elements that are provided to each program participant must be documented if any conclusions are to be drawn regarding the effectiveness of SOTU and its ability to decrease the rate at which juvenile sex offenders reoffend. Without such documentation, IDOC will be unable to replicate the SOTU program or even to be certain that it is continuing to provide the same program from month to month. A well-documented program also provides a sound basis for program changes, which should be grounded in an awareness of what treatment elements have been used and what their results have been. From a research point of view, it is better to know what did not work than to not know what did work.

Therapeutic Community (TC)

One treatment component deserves special attention because of its central focus in the IDOC grant application. The grant proposal identified SOTU as a Therapeutic Community (TC), an approach which is based in social learning theory (Jones, 1968) and organization theory (Manning, 1989), and which is used extensively in substance abuse treatment. The TC model was designed with the intent of increasing communication between the mental health staff and the patients in psychiatric settings. According to Jones (1968), the goal was to establish two-way communication between patient and staff, and to create opportunities for decision-making at all levels of the hierarchy (i.e., doctors, nurses, operational staff, patients). IDOC indicates they currently operate TCs at IYC- Joliet, St. Charles, and Valley View (in a sex offender treatment program). The original intent was to model IYC-H as a TC also.

Therapeutic Communities (TCs) generally fit into two broad categories: TC proper and TC approach. Both have been broadly defined as "describing a variety of drug-free residential programs" (De Leon, 1986, p. 6). Each utilizes a peer hierarchy, which is not evident in SOTU. For the purposes of this evaluation, the major differences between the two categories of TCs

are that the TC proper utilizes little staff control over the residents and the TC approach is more frequently found in outpatient facilities. SOTU is a residential facility. Limited staff control is certainly not the case in this correctional setting. A TC proper requires relative isolation from others, something which is compromised at SOTU during work, schooling, dining, and outdoor movements. A TC proper is characterized by extensive training of all staff to give constant reinforcement of treatment issues, different rules for operation in terms of rewards and punishment, and frequent staff meetings. It also requires a commitment to transfer a certain amount of authority and responsibility to the youth to manage themselves. This has not been done in SOTU and may not be possible at all in the correctional setting. The medical definition of the TC, described as "any type of psychiatric disorder undergoing treatment, which utilizes large or small group settings in a democratic social organization" (Jones, 1986, p. 20), also fails to accurately describe SOTU.

One major concern in implementing a TC within a correctional setting is the opportunity for abuse of power. The correctional setting is a closed system. The juvenile correctional setting is even more restricted, because of the issues of confidentiality. The TC is also a closed system, based on peer pressure, peer role modeling, and confidentiality. There can be little supervision of its operation because "outsiders" cannot penetrate the system to determine if there is an abuse of power (See Bratter, Bratter, & Heimberg, 1986; Bullington, 1977; or Weppner, 1983 for a more complete discussion).

A second issue is that peer role modeling includes the use of a power structure within the treatment population. In a TC, the youth are structured in ways similar to that of a family. Each member has tasks and participates as part of a healthy family system. There is an internal hierarchy, which usually includes one head of household with various elder "siblings". The siblings have a higher status in the TC, have spent greater time in treatment, and have made more progress in treatment. The siblings act as the parents of the family, giving guidance, granting and denying requests, and recommending changes in behavior. There is a

fine line between this family role and the role of a person who has the formal power to punish. In many states this raises legal issues related to the possibility of one inmate supervising another inmate. In SOTU, youth have moved through the Phases as a group, which has not permitted the TC hierarchy to evolve.

In summation, SOTU does not meet any of the definitions for a TC, although it is drug free. However, the evaluation indicates that SOTU was implemented as a 'Therapeutic Environment' with some of the characteristics of a TC (such as a separate treatment setting, confrontational group therapy, and efforts to create a general environment of emotional and physical safety for divulging personal information). Research has not been conducted to determine whether the TC is an effective treatment method with adult or juvenile sex offenders, and, if so, which aspects of the TC are most important to its effectiveness. If policy makers desire to test the TC concept in this treatment program, further discussions can occur between the program staff and researchers with the aim of designing a TC model that can be implemented.

RECOMMENDATION 12: Continue to implement the Therapeutic Environment as identified in the SOTU manual. The evaluation to date suggests that selected TC components can be implemented effectively in a therapeutic environment. A TC proper would require additional SOTU staff and substantial changes in current program organization and operation.

On-Site Observation

Observed Treatment Elements

One Research Assistant observed various aspects of SOTU for sixteen consecutive days in August, 1997. The SOTU activities observed by the Research Assistant are discussed in detail below. (See Table 5.2 for a summary of the observational findings.)

Sex Offender Group Therapy. Two Sex Offender Therapy group sessions were observed. The first group observed convened in the morning and three youths were present.

The second group convened in the afternoon and was attended by five youths and one Correctional Officer.[2] Within each session, verbal and non-verbal interaction between the therapist and the individual youths were observed more frequently than verbal and non-verbal interactions among the youths. The smaller group exhibited intense interaction during the "confession" phase of the session, but the youths appeared to lose focus after that exercise and remained less attentive for the remainder of the session. The larger group included one youth who appeared unfriendly and negative, making efforts to avoid inclusion in and interaction with the treatment group. Only three interactions between this youth and the rest of the group were recorded during the session. The Correctional Officer was an active participant in the second group, although none of the youths addressed him directly.

Substance Abuse Group. One Substance Abuse Therapy group was observed. During this session, the six youths attending viewed a thirty-minute video on the effects of alcohol. All of the youths were attentive, with the exception of one who had been awakened to attend the session.

School. Four half-days of school were observed. Classes in Math, Government, U.S. Constitution test preparation, and GED test preparation were observed. Instructors used a variety of teaching methods with the youths, including group and individualized instruction, as well as videos, to facilitate learning. Substance Abuse program youths were intermixed in the classroom with SOTU youths and some social interaction between the two sets of program youths was observed. Attendance in some of the observed classrooms was particularly small, as several youth were in the Medical Unit during class time.

Leisure Time Activity. Leisure Time Activities (LTAs) are structured recreational activities for the youths, such as bingo and softball. LTAs were observed to take place each

[2] While this does not necessarily mean that only two groups were held during this time, it does mean that only two groups were held during the shifts observed.

day of the week, occurring twice on weekdays, with LTA time periods extended on Saturday and Sunday.

Free Time. The unstructured time a SOTU youth has is defined as "Free Time". SOTU youth were observed during Free Time in the dayroom, at outdoor locations, the gym, and during LTAs. A time interval sampling procedure was developed by the researchers to assist the Research Assistant in observing SOTU youths during Free Time. Each youth's behavior was observed once every 10 minutes and assessed for any of seventeen observable behaviors, such as verbal hostility. (See page D-3 for a complete listing of the behaviors.) The results of the time interval sampling observations are presented in Table 5.3. During the sixteen-day observational period, 224 ten-minute sampling intervals were recorded, with no data being collected the first day. Each SOTU youth was observed a minimum of 69 times, with some youths being observed as many as 224 times. Seventy-eight (78) percent of the Free Time observations were in the dayroom of SOTU.

Table 5.3 Activity during free time.

	Frequency of Observations	Percent	Cumulative Percent
Recreation in the Dayroom	175	78.1	78.1
Structured Outdoor Locations	29	12.9	91.1
Gym	3	1.3	92.4
LTA Activities	16	7.1	99.6
Activity not recorded	8	1	.4
TOTAL	224	100.0	100.0

Table 5.4 itemizes the types of behaviors observed during the time interval sampling for each SOTU youth. Negative behaviors included activities such as verbal hostility, negative interaction with an authority figure, and unbecoming social characteristics (e.g., sneaky or manipulative behavior). The majority of the positive behaviors included voluntary social

avoidance activities (e.g., sitting alone to listen to headsets), competitive social inclusion, and positive interaction with authority figures.

During a total of 37.3 hours of observed of Free Time, each youth was observed for an average of 20.3 hours. The 18 youths averaged 11.5 (9.4 percent) negative behaviors and 110.9 (90.6 percent) positive behaviors. Proportionately, youths tended to be more negative during Free Time activities scheduled for designated recreation areas. Most of the negative behavior was verbal hostility during competitive sports.

Table 5.4 Number of observed behaviors during free time over 16 days of observation.

Youth	Dayroom		Zone		Gym		LTA	
	+	-	+	-	+	-	+	-
1	102	9	26	2	3	0	4	0
2	75	11	26	3	1	2	4	0
3	40	2	15	3	3	0	5	0
4	84	8	23	1	3	0	4	0
5	46	3	24	0	3	0	1	0
6	106	6	27	2	0	3	9	2
7	84	7	27	2	2	1	15	1
8	64	7	19	6	2	1	4	0
9	96	12	22	7	3	0	13	0
10	70	3	24	5	3	0	13	0
11	71	15	21	8	3	0	1	0
12	103	16	28	1	3	0	16	0
13	20	1	25	2	0	3	5	0
14	111	4	24	1	1	2	16	0
15	67	7	24	2	0	3	1	0
16	98	11	26	2	2	1	5	0
17	48	11	26	2	3	0	4	0
18	77	3	28	1	1	2	1	0

This first year observation period provided a baseline for the second year observation when both treatment programs will be fully operational.

Other Components

Education

There are a number of correctional programs that are provided to the general population at IYC-H. The most important of these is education. District 428 offers classes that focus primarily on the basic educational needs of IYC-H youth, including preparation for eighth grade diplomas and the GED certificate. A smaller number of youth are working to complete classes required for a high school diploma, or to gain community college credits. Youth who have not yet completed high school or obtained a GED certificate are expected to attend school. Youth housed in Building B (both SOTU and Substance Abuse Treatment Unit) attend classes in Building B, apart from the general population. Teachers who teach there are assigned exclusively to Building B, and are aware in general terms about the special treatment programs housed there. However, the educators are not incorporated into the treatment program, and do not interact regularly with the SOTU treatment providers.

ENHANCEMENT 12: Include the education staff, including both teachers and the supervising Assistant Principal, more fully in SOTU. This could be done by including a member of the education unit in the monthly staffings for each SOTU youth, and by including education staff in SOTU staff meetings and training activities. Education is not currently viewed as an integrated element of the SOTU treatment program, although academic achievement is listed as one of the goals for SOTU youth. The teachers could be an important source of assistance in attaining treatment goals and in reinforcing behavior standards. In addition, life skills education activities could be modified or expanded to include sex offender-specific treatment activities.

Treatment programs provided to the general population often include elements that are important for juvenile sex offenders. In her study of juvenile offenders in Washington State, for example, Milloy (1994) found that similar treatment elements were often recommended for sex

offenders and for non-sex offending juveniles, including anger management, interpersonal social skills development, family counseling and academic education. IYC-H has expanded its substance abuse programming over the past few years with the goal of providing every youth with an eight week substance abuse avoidance program before their release. Treatment activities that are available to all other IYC-H youths should be integrated into the overall SOTU treatment program wherever possible. However, to maintain continuity and program integrity, treatment professionals providing these programs should be aware of the specific goals that SOTU youth have agreed to work toward. Particularly, when SOTU youth are receiving programming apart from other IYC-H youths, treatment providers can reinforce the standards of behavior and responsibility that are expected within SOTU.

Chapter VI: Recommendations

Introduction

The first goal of this interim report was to document and discuss the preliminary assessment of the implementation process of SOTU by placing it in context of the research literature and the correctional setting to provide guidance to IYC-H personnel for enhancing the program based on state-of-the-art research results. The second goal was to provide preliminary review of the factors necessary to develop a manual describing the process of implementing a sex offender treatment program in a correctional setting. During the program evaluation process, the research team identified three areas of interest on which to comment; compliments, recommendations, and enhancements. Each of these was recorded in Chapters Four and Five in context. The following list restates and categorizes the concepts.

First, the research team would like to recognize two particularly positive achievements.

Compliments

- Goals and objectives adopted by the grant and SOTU are similar to those recognized in the research literature and adopted in other treatment programs.
- The research team recognizes that the SOTU Social Worker hired to develop the SOTU goals and objectives and to provide individual and group therapy has done a remarkable job of designing and implementing a treatment program that incorporates a wide range of broadly accepted elements and approaches for the treatment of sex offenders. She researched available treatment elements, modified them for implementation in the IYC-H setting, and brought them together into a series of coherent modules. Interviews consistently indicated that she gathered extensive materials and generated a great deal of enthusiasm on the part of both professional staff and line personnel in the facility.

Second, the research team offers the following 10 recommendations categorized into three groups: Treatment Environment, Program Administration, and Staffing Issues.

Recommendations

Treatment Environment

- SOTU has an unusual opportunity to revisit the grant program and reach agreement on common goals and objectives because of the recent changes in key personnel (see Recommendation 1).
- Clarify the VIP position's responsibility for individual counseling and integrate any such responsibilities with the existing treatment programs on the SOTU (see Recommendation 3).
- Create a method of holding the youth accountable for inappropriate treatment behavior (e.g., a youth may behave in a way that is not beneficial to treatment, but the behavior is not sufficiently inappropriate to warrant the loss of points) (see Recommendation 7).
- Create a *workable* schedule and adhere to it (see Recommendation 10).
- Document each contact with each youth in a simple check list format (see Appendix G for a sample form) (see Recommendation 11).
- Continue to implement the therapeutic environment as identified in the SOTU manual. The evaluation to date suggests that selected TC components can be implemented effectively in a Therapeutic Environment. A TC proper would require additional SOTU staff and substantial changes in current program organization and operation (see Recommendation 12).

Program Administration

- Where it is difficult to attract applicants with specific preferred experience and/or expertise, plan to provide training in treatment areas to build the necessary skills and develop expertise. Encourage the growth and development of a treatment team approach that involves the Program Manager in the design of program materials and the delivery of treatment in both treatment units (see Recommendation 2).

- ❖ Identify and, if necessary, provide training for another mental health professional to provide crisis response and treatment to sex offenders who are not assigned to the SOTU (see Recommendation 5).
- ❖ Priority should be given to fully document the elements used in the program and to document changes as they develop. Established procedures, including biweekly interviews conducted by the research staff and the monthly reports prepared by SOTU, document some aspects of the program but need to be supplemented with more detailed information (see Recommendation 9).

Staffing Issues

- ❖ Continue the policy of selecting personnel for regular security staff assignments on both SOTU wings from volunteers, and extend it to include replacement staff as much as possible (see Recommendation 4).
- ❖ Add a module to the annual cycle training of staff about the SOTU and its treatment modality, required for all employees at IYC-H. Expand the training on SOTU available to staff, in order to increase institutional awareness of the program (see Recommendation 6).
- ❖ Training should be provided to selected interns and on-site employees to ensure that assessment tests and screening instruments selected for use are administered in a consistent and reliable manner (see Recommendation 8).

Finally, the research team members offer the following suggestions for program enhancements.

Enhancements

Treatment Environment

- ❖ The involvement of the Correctional Counselor II in the therapeutic and treatment activities of the SOTU should be encouraged and supported where possible. Close cooperation between the SOTU Social Worker and the Correctional Counselor is an essential aspect of

the proposed continuum of care that connects the IYC-H and the CCJPD (see Enhancement 2).

- To more fully develop an intensive treatment environment, it would be helpful to train and increase the involvement of the security staff as treatment providers in the role of surrogate parents or alternative positive role models (see Enhancement 5).
- More fully include the education staff in the program (e.g., monthly staffing for each youth). The educational staff could prove to be an important source of assistance in attaining treatment goals, particularly through life skills education (see Enhancement 6).
- Connect the existing disciplinary point system to the treatment provided through SOTU. Encouragement to attend to the treatment may increase treatment cooperation (see Enhancement 9).

Program Administration

- Provide more budget information through the Program Manager to SOTU staff, so that they have a realistic sense of what can be supported and can plan to seek training accordingly (see Enhancement 7).
- Design the overall objectives that all participants will achieve. Then develop ITPs for the other needs. For example, there may be 13 characteristics that appear to be common to many juvenile sex offenders, as evidenced by the 13 treatment objectives on IYC-H's Treatment Recommendations Form or 5 characteristics as evidenced by SOTU program manual. The ITP would then address the individualized needs that deviate from the 13 or 5 common characteristics (see Enhancement 10).
- Document the specific treatment elements and the duration of each element more completely and consistently in each youth's file (see Enhancement 11).

Staffing Issues

- Build morale within the SOTU by recognizing the accomplishments of staff and giving appropriate credit. The SOTU Social Worker developed the treatment program that is

currently being offered with little assistance or feedback from her supervisor. Based on information received to date, the current Program Manager will acknowledge the primary role of the SOTU Social Worker in creating the program while serving as an active advocate for the program, which should have a very positive effect (see Enhancement 1).

- Provide additional VIP training to increase the employees' ability to develop treatment modules and train others in their delivery (see Enhancement 3).
- Explore the possibility of longer-term assignments of support staff to special treatment units (see Enhancement 4).
- Increase support for additional training for SOTU staff that focuses specifically on treatment needs and programs for juvenile sex offenders (see Enhancement 8).
- Include the education staff, including both teachers and the supervising Assistant Principal, more fully in SOTU. This could be done by including a member of the education unit in the monthly staffings for each SOTU youth, and by including education staff in SOTU staff meetings and training activities (see Enhancement 12).

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Appendices

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An Evaluation of the Illinois Department of Corrections' Juvenile Division Special Supervision Units Program; Sex Offender Treatment Unit

INFORMATION AND CONSENT FORM

The Center for Legal Studies of the University of Illinois at Springfield is conducting a study sponsored by the Illinois Criminal Justice Information Authority (ICJIA). ICJIA is interested in evaluating the two components, Sex Offender Treatment Unit at IYC-H and Cook County Juvenile Parole District, while they are still relatively new, to learn how their implementation is proceeding and to discover the impact of these programs on the offenders and the criminal justice systems in these two areas. It is hoped that this evaluation will provide information to program administrators and staff that will help improve the programs and allow them to work more effectively.

As part of the information gathering process for this study, we are interviewing many individuals such as yourself who are involved with these programs. Our purpose is to gather impressions of the programs from a variety of people involved with different aspects of the programs to help us better understand how they work. If you are willing to participate, we would like to ask questions designed to gather this information. The interview will take approximately one hour. All information that you provide will be strictly confidential. All findings summarized for report purposes will be written so that no one's answers or name can be identified. The information you provide will be used for research purposes only and no one outside the study project will have access to the information that you are providing. If you have questions concerning this research, you may contact Dr. Cindy Smith or Dr. Barbara Hayler of the Center for Legal Studies, University of Illinois at Springfield: (217) 786-6097.

You should understand that taking part in this interview is purely voluntary. There will be no consequences if you decide you do not want to participate. This research project has been reviewed and approved by the UIS Institutional Review Board. Dr. Harry Berman can answer questions about your rights as a research subject. He can be reached at 217-786-7411.

My signature below shows that I have read the above, and that I consent to take part in this study under the conditions presented.

_____ _____

Signature Date

_____ _____

Witness Date

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Interview Protocol

Interviewer _____ Notetaker _____

Date_____

Control Number _____

Name of Person Interview: _____

Position: _____

Office or Department: _____

Program Association

1. What is your association with the Sex Offender Treatment Unit?
2. When did your association with the Sex Offender Treatment Unit begin?

Personnel Resources

3. Can you describe how you got into this type of work -- with sex offenders?
4. Sketch out your credentials and your career history.
5. Do you have any special training or credentials that assist you in working with this population?
6. Who pays for your special training?
7. When was your last training seminar?
8. How does your interaction with the Sex Offenders differ from other correctional programs you've been a part of?
9. What is your perception of administration? How are decision made? By whom? How is new information regarding decisions disseminated?
10. Is there an administrative presence with the staff and juveniles?

11. What is the level of administration's commitment and involvement in the program?

12. Is the staffing of SOTU adequate?

13. Before SOTU, what was the ratio of _____ (insert the type of personnel you are speaking with) to the juveniles?

14. Before SOTU, what was the caseload size for primary case managers?

15. What, if any, community resources were used for the DOC clients?

Resources	Number of clients served

Program

16. What do you do with the sex offenders? What is the composition of your program/interaction with them? For example: What do you do with behavior/discipline problems?

17. What is the type of interaction you use with the offenders? Rank from most often used to least often.

_____ individual

_____ small group

_____ large group

_____ lecture

_____ peer tutoring

18. Is there a type you NEVER use? Why?

19. Do you teach life skills? How?

20. Do you have attendance problems? *Yes* *No* If yes, what sort?

Testing

21. Do you administer any testing to the Sex Offenders? *Yes* *No*

22. Do you administer the same tests to all Sex Offenders? *Yes* *No* If no, why not?

23. Are these tests different from those administered by others? *Yes* *No*

24. How were these tests chosen?

25. Where are the test results maintained? *Program files* *Master Files* *Other:*_____

26. Do you give the same tests to substance abusers? *Yes* *No* If no, why not?

Sex Offender Treatment Program Issues

27. Do you know when the special Sex Offender program began? *Yes* *No* If Yes, when?

28. Describe any significant events or circumstances that occurred as SOTU was being developed? (*create a timeline with the interviewee)*

29. Describe the original purpose/goals of SOTU.

30. Describe any changes in the original purpose/goals of SOTU since inception.

31. Describe the mission of SOTU.

32. Describe any changes to the mission since inception.

33. Describe the program elements or components of SOTU.

34. In your opinion, has the programmed changed or evolved since inception? *Yes* *No* How?

35. Have you observed any changes in the sex offenders since the program's inception? Please explain. (Be sure they cover changes in the following topics; but DO NOT limit them to these.)

_____ educational

_____ self-esteem

_____ conflict resolution

_____ acceptance of responsibility

_____ victim impact

_____ empathy

_____ impulsiveness

36. Is there a sex offender that sticks out in your mind as being different from the others? *Yes* *No*

Why?

37. Other than Valley View, was there a pre-existing program for sex offenders? *Yes* *No* If yes, where? _____ How long? _____ How many offenders did it service per year? ____ What was it's function? _____

38. How were sex offenders identified/processed prior to SOTU?

39. Define or give a general description of the program. (*Include length of stay; requirements for continuation in the program; treatment goals-tailored to individual?*

40. *Treatment elements - different groups etc.; treatment planning - when begin - who is involved in planning.)*

Communication

41. Describe your relationship with security staff:

42. Describe your relationship with mental health staff.

43. Describe your relationship with teaching staff

44. Is this different than you have experienced in other institutions? *Yes* *No* Why?

45. Do you receive all the information you need from other staff within the institution to make the decisions you are required to make about your client population? *Yes* *No*

If no, does it affect program activity? *Yes* *No* *How?*

If no, does it affect goal accomplishment? *Yes* *No* *How?*

46. Do you receive the information you need In a timely manner? *Yes* *No*

47. What type of information do you receive?

48. How do you resolve disagreements about any decision relating to an offender between you and other staff?

49. Have any disagreements or conflicts affected program activity? *Yes* *No* If yes, how? When?

50. Have any disagreements or conflicts affected goal accomplishment? *Yes* *No* If yes, how? When?

51. If you have suggestions regarding a client, is there a forum in which your concerns can be heard and responded to? *Yes* *No*

    If no, does it affect program activity?

    If no, does it affect goal accomplishment?

52. Assess the level of availability and openness of other decision-makers (id who) to new ideas, suggestions, criticisms, conflict...?

53. How does this affect program activity?

54. How does this affect goal accomplishment?

55. Describe the level of cooperation between you and security staff.

56. Describe the level of cooperation between you and mental health.

57. Describe the level of cooperation between you and school staff.

58. Since program inception, has the level of cooperation between you and security staff changed? *Yes* *No* How?

59. Since program inception, has the level of cooperation between you and mental health staff changed? *Yes* *No* How?

60. Since program inception, has the level of cooperation between you and school staff changed? *Yes* *No* How?

61. Do you have any inter-agency agreements? *Yes* *No* If yes, do you have any problems with them? *Yes* *No*

62. What is the process of transferring records when an offender leaves?

63. Have you had any interaction with CCJPD? *Yes* *No* What is the nature of that interaction?

64. Have you had any interaction with St. Charles? *Yes* *No* What is the nature of that interaction?

Implementation Process Results

65. What kinds of things would you like to see added to the your program/interaction that aren't currently being offered or done?

66. What kinds of things would you like to see deleted from your program/interaction that are currently being offered or done?

67. If you were to implement a SOTU program in another facility, how would you provide for better use of resources?

68. Is there anything you would like to tell us that we failed to ask?

Thank you for giving us your time. We certainly appreciate it.

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Teacher's Interview Protocol

Interviewer _____ Notetaker _____

Date_____

Control Number _____

Name of Person Interview: _____

Position: _____

Office or Department: _____

Program Association

1. What is your association with the Sex Offender Treatment Unit? *Teacher* *Other*_____
2. When did your association with the Sex Offender Treatment Unit begin?
3. I understand that a group of you were brought in at the same time. Has this made a difference?
4. When will you be leaving?
5. What will happen to the students when you leave?

Personnel Resources

6. Can you describe how you got into this type of teaching -- with DOC ?
7. Sketch out your credentials and your career history.
8. Do you have any special teacher training or credentials that assist you in teaching this population?

Educational Program

9. What is the teacher/student ratio in the class?

10. Is your staffing adequate?

11. What is the type of instruction used. Rank from most often used to least often.

_____ individual

_____ small group

_____ large group

_____ lecture

_____ peer tutoring

12. Is there a type you NEVER use? _____ Why?

13. What courses do you teach?

14. Do you teach life skills?

15. Do you have attendance problems? Yes No If yes, what sort?

16. How does the Education/School Program for Sex Offenders differ from other school programs you've been a part of?

17. What is the composition of the educational program? For example: What do you do with:

- identified special education students?
- unidentified students who need help or referred to special education?
- behavior/discipline problems?
- remedial level versus grade level?

Testing

18. What testing is given by you to your Sex Offender students?

19. Do you administer the same tests to all Sex Offender students? *Yes* *No* If no, why not?

20. Are these different from those received by others? *Yes* *No* How were these tests chosen?

21. Where are the test results maintained? *Program files* *Master files* *Other :* _____

22. Do you give the same tests to substance abusers? *Yes* *No* If no, why not?

Sex Offender Treatment Program Issues

23. Do you know when the special Sex Offender program began?

24. Describe the original purpose/goals of SOTU.

25. Describe the program elements or components of SOTU.

26. In your opinion, has the programmed changed or evolved since inception? *Yes* *No* How?

27. Have you observed any changes in these students since the program inception? Please explain. (Be sure they cover the following topic; but DO NOT limit them to these).

- educational
- self-esteem
- conflict resolution
- acceptance of responsibility
- victim impact
- empathy
- impulsiveness

28. Is there a student that sticks out in your mind as being different from the others? *Yes* *No* Why?

Communication

29. Describe your relationship with security staff:

30. Describe your relationship with mental health staff.

31. Describe your relationship with other teaching staff

32. Is this different than you have experience in other institutions? *Yes* *No* Why?

33. Do you receive the information you need? *Yes* *No* From whom?

34. Do you receive the information you need in a timely manner? *Yes* *No*

35. What type of information do you receive?

36. Describe the level of cooperation between you and security staff.

37. Describe the level of cooperation between you and mental health.

38. Describe the level of cooperation between you and other school staff.

39. Since program inception, has the level of cooperation between you and security staff changed? *Yes* *No* How?

40. Since program inception, has the level of cooperation between you and mental health staff changed? *Yes* *No* How?

41. Since program inception, has the level of cooperation between you and school staff changed? *Yes* *No* How?

42. Do you have any inter-agency agreements? *Yes* *No* If yes, do you have any problems with them?

43. What is the process of transferring records when students leave?

Implementation Process Results

44. What kinds of things would you like to see added to the school program that are not currently being offered or done?

45. If you were to implement a SOTU program in another facility, how would you provide for better use of resources?

46. Is there anything you would like to tell us that we failed to ask?

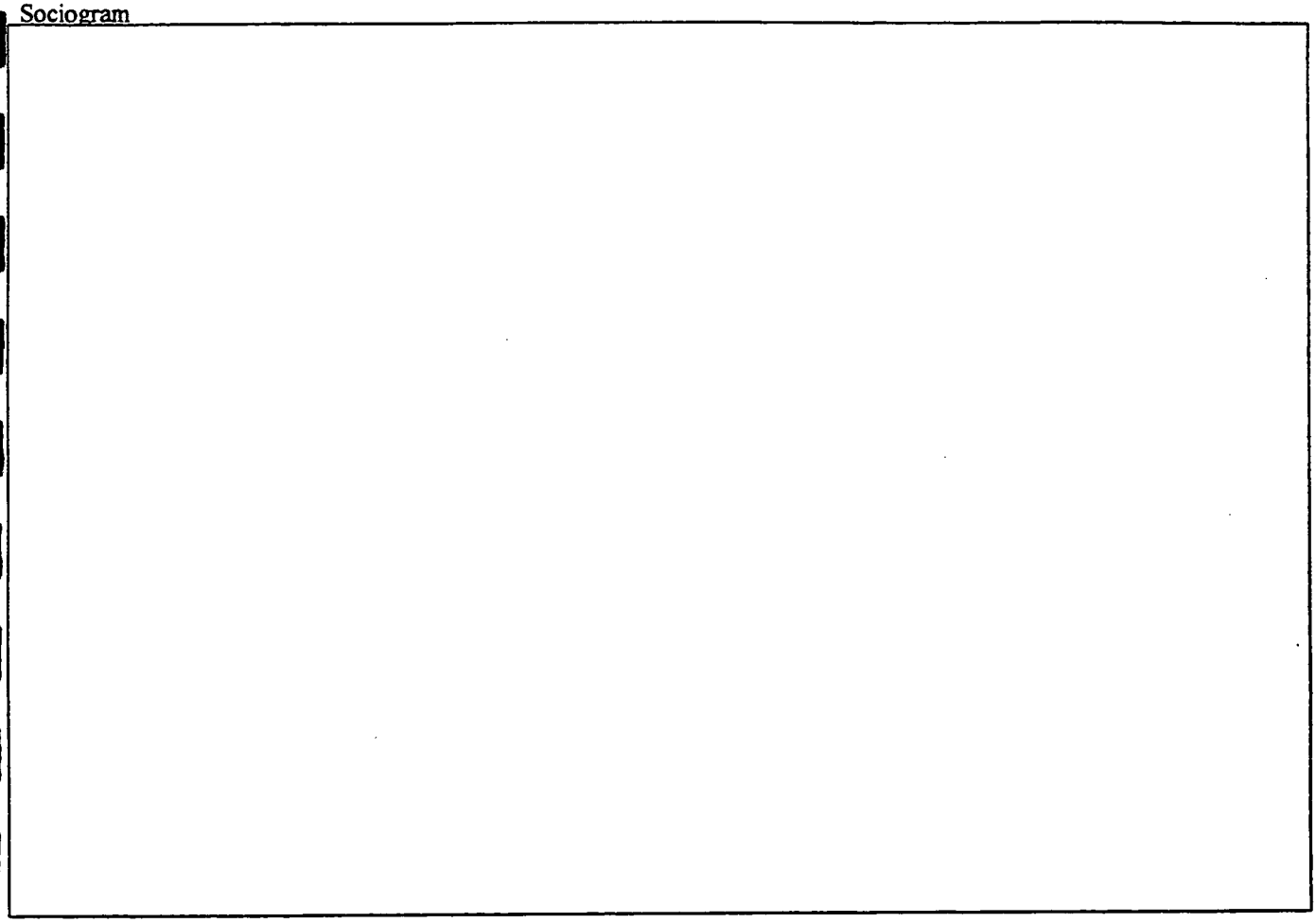
Thank you for giving us your time. We certainly appreciate it.

Group Data Collection Form for Harrisburg Facility

Date:_____ Official Starting Time:_____ Actual Starting Time:_____

Official End Time:_____ Actual End Time:_____ Unit:_____

Sociogram



Narrative:

Issue(s):

_____

_____

_____

_____

Who the Leader Focused On and Why:

_____

_____

_____

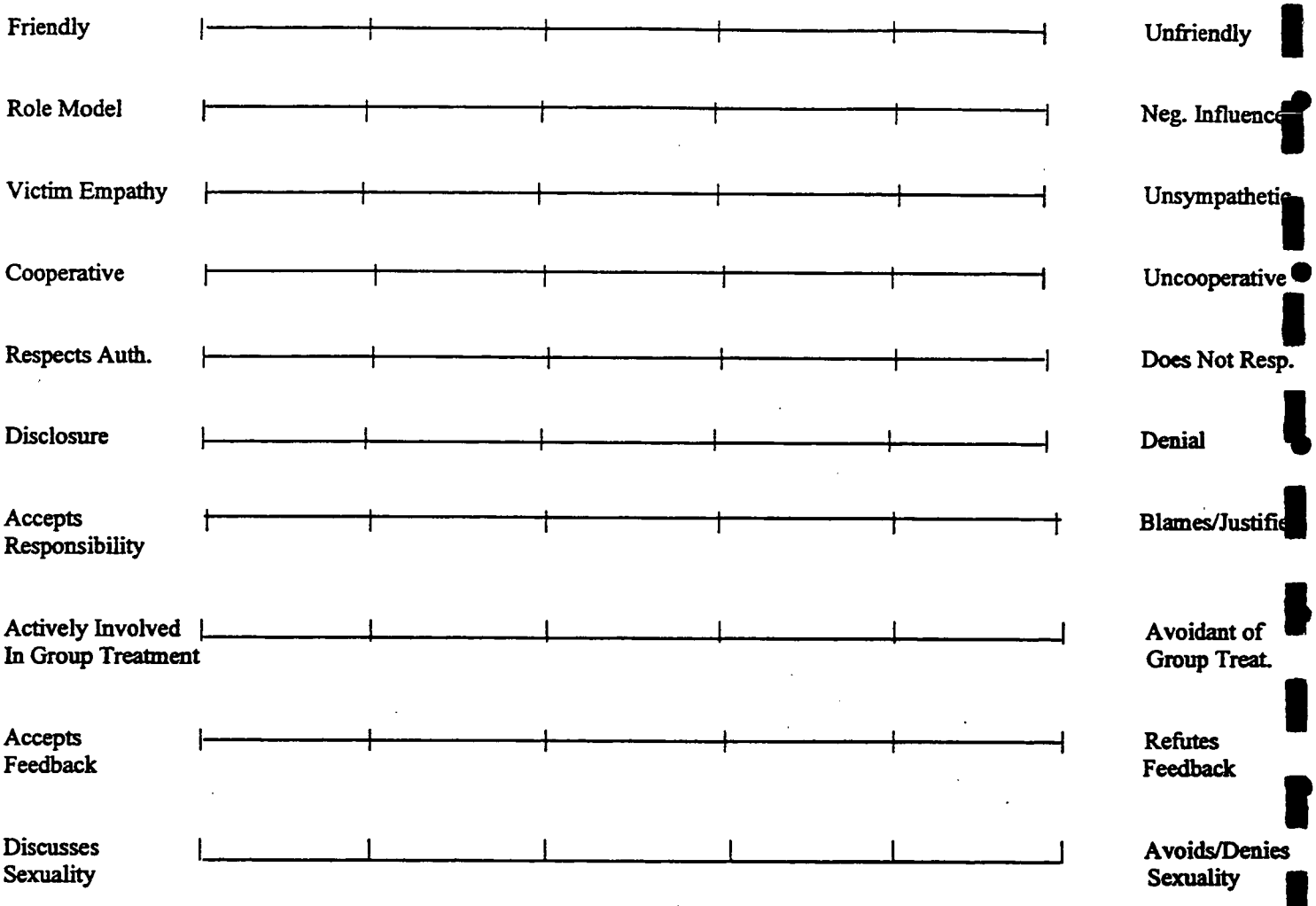
Other Narrative:

_____

_____

Likert Measurement

Measurement of Individual Behavior Through Group Therapy



Questions and or Additional Comments While Observing:

Date: _____ Official Start Time: _____ Actual Start Time: _____

Official End Time: _____ Actual End Time: _____ Unit: _____

Leisure Time Activity Time Series Data Collection Form for the Illinois Youth Center at Harrisburg

Subject	1	2	3	4	5	6
I. Verbal: Hostile						
Appropriate Expression of Anger						
Aggression						
II. Physical Hostility						
III. Social Avoidance: Voluntary						
Rejection						
IV. Social Inclusion : Competitive						
V. Interaction With Auth. Firg.: Positive						
Negative						
VI. Sexual Behavior: Alone						
Partner						
VII. Verbal Sexual Behavior: Comments						
Flirtation						
VIII. Social Char.: Sneaky						
Manipulative						
Risk Taking						
Projecting Blame						

Coding Key:

Y = yes
N = not observed
X = unable to observe
# = subject of interaction

Leisure Time Activity Time Series Data Collection Form for the Illinois Youth Center at Harrisburg cont.

Subject	7	8	9	10	11	12
I. Verbal: Hostile						
Appropriate Expression of Anger						
Aggression						
II. Physical Hostility						
III. Social Avoidance: Voluntary						
Rejection						
IV. Social Inclusion : Competitive						
V. Interaction With Auth. Firg.: Positive						
Negative						
VI. Sexual Behavior: Alone						
Partner						
VII. Verbal Sexual Behavior: Comments						
Flirtation						
VIII. Social Char.: Sneaky						
Manipulative						
Risk Taking						
Projecting Blame						

Coding Key:

Y = yes
N = no
X = unable to observe
# = subject of interaction

Leisure Time Activity Time Series Data Collection Form for the Illinois Youth Center at Harrisburg cont.

Subject	13	14	15	16	17	18
I. Verbal: Hostile						
Appropriate Expression of Anger						
Aggression						
II. Physical Hostility						
III. Social Avoidance: Voluntary						
Rejection						
IV. Social Inclusion : Competitive						
V. Interaction With Auth. Firg.: Positive						
Negative						
VI. Sexual Behavior: Alone						
Partner						
VII. Verbal Sexual Behavior: Comments						
Flirtation						
VIII. Social Char.: Sneaky						
Manipulative						
Risk Taking						
Projecting Blame						

Coding Key:

Y = yes
N = no
X = unable to observe
# = subject of interaction

General Data Collection Form for Harrisburg Facility

Date:_____ Type:_____ Official Starting Time:_____ Actual Starting Time:_____

Official End Time:_____ Actual End Time:_____ Unit:_____

Sociogram

Narrative:

IDOC Treatment Objectives Established for IYC-H SOTU Youth

1.	Acknowledge and accept responsibility for complete sexual abuse/assault history.	15
	a. Take one-hundred percent responsibility for his sexual offenses.	1
2.	Develop knowledge and understanding of human sexuality, including own arousal patterns.	15
3.	Identify general and specific thinking errors and correct them.	1
	a. Learn to identify and correct general and specific thinking errors.	3
	b. Identify and correct general and specific thinking errors.	11
	c. Learn basic concepts of sexual abuse and relapse prevention.	1
4.	Learn to identify feeling states and respond with healthy behaviors.	12
5.	Gain understanding of how sexual abuse/assault negatively impacts victims and develop empathy for own victims.	10
	a. Gain understanding of how sexual abuse/assault negatively impacts victims and develop empathy for people he victimized.	2
	b. Gain understanding of how sexual abuse/assault negatively impacts victims and develop empathy.	2
	c. Work towards developing empathy for other people- especially people he has victimized.	1
6.	Develop healthy social relationships.	4
7.	Cooperate in learning social skills with assigned intern (including to be patient).	1
	a. Develop skills necessary to control/modify his abusive behavior.	1
8.	Address father/family issues related to grief and abandonment.	1
9.	Participate in the IYC-H Sex Offender Program.	1
	a. Actively participate in and complete the sex offender program.	1
10.	Address substance abuse issues.	1
11.	Explore dysfunctional family issues.	1
12.	Assist in a positive adjustment to this facility.	1
13.	To increase self-esteem.	1
14.	Participate in the IYC-H Sex offender program.	

PHASE I

Name _____ **IYC-H**

IDOC# _____ **ENTRY DATE** **SOTU**
To:

Phase I

Unit **K** **L** **A**

Program Components	Time (hrs.)											
SO Group therapy	1/wk											
Education Module 1	1/wk											
Education Module II												
Education Mod												
Substance A												
VIP												
Family Gro												
Individual Counseli	our											
Leisure Ti tivity	wk											
Fitness Ac	2/wk											
Victimization	½ hour											

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